COMMUNITY HEALTH CELL
326, V Main, I Block
Koramangala
Bangalore-560034
India

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FUNCTIONAL CLASSIFICATION OF DISEASES

N.H. Antia

Classification of diseases is necessary for diagnosis as well as treatment. While diagnosis must theoretically precede treatment, in the majority of cases when the patient first presents her / himself, treatment is chiefly on a symptomatic basis after eliminating any serious condition posing an immediate threat to life or limb. Else the diagnosis is self-evident and can be treated on the basis of simple clinical examination.

This approach is not only cost effective in time and expense for both the patient as well as the doctor, but it also avoids unnecessary investigation. What most patients need at this stage is assurance and information, as to when and how to seek additional advice and/or treatment, in the unlikely event of this being a prodromal symptom or sign of a more significant disease. In actual practice, waiting and watching is one of the most important tools in the medical armamentarium.

Graded Facilities: optimising health care

The degree of confidence with which an ailment can and should be diagnosed or managed depends not only on the skill of the physician but also on the disease itself. It also depends on the individual and national resources, which may be the predominant factor in countries where the overall health manpower, the public and the personal resources are limited or scarce. This constraint also operates among the poor sections in affluent countries where health services in the public sector are restricted. Even in a country like Britain, with a tradition of good health care in the public sector which is available to all its citizens, the burgeoning cost of health care necessitates that the utilization of available medical manpower and resources be optimized. This has been achieved by encouraging self-care and the use of paramedics and nurses, for help in the home as well as in general practice and in hospitals. This relieves the load on the more expensive general practitioner and much more expensive hospital and specialist services. Expensive investigations and services are also rationed.

Such an appropriately graded form of health care is not only cost-effective, but is generally more acceptable to the patient. This is because it is more readily available and permits intimate interaction and caring, so often lost in the increasingly technologically oriented medicine. While desirable in a country like Britain, there is no alternative to such a graded system of care in a country like India, if health care is to reach the majority of our people who are dispersed in the 600,000 villages. The proliferation of allopathic doctors from 59,338 to over 3,00,000 since 1947 has failed to solve the problem of the control of communicable diseases. These are still responsible for the major mortality and morbidity load on our people. We have a plethora of public and private medical practitioners and specialists in the cities and towns. But 70% of the population which lives in rural areas does not have access even to the most elementary form of health care. The current medical education, which has tried to imitate the latest technology trends of the West, is steeped in the diagnostic approach, based on pathology. In actual practice, because of the absence of even the elementary facilities for investigation in most situations, a dangerous blunderbuss type of symptomatic medicine is the rule.

It is hence necessary to evolve a more functional classification whereby diseases are classified not according to their pathology, but according to the varying levels of skills and facilities needed for their diagnosis, management and care. Experience in health care projects, such as our own at Mandwa, has demonstrated the advantages of differentiating diseases by utilizing a more practical and functional approach. In this approach diseases are classified not according to pathology but also more according to the knowledge, skills and facilities required for their diagnosis, treatment, prevention and control.

The Categories of Diseases

Broadly speaking, diseases can be grouped in the following five categories:

Dr. N. H. Antia is the Director, Foundation for Research in Community Health, Bombay and Pune.

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Category A:— A PHC study by the National Institute of Mental Health and Neuroscience revealed that 25% of all the attendance at a PHC comprised of psychosomatic problems which needed understanding and explanation rather than a pill or an injection.

Category B:— These comprise of simple, self-limiting diseases which can be adequately handled by the individual and/or the family, eg. minor coughs, colds, diarrhoeas, bodyaches, headaches, cuts, bruises, boils, minor allergies and a host of everyday conditions. Both the diagnostic as well as the treatment skills are known to most families and the community, who can manage by utilizing home and folk remedies and/or some cheap and safe over-the-counter drug like aspirin.

Category C:— These are diseases which are not life threatening but are nevertheless responsible for a substantial part of the community's morbidity load, such as scabies, worms, moderately severe diarrhoea, dysentery, acute tracheo-bronchitis, moderately severe cuts, bruises, abdominal colic, osteoarthritis, chronic dermatosis, common fever and chronic obstructive pulmonary disease. They can be adequately diagnosed and looked after by a properly trained paramedical worker with a modest repertoire of safe but effective drugs. Even more important than the drugs is the advice for the management of diseases eg. ORT, steam inhalation, application of sulphur ointment or benzyl benzoate. Such advice would be more appropriate than that by a doctor, because of the physical and cultural proximity of those workers to the people, as well as the low cost of such an approach.

Category D:— This category comprises of diseases like severe gastroenteritis and dysentery, acute respiratory tract infection, tuberculosis, tetanus, leprosy, malaria, poliomyelitis, measles, pneumonitis, rheumatic heart disease and sexually transmitted diseases.

They are the major killers and maimers in the tropics today despite the fact that we have effective knowledge and means for their prevention, treatment and control. The knowledge and technology for this is remarkably simple, cheap, effective, and safe. Yet the medical profession has revealed its inability to control these diseases despite monopolizing health care services. Experiments such as at Mandwa, Banaswari and Jamkhed have revealed that even these diseases can be effectively tackled by the people themselves in conjunction with their paramedical workers. The problem therefore lies not in the inadequacy or non-availability of medical science and technology, but in the inability to reach it to the people through the over-professionalized and over-bureaucratised health system in both the public as well as the private sectors.

Four decades of experience under the prevailing conditions dictates that this can only be attained through the community's own efforts closely supported by community-based paramedical workers, who, in turn, must be taught and supported by the medical profession and the health services. Withholding this simple and readily available knowledge and technology merely because of the dangerous consequences of these diseases (especially if not diagnosed and treated in the early stages) and a few untoward reactions to drugs, has proved counter-productive.

Many of these diseases can be prevented by attending to nutrition, environment, water and sanitation besides the immunization of the high risk groups within the community. Even diseases like tuberculosis and leprosy can be readily suspected by trained community health workers and paramedics and referred to the doctor for confirmation of diagnosis. The prescribed treatment regimen can be given and supervised by the local workers. The patient can then be referred back only for an occasional check-up, or if any of the well-known complications of the disease or untoward effects of treatment arise. Others, especially in situations where medical help is not available, can be treated by trained community workers with short courses of drugs like chloroquine, enteroquinone, sulphonamides, metronidazole, aminophylline or oral penicillin and can be referred only if the seriousness of the condition so warrants. The role of the medical profession must be of a guiding, encouraging and supportive nature not appropriative. Professionals, however highly trained, have clearly demonstrated their inability to achieve the desired result. It is often difficult for the profession to understand this in view of the impersonalized and curative nature of present day medical education and practice.

Category E:— Comprises of those high profile but relatively few conditions which need skills and facilities that can be provided only by the medical profession and the hospital. These include major medical and surgical problems and emergencies which are beyond the scope of the paramedical worker who can nevertheless be taught to provide adequate first aid before referral, follow-up and after care. Early diagnosis by such workers, as for cancer, tuberculosis and leprosy, can greatly reduce the load and expenses for the treatment of an advanced disease as often seen in our hospitals. This would also be far more humane, as far as the patient is concerned.

It is understood that in a few cases in each category, the severity of the diseases may increase and upgrade it to the next higher category or categories. A holding period of 48 or 72 hours is generally indicated following which, persistence or exaggeration of symptoms indicates referral to the next level of care. The paramedical workers can be taught the signs and symptoms of a few diseases / problems like meningitis and abdominal pain or injury where immediate referral is necessary, when in doubt.

The Rationale for this Classification

Such a classification may seem to smack of over-simplication and even dangerous practice to those who work in countries where quality medical services are readily available to all. Yet a similar attitude by the medical profession in countries where even elementary medical services are inaccessible to most has been extremely counter-productive because it denies available medical knowledge and technology to the majority of the people. This approach also leaves relatively few problems requiring greater knowledge, skills and facilities for the

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Some Issues in the Community Participation in Health Care Services

A Review Paper Prepared for the
ICSSR-ICMR Joint Panel on Health, Dec. 1990.
Dr. Amar Jesani with Ms Shilpi Ganguly.

Pages: 30, Price: Rs. 25/-, Postage: Rs. 8/-

This Paper examines in detail the concept of Community Participation (CP). CP is now thought to be a pre-condition for succesful provision of primary health care as the government health system has failed to reach a large proportion of the population. Innovative experimentation by NGOs and the role of the *Panchayats* in the promotion of CP are discussed. Finally the report stresses that the participatory process remains an empty shell if it does not bring about redistribution of power and resources.

CANADA

Sonya Gill

This is the sixth article in the series, "Health Financing and Costs: comparative perspectives". (No.1 - Japan; No.2 - Zambia; No.3 - China; No.4 - Brazil; No.5 - Sri Lanka).

Canada's system of universal medical and hospital insurance, known as Medicare, has guaranteed every Canadian equal access to high quality health care. The Canadian model of national insurance departs from both the National Health System of Britain and the social insurance systems of other OECD countries. Medical care in Canada is provided by private (though not-for-profit) facilities which are paid from general tax revenues by department of Health of the different provinces. This model is uniquely adapted to the loose federal policy of Canada wherein the provision of health services is the responsibility of the provincial governments but funding is shared by the centre, which also enforces a uniform health policy framework.

Health Status

Canada, with a population of 26 million (1989) has achieved favourable levels of health status. It ranks after Japan and Sweden in its life expectancy rate at birth (72 years and 80 years, for males and females respectively) and infant mortality rate (8 per 1000 live births) (Table 1). Maternal mortality has declined from 45 per 100,000 live births in 1960 to 1/100,000 in 1986. As in other industrialised countries, ischaemic heart diseases, cancers and accidents account for 60% of adult mortality. Similarly Canada is also experiencing a general ageing of its population. However the birth rate of 15 per 1000 population in 1985 is high for a western society, and coupled with low IMR, the rate of natural increase is substantial.

TABLE I
HEALTH STATUS

YEAR	CRUDE BIRTH RATE (PER 1000 POPULATION)	CRUDE DEATH RATE (PER 1000 POPULATION)	MORTALITY RATE INFANT PER 1000 BIRTHS	MORTALITY RATE MATERNAL PER 100000 BIRTHS	LIFE EXPECTANCY AT BIRTH (YEARS)
1960	26.7	7.8	27.3	45.0	71
1985	15.0	7.0	8.0	1.0	76

Source : United Nations, World Tables Vol. II, 1983 and 1989-90 editions.

The author was co-researcher in the above FRCH study. She is presently involved in revising and editing the forthcoming updated volume of "Health Status of the Indian People".

Medicare : A federal - provincial system of public reimbursement

A series of separate, provincially administered, insurance plans form the core of the Canadian Health System. These are operated or supervised by the provincial health departments. The role of the federal government, however, has been substantial, as it sets certain terms and conditions which provinces have to comply with in order to qualify for federal funds. These national standards have ensured that health care is available to all as a right and there are no income-related barriers to access. The provincial plans must be universal rather than selectively covering certain groups as in the USA; comprehensive (covering all "medically necessary procedures"); accessible, which in the 1984 Canada Health Act was classified to mean the prohibition of direct charges to patients; portable, to enable coverage any where in Canada; publicly administered, thereby limiting the role of expensive private insurers; and, providing access to information regarding implementation of the programme.

Medicare developed incrementally in the two decades after World War II. Two legislations, passed in 1957 and 1966 respectively, committed federal funding for the existing voluntary programmes of hospital and medical care insurance. Medicare was fully established in all provinces by 1971. These legislations were replaced in 1984 by the Canada Health Act which sought to financially penalise provinces imposing hospital user-fees or direct charges on patients. Having one insurer per province rather than multiple plans has made the administration of medical insurance efficient and low cost.

Health Care Services

The Canadian Health Care System is a mix of public funding and private provision. Private medical practitioners, both generalists and specialists, and not-for-profit private hospitals constitute the country's health delivery system. Office-based private practitioners are contracted to the provincial insurance plans and are paid by the latter according to a fee-for-service arrangement. A common province-wide fee schedule for each item of medical service or procedure, is established through negotiations conducted at regular intervals by the respective medical associations and insurance plans of the provinces.

Private practice wherein the doctors set their own fees is permissible, but in sharp contrast to the British NHS, it is prohibited for doctors and hospitals which have a contract with the insurance plans. This prevents the development of a two-tier health care system and protects all citizens against the economic costs of illness. As Evans points out: "The British private consultant can use his dual role to select and steer patients according to their resources and the nature of their problems. He can even use his position within the NHS to manipulate waiting lists and other aspects of access to ensure that private care will be preferable to those who can afford it. The Canadian physician who decides to "go private" must go all the way. He cannot use a strategic

COMMUNITY HEALTH CELL
326, V Main, I Block
Koramangala
Bangalore-560034

position within the public system to cream off only the profitable patients for his private services."

Canada had 209 active physicians per 100,000 population by 1986. Slightly over 50 percent are general practitioners. Medical education policy has attempted to control the growth of physician supply and the relative proportions of generalists and specialists. The provinces have used various methods to overcome the maldistribution of health personnel, such as higher reimbursements for practicing in under-doctored areas, the rotation of residents to outpost hospitals, cottage hospital systems, and systems of nurse practitioners or frontier-nurses. The common fee schedule is another incentive for physicians to relocate in underserved and poorer areas which would have a lower physicians - population ratio than more developed areas.

Almost 90 percent of the 1,298 Canadian hospitals (1986) are voluntary, non-profit institutions, called "public" hospitals, which were developed by local communities to meet perceived needs for care. These are managed by independent boards of trustees drawn from the local area, and are funded on a prospective budget basis by the plans. Investor owned hospitals have, generally, been prohibited after 1967, and private insurance companies have been restricted to supplementary benefits that are not fully covered by public programmes.

Alternative models of health delivery are increasingly being suggested in the context of an ageing population, the increasing proportion of chronic and degenerative diseases and rising costs. The financial coverage for all medically necessary services has skewed the delivery system towards intensive hospital and physician care. With rapid technological developments this leads to the increasing use of medical interventions and hospitalisation for the chronic illness among elderly population which has sharply increased the costs. The health delivery reforms are advocating the expansion of community-based services such as home care services, paramedical services based on visiting nurses, day surgery and preventive and promotive care as more cost-effective services for the 1990s. These modifications in delivery pattern would be complemented by increased planning of resources and the devolution of planning and some financial responsibility to regional councils within each province.

TABLE 2
HEALTH DELIVERY

YEAR	PHYSICIANS	NURSES	DENTISTS	BEDS
	(PER 100,000 POPULATION)			
1960	117	---	32	1,057
1986	209	935	52	1,628

Source : OECD, Health Care Systems in Transition, 1990.

Health Expenditures & Cost Containment

Canada, with a per capita medical care expenditure of US $ 1,4983 and 8.6 % of GDP devoted to medical care, ranks as one of the higher spending health care systems. It has, however, had a lower rate of growth of health expenditures than other OECD countries in the period 1975-87, and its national health expenditures are far below those of the USA.

Until 1971, the two countries had similar health delivery systems and spent the same proportion of their respective GDPs on health. With the establishment of universal medicare in 1971, the health expenditure patterns of the two countries began to diverge. Unlike the multiple insurance plans in the USA, which are administratively expensive, inequitious in coverage and loading the costs of health care on the manufacturing sector, medicare is funded by a combination of federal and provincial general revenues. This spreads the costs across the economy as well as centralises the disbursement of funds in a single public agency, the provincial ministries of health.

The monopoly of funding has "served as a powerful, if indirect, form of regulation" (Evans). The administrative costs of the insurance plans are just 2.5 to 3 percent of total health expenditures as against the US spending of 8.2 to 15 percent. Raising additional funds through taxation is much cheaper than collecting premiums, and the process of claims payment handled by a single agency is far more efficient.

The inflationary potential of the fee-for-service reimbursement system is to some extent offset by the uniform fee-schedules. These have restrained the escalation in physicians' fees to 15% of total costs as against over 20% in USA. Fee-schedules control fee levels but do not attempt to change or control practice patterns as the highly intrusive prospective payment system in the USA does. It is the medical licensing body in each province, and not the reimbursement agency, which controls the quality of service and deals with cases of malpractice.

Hospital care consumes the largest chunk of expenditures (40%). An important feature of the funding process is the separation of operational and capital costs. The provincial plans provide each hospital with an annual, inflation-adjusted global budget, negotiated in advance with the respective ministries, to meet operational costs. Capital costs are met mainly from government grants, but require prior scrutiny and approval from provincial ministries. In the absence of approval, the insurance plans can deny the institutions the necessary operating funds to implement the new activity. The public investment approach based on the province's needs for institutional care, rather than as profitable ventures, successfully constrains hospital investments.

Some pressures and conflicts have arisen on the issue of "rationing" of health care, which limits access to sophisticated technology and increases the waiting time for hospital admissions. As compared to USA or Germany, Canada has a much lower rate of diffusion and utilisation of the "state-of-the-art" technology. Most major technologies are restricted to teaching hospitals only and provinces deliberately regionalise high-technology units to ensure optimal use. Studies, however, indicate that the number of beneficial procedures for elderly citizens, barring coronary bypass surgery, is not less than that in the USA.

TABLE 3
NATIONAL HEALTH EXPENDITURES 1960-86

YEAR	TOTAL EXPENSE $MILLIONS	PUBLIC EXPENSE TO TOTAL EXPENSE %	TOTAL EXPENSE TO GDP %
1960	2142	43.1	5.5
1970	6256	70.3	7.2
1980	22658	75.0	7.4
1986	44276	76.0	8.5

Source : OECD, Health Care Systems in Transition, 1990.

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DROUGHT OF HEALTH IN DROUGHT AREAS

Bharat Patankar

It was 1971-72 in Maharashtra. Groups of interns from Government Medical College, Miraj, were given the duty to visit drought affected people labouring on drought relief works. In this very severe drought year every village in Maharashtra was affected. Hundreds of men and women were working on drought relief works, forcibly, because nothing could grow on their lands. They were toiling peasants, landless labourers and even well to do middle class farmers.

Home Truths for a Young Doctor

Interns were supposed to take a kit of medicines with them in a jeep, visit various sites, examine patients and give them required treatment. Their kit included vitamins and iron tablets, anti-bacterial and anti-amoebic drugs, etc. One of these groups was giving doses of medicines according to what they had been taught in the course of their medical education. They finished their stock soon and went to the Zilla Parishad to refill their stock. The person responsible for supplying medicines was not ready to give any more because a team was supposed to pull through a whole week with the help of the limited stock of medicines given to them. But these interns were not willing to go by such a rule. They went to visit the DHO (District Health Officer) and demanded that they be given more medicines. The DHO who was used to behaving in a dictatorial and arrogant manner said, *"You kids do not understand that this programme is not really for treating these patients. You are supposed to give some medicines to those people only for their psychological satisfaction!"* But the interns were not ready to listen. They said, "We will give medicine according to the people's requirements. If a patient is having severe anaemia we will give them the tablets stock for one month because nobody is going to visit them again for a month". But the DHO would not relent. In the end, these interns threatened to report the matter to the press. Only then did he agree to give the required medicines!

This experience gave me a big shock. I started thinking that hospitals and doctors were useless for poor people. The existence of medicines in the market does not mean anything to them because they cannot buy these medicines. Their vitamin and iron deficiency syndromes arise due to their poor living conditions. The main reason for ill health is poverty. Unless it is eradicated; medical knowledge, hospitals and health programmes cannot help majority of Indian people who are poor. The conclusion was to work for creating a society without exploitation, without poverty. One cannot do much by merely working in the field of health, to help poor people remain healthy.

Experiencing Drought : changing perceptions

Years went by. Many more irrigation schemes were completed but drought still remained a dominant aspect of Maharashtrian rural life. The number of the drought prone *talukas* of Maharashtra went on increasing. In 1973 the government had been compelled to enact a law which led to the formulation of Employment Guarantee Scheme (EGS). Under this scheme, under drought conditions the State was obligated to provide employment on development works to toiling peasants and labourers, so that they could subsist inspite of partial or total failure of agricultural operations. Provision for medicines and visits by a doctor from the nearby centre at the site of EGS work were compulsory facilities to be provided in this scheme. Still, the problem of ill health of the drought affected people remained unsolved.

Our conception about the relation of health with poverty in general and drought in particular, changed radically during all these years. The experience of people's struggles for a better life told us many things. We learned that poverty is not the only reason for ill health. Factors like pollution, condition of drainage systems, type of irrigation, cropping pattern and food habits can and do cause ill health in the affected population. Curative and medicine-oriented business approach can and does create problems in the field of health. We realised then, that eradication of poverty or drought will not automatically solve the problems of health. It would require a new approach to health and, on this basis, a new approach even towards the way in which drought would be eradicated. This new approach consisted of looking towards the problem of drought in a different way. Drought of clean water, of clean air, of vegetables and pulses may be included in `drought' related to health. Drought which is generally understood as a situation where crops fail and scarcity of drinking water is created should also include the above aspects.

Drought Related Health Problems

The first and generalised effect of drought is on mental health. The feeling of insecurity about one's own and the family's existence creates mental irritability in drought affected populations. In spite of the existence of the EGS law one is not sure of getting employment continuously during the period of drought. Once the work at one site is complete one does not know whether another work would start immediately. So one is faced with the prospect of not having something to eat from the very next day. People are forced to sell their land, trees and similar assets for the mere existence of the family. Quarrels in the family go on increasing. Many times drinking and wife-beating are forms taken for coping with mental instability in this male-dominated society. There are cases where women are sexually abused by the employees who control the guarantee of work at the immediate work-site. There are rare but definite incidences of suicides because of mental tension. Landless labourers and women in general are the worst affected in all drought situations.

Unhealthy drinking water is also a common problem in droughts. Water is either provided from tankers directly or poured into dried-up

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The author is a doctor by training, who has been a social-political activist since two decades. He is involved in the mobilisation of the rural masses in Sangli district in Maharashtra.

wells in the villages. This water is brought by tankers' owners from any source which would be at the shortest distance. Because, for tanker owners it is always an opportunity to earn a lot of money. They are not bothered about providing clean water. This results in repeated dysenteries and diarrhoea further reducing resistance to other infections. Food intake is also repeatedly reduced. Along with decreased quantity of food intake, quality of the food available creates ill health in such situations. Failing of the crops makes import of the food materials from outside the market inevitable. With limited cash in hand, the main food intake remains restricted to jowar or wheat and a very small quantity of '*dal*' if possible. Generally jowar or wheat *roti* are eaten with just onion and chilly powder and a very small amount of oil. This results in various kinds of vitamin deficiency syndromes, anaemia, protein deficiency syndromes, etc. In such situations incidence of infections like tuberculosis also increases.

As it becomes difficult to get even drinking water, it becomes almost impossible to have a bath everyday or even once in a week. Spread of skin diseases becomes rampant because of this. Under such conditions curative approach towards health leads only to temporary relief, but repeated occurrence of ill health cannot be prevented. In fact preventive approach can easily help in keeping people healthy. It is not very difficult to provide healthy drinking water with very simple measures. It is also possible to provide food components, which could be bought within the range of people's wages, thus preventing deficiency syndromes and the possibility of other infections. People could be advised to keep their skin clean with simple methods requiring small amounts of water.

Drought Eradication and Health

At this point one would think that eradication of drought is the real solution to all these health problems. But unfortunately it is not true. Today's method of drought eradication consists of providing water for agriculture, that is, providing water to a small area with mono-crop domination and mainly to the lands of the elite section of rural society. This results in cash crop (such as sugarcane) production in a small area and paucity of necessary food components. People from the remaining non-irrigated drought affected areas become migrant workers at nearby irrigated areas or agricultural labourers on the lands of those who have control over water resources. Over-use of water, accumulation of water in low level lands, etc. create new health problems. Even if there is plenty of water available for drinking in some of the irrigated areas it is polluted either because of contamination from over-use (or wrong use) of chemical fertilizers and pesticides or because of the effluents coming out of sugar factories, liquor factories or paper mills. New kinds of skin diseases are also induced by the use of such water.

Hence it is neccessary that the perspective on health should be integrated to a new approach and should include strategies for drought eradication. This would encompass :— **a)** Water utilisation based on principles of equitable distribution, thus ensuring water availability to wider areas; this would mean water-shed development and redistribution of waters from big dams in the valleys, **b)** Bio-mass based, sustainable agriculture primarily providing all necessary food components to each family , **c)** Establishment of cropping pattern cycles to make this possible, **d)** Decentralised industry based on renewable materials and energy, whereby pollution could be minimised and controlled.

While my focus has been to pinpoint the links between drought and health, it goes without saying that all these are part of a broader vision of development which sees a society free from social and economic exploitation where human beings live in harmony with nature.

Private Sector and Privatisation in the Health Care Services

A Review Paper For The ICSSR-ICMR Joint Panel on Health, August, 1990

Dr. Amar Jesani with Saraswathy Anantharam

Pages: 97, Price: Rs. 50/-, Postage: Rs. 8.50

This Paper was among those commissioned by the Joint Panel on Health to review the achievements of the decade 1978-88. We know almost nothing about the private health care sector in India to which 80% of doctors, from all the systems, belong. The authors narrate: the State involvement in Health Care in India and abroad; the growth of the public and private sectors in India and the nature of medical practice therein. In India, making health care services accessible to all, without financial barriers, is the central problem. But the private sector and the market mechanism have not shown access-consciousness.

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Conclusion

Medicare remains the most popular public programme in the country. The Canadian system is unique in the virtual absence of private sector involvement in health insurance, and the unwillingness of policy makers to seek private finances to ease the financial pressures on its tax-financed programme. It continues to uphold the principle of equal access to health care and has so far refused to raise additional finances through patient-based direct charges.

Nevertheless, the public insurance system is facing new pressures from the wider economy. High unemployment and inflation rates and a massive budget deficit (6% of GDP in 1986-87) have reduced the contribution of the federal government to the plans. The cutbacks in federal finances come at a time when utilisation of medical services is growing, and health care costs are exceeding the growth in provincial revenues. Economic forces have thus placed pressure on the provinces to find innovative approaches. Between 1987 and 1991 at least 6 provinces have reviewed their health systems and made broad policy recommendations for the 1990s. Having achieved equitable access to health care, Canadian medicare is now grappling with the wider issue of equitable access to health. The emerging policy directions point towards greater community-based care, consumer participation, improved efficiency and effectiveness, and a modification of the organisational structure.

The success of medicare has provided the conditions for Canada to consider these options. At the same time, its US neighbours across the border are weighing the option of the Canadian model to create a universal health system for themselves.

Select References

1) Evans R.G., **Public Health Insurance: the collective purchase of individual care**, *Health Policy*, (7), 1987
2) Evans R.G. et. al, **Controlling Health Expenditures : the Canadian reality**, *New England Journal of Medicine*, Vol. 320 (9), 1989.
3) Iglehart J.K., **Health Policy Report : Canada's health care system** (three parts), *NEJM*, 1986.
4) Iglehart J.K., **Canada's Health Care System Faces Its Problems**, *NEJM*, Vol. 332 (8), 1990.
5) Mhatre S.L. and Deber R.B., **From Equal Access to Health Care to Equitable Access to Health : a review of Canadian provincial health commissions and reports**, *International Journal of Health Services*, Vol. 22 (4), 1992.

UPDATE ON FRCH PROJECTS

School Health Education Project: This project sponsored by the Ministry of Human Resource Development has been completed now. It started with the aims of imparting knowledge of health and disease to teachers and students and developing simple teaching means and methods. The manuals for teachers and children are ready and will be published soon.

Health Status of the Indian People: The second volume consisting of two parts is being prepared. The first part will have three theme papers which will deal with public and private sectors in health care in India and health research and information system in India. The second part will give the statistical information and a brief write-up about health status of Indian people updating the information in first volume.

Manual of Primary Health Care: The hospital-oriented training that the doctors receive in urban-based medical colleges does not equip them to perform the curative and preventive health care activities in a Primary Health Centre (PHC) covering about 25,000 population. This manual covers the common clinical problems as well as the common administrative procedures and problems that a medical officer may encounter. It will be published soon.

Leprosy Footwear: FRCH in conjunction with the plastic shoe industry of Bombay/Thane has devised footwear to suit the anaesthetic feet of leprosy patients. Two thousand pairs have already been provided to the Government of India for trial in five leprosy institutions. A new form of neuro-vascular surgery has been devised at our sister organisation the Foundation for Medical Research.

Study of the Supply, Use and Cost of Drugs & Pharmaceuticals: This project has completed its first phase where data regarding supply, use and cost of drugs and pharmaceuticals was collected at nine PHCs, three Rural Hospitals, one Cottage and one Civil Hospital in Satara district. The second phase, now attempts to make an estimate of the volume of drugs and pharmaceuticals in the private sector. Interviews of providers to study prescribing and dispensing behavior and analysis of prescriptions to determine degree of irrationality are also planned.

The 'Health Investment & Expenditure' in a District: This study is being conducted in Ahmednagar district. In the first phase of the study, an inventory of all health resources in the district has been made. It includes medical practitioners belonging to all systems of medicines, small and large hospitals, dispensaries, consulting rooms, medical stores, pathological laboratories etc.; from both the private and the public health sectors. In the second phase, detailed investment and expenditure patterns of a few health establishments from the above inventories are being studied.

Community Health Care Model Project: This will be a six year project. The Government and the Zilla Parishad have shown their willingness to hand over Parinche PHC (Purandar *taluka*, Maharashtra) to FRCH for that duration. The objectives of the project will be:

a) Developing a community based health care system with a view to determine the steps involved in eliciting participation of the community **b)** Developing training methods/material for that purpose **c)** Assessing its effectiveness and studying its macro implication.

The Study of Social & Operational Constraints in Tuberculosis Control Programme: The objective is to find out the constraints responsible for the persistence of the TB problem. This study is undertaken in urban and rural areas of Pune district. The project started with the orientation of the researchers and planning and preparing the research tools. The data was collected from the households, patients, medical officers in PHCs and other health workers. This data was coded and analyzed. The next phase includes private practitioners in addition to the other sources in the first phase. Now this data is being compiled.

Public Information: This project aims at information dissemination about Government schemes for poverty alleviation as well as other social issues. This is done through various methods of communication like pamphlets, group meetings, posters, films etc. This work is going on in fifteen villages of Purandar *taluka*, fifteen villages of Parner *taluka* and fifteen villages in the surrounding area of Ralegan Siddhi. The pamphlets produced so far have been: **a)** Government health services, **b)** IRDP, **c)** EGS, **d)** Gram Panchayat and **e)** Schemes for SC-STs. Those in the pipeline are: **a)** Women and law, **b)** Rural-urban disparities, **c)** Corruption and **d)** Water management.

Village Library Movement: The target group of this activity is: neo-literates, young school and college goers and literate adults in villages. Through reading material like books, magazines, and newspapers on various subjects the aim is to create social awareness, change 'feudal thinking' and initiate development. This work is supplemented by *Balwadis* and Adult Education which involve the enthusiastic support of the locals.

IDS Kasare: Kasare self-help project was developed on the model of Ralegan-Siddhi. It has mobilised residents of the village and organised them into village development committees. Various informative and action oriented programmes such as animal husbandry, water-shed development, road-repairs, horticulture, libraries, procuring IRDP loans are being carried out.

Stree-Dhan: This is a women's savings and credit group on the lines of *Grameen*-Bank of Bangladesh in Malshiras (*taluka* Purandar, District Pune). Here women are disbursed loans upto 1000 Rupees for household expenditure, repaying old loans, buying sheep, without any collateral. Since these are neighbourhood saving groups, the repayment is 100%. This savings and credit group has initiated women's empowerment in the three villages where this work is carried out and given the motivation to expand to more villages.

This gives a brief idea about FRCH projects. Detailed report of each project can be found in the Annual Report 1992, to be published soon.

LIBRARY NEWS

Books

1) Bridahl H. and Court J., **Diabetes**, A.H. Wheeler and Co. Pvt. Ltd., Allahabad, 1987, pgs. 66.
2) Brown Y. and Crack D., **Your Children's Teeth**, A.H. Wheeler and Co. Pvt. Ltd., Allahabad, 1985, pgs. 45.
3) Buchanan N., **Childhood Epilepsy**, A.H. Wheeler and Co. Pvt. Ltd., Allahabad, 1985, pgs. 66.
4) Coleman V., **Health Scandal**, Mandarin, London, 1989, pgs. 245.
5) Coovadia H.M. and Benatar S.R., **Century of Tuberculosis : South African perspectives**, Oxford University Press, Oxford, 1991, pgs. 319.
6) Gopalakrishnan S. and Mahendru B., **Growth Monitoring : an annotated bibliography**, N.I.P.C.C.D., New Delhi, 1992,pgs. 74.
7) Gopalan C., **Science and Nutrition in the Future**, International Congress of Nutrition, Seoul, 1989, pgs. 21.
8) Jain A.K., **Managing Quality of Care in Population Programmes**, Kumarian Press, U.S.A., 1992, pgs. 162.
9) Jesani A., and Ganguly S., **Some Issues in the Community Participation in Health Care** : a review paper prepared for the ICSSR-ICMR joint panel on health, FRCH, Bombay, March 1993, pgs. 30.
10) Kothari D. and Gulati A., **An Inter-Sectoral Coordinating Mechanism for the Indian Population Programme : a framework**, I.I.H.M.R., Jaipur, 1992, pgs.24.
11) Kothari D. and Gulati A., **District Level Approach to Family Welfare Programme: a proposal for effective action**, I.I.H.M.R., Jaipur, 1991, pgs. 20.
12) Kothari D., **Family Welfare Programme in India: an alternative approach**, I.I.H.M.R., Jaipur, 1991, pgs. 20.
13) Kothari D. and Gulati A., **Recent Government Policies and Strategies to Control Population Growth: a critique**, I.I.H.M.R., Jaipur, 1992, pgs. 26.
14) Krishna V. etc., **Collaborative Study on High Risk Pregnancies and Maternal Mortality**, I.C.M.R., New Delhi, 1990, pgs. 214.
15) Montgomery B., **Coping with Stress**, A.H. Wheeler and Co. Pvt. Ltd., Allahabad, 1987, pgs. 56.
16) Mustaph J., **Backpain**, A.H. Wheeler and Co. Pvt. Ltd., Allahabad, 1987, pgs. 68.
17) Norton L., **Preventing Heart Disease**, A.H. Wheeler and Co. Pvt. Ltd., Allahabad, 1988, pgs. 77.
18) Prashant S., **Drug Abuse and Society**, Ashish Publishing House, New Delhi, 1993, pgs. 219.
19) **Selected Chapters From the 8th Five Year Plan Document of the Government of India**, Voluntary Health Association of India, New Delhi, 1993, pgs. 61.
20) Subrahmanyan S., **Status of Women and Children in Andhra Pradesh**, UNICEF, South East India Off., Hyderabad, 1991, pgs.208.

contd. from page2

medical professionals. They can then devote much more of their time as well as the limited expensive resources for secondary and tertiary care for which they are specifically trained. The risk of not utilizing the available knowledge and technology far outweighs the danger of withholding it, certainly under the prevailing circumstances, and even when the socio-economic conditions improve.

The present approach has succeeded only in mystifying health and medical care and placing it within reach only of the affluent minority who can afford to pay for services or, through influence, monopolize whatever effective services are provided in the public sector. The medical professionals, who increasingly perceive medicine as a lucrative business, have also mesmerized themselves into believing that 'West is Best'. They have alienated themselves from the masses as well as from their socio-economic problems and culture. The result is that they firmly believe that there is no alternative to the present system, despite its proving to be increasingly counter-productive. The pharmaceutical and medical instrumentation industry, whose sole motive is profit, has spared no effort in reinforcing the belief among the professionals and the public that modern health care must follow the latest Western pattern however expensive and inappropriate it may have proved to be even in the countries of their origin.

An Alternative Approach

The alternative model, as proposed in the ICSSR/ICMR report "*Health For All - An Alternative Strategy*", envisaged that the vast majority of all preventive, promotive and curative health care would be undertaken by and within the *Gram Panchayat* and *Panchayat Samiti* at one lakh level. It was based on the principle that health lends itself both technically and culturally to be operated most cost-effectively in a decentralised system as conceived under *Panchayati Raj*. This is possible provided the public health and illness approaches are graded and operated according to the skills and facilities, as indicated by the categories described above.

Such an approach would involve the people in their own health care and would help release them from the clutches of the health industry. It would also establish the rapport and confidence between the people and their most important first level contact, the paramedical workers, without whom no programme can succeed. This will require the provision of more knowledge and availability of essential drugs with Community Health Workers and other paramedical workers.

A vast country like India with so much diversity, calls for a modified approach to suit the prevailing epidemiological and social realities which vary from urban to rural areas, from region to region and often from village to village.

References

1) Antia N.H., The Mandwa Experiment : an alternative strategy, *British Medical Journal*, pp. 292, 1986.

FREE ABSTRACTING

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COMMUNITY HEALTH CELL
326, V Main, I Block
Koramangala
Bangalore-560034
India

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MALSHIRAS : THE STRUGGLE CONTINUES

Sadhana Natu

FRCH believes that health as an issue is not unidimensional. It is influenced by socio-economic factors. Hence if the health status of the people is to be improved then their socio-economic problems should also be addressed.

This perspective was the backbone of the five year action research project at Malshiras in Purandar *taluka* (district Pune, Maharashtra) from 1987 to 1992. A team of senior researchers imparted health education to the people of eighteen villages through close interaction. This was possible because they resided in the village. Also their personal involvement with the wider movement and diverse social issues made them sensitive to respond to the issues articulated by the people. Hence during the course of five years a strong bond had been established with the villagers of Malshiras and surrounding areas. Using health as a starting point the work evolved to include relevant socio-economic issues like drought, alcoholism and women's oppression.

An offshoot of this was the formation of a *Mahila Mandal* called *Jagrut Mahila Mandal* where these diverse and crucial issues concerning women could be addressed. Also the need for income generation arose and to carry out these activities; a trust : *Mahila Sarvangeen Utkarsh Mandal* (MASUM) was formed. MASUM has championed the cause of oppressed women; whether it was in the struggle for prohibition or in case of the gruesome murder of a daughter of Malshiras village or in a molestation attempt on a minor girl by a high-caste villager. It has taken up cudgels on behalf of the exploited time and again.

Drought, Women and Mobilisation

Ever since the massive drought of 1972 the area has not received adequate rainfall. In fact the whole of Purandar *taluka* lies in the scarcity zone; receiving an annual rainfall ranging between 600 mm to 700 mm. In this drought prone area, women are the worst hit as they have to spend three to four hours every day to fill enough water just to satisfy household needs. While the natural sources of water have dried up, the other sources like bore-wells and wells with electric motors and hand pumps belong to the rich farmers. Hence the women from Below Poverty Line (BPL) families are left bereft of two water related criteria crucial to achievement of good health — having access to water and having enough of water.

Being witness to this recurring scenario, from the initial funds that it had received, MASUM advanced substantial amount towards getting a pipeline into the village. But the work remained incomplete and some of the money unutilised. Accounts were not settled, nor was the pipeline completed even after constant reminders. In those places where the pipes had been installed on certain wells, on the understanding that there would be open access to drinking water, the women were still denied their right to fill water.

The situation had become very grim. On one hand the money given for a specific purpose was not utilised properly. On the other hand the women were left with dubious choices : spend three-four hours to get just one potful of water or pay three rupees per *kavad* (tin)! (those who could afford it that is — and these were abysmally few). A meeting of *Jagrut Mahila Mandal*, MASUM members, and the village women was therefore called. In the meeting the women articulated their thoughts : they were exhausted with their mile long treks for water, saddened at the numerous accidents that took place when women slipped and fell into steep wells and inconsolable at the deaths that took place during this perilous task. But they were ready to fight it out. Ready to demand answers to the question regarding the pipeline and MASUM money.

Two of the trustees of MASUM declared that since they had given money to the villagers and had received no answers for two years they felt morally responsible for the situation. Hence they would write to the village elders and issue an ultimatum — if the accounts were not settled and the issue of water not discussed in a *Gram Sabha* (village-meeting) by 8th of March then they would go on a hunger-strike till these two demands were met. The women supported this proposal unanimously and were ready to join in the hunger-strike too.

The author is a researcher at FRCH, involved in the Public Information Project and MASUM work. She has a post-graduate degree in Clinical Psychology.

FOR PRIVATE CIRCULATION ONLY

So the stage was set.....

International Women's Day was celebrated with its usual gaiety in the village. But a solemnity underlined all the celebration : every song, speech, presentation had the theme of drought and water-scarcity finely interwoven into it. The programme also provided an effective platform to clear out all the cob-webs from the minds of the few doubting villagers about the role of MASUM in the village, and to allay their fears about the hunger-strike being a political gimmick. They were convinced that political power or alignment with any political party has never been or never will be the mainstay of MASUM or MASUM activists.

The clarion call for mobilization was given and the women dispersed vowing to turn up in large numbers from *wadis* and *vastis* to support the hunger-strike. The local political big-wigs started feeling uneasy and their Machiavellian machinations began. They tried to negotiate with MASUM trustees about clearing up the accounts that very night. But the trustees flatly refused. Everything had to be discussed in the open in the *Gram Sabha*.

A series of environmental tragedies over the last decade — Minamata, Chernobyl, Bhopal, the contamination of the Rhine with toxic effluents from Roche, the oil spill in the Gulf, etc. — have focussed attention on the increasing 'chemicalisation' of the environment; more or less at the same time, the Thalidomide, SMON (subacute myelo-optic neuropathy) and DES (diethyl stilbaestrol) tragedies and, more recently, the increasing incidence of iatrogenic diseases and pesticide poisoning have dramatically illustrated the growing 'chemicalisation' of the body. Both developments have forced us to realise that health and environmental issues cannot be dealt with in isolation, not only are they intrinsically linked to each other, but neither can be easily solved by a quick technological fix. For pollution today is not only chemical, it is also biological, social and psychological..... To my mind, the problem may be articulated as one of extreme deprivation on the one hand, and of irrational excess on the other. The deprivation is that of 'essentials' such as food, clean and adequate water, air, health care, and safe living and working conditions. The excess consists of bombarding our beings, over lives, and our environment with hazardous gases, chemical and biological contamination, i.e., irrational and 'inessential' toxification..... It did not require the study of social and preventive medicine to demonstrate the great importance of adequate and clean drinking water in ensuring good health, and of the nature of water borne diseases. Medical books have informed us that 70 % of all diseases are water-borne and therefore preventable, and that one-third of all paediatric hospitalizations are due to diarrhoea..... History has shown that laws can act as a deterrent whereby social conscience and responsibility take precedence over individual profiteering. But where vested interests have ensured an accumulation of power and money, the silence of the tormented is enforced, and that of law enforcers bought. Legal loopholes are given precedence over morality and ethics, and unjust laws are passed, while attempts to enforce controls are scuttled whether they related to Bhopal gas tragedy, the violation of the Baby Food Code, drug dumping or the indiscriminate use of toxic pesticides. Ecological and health hazards cannot be prevented or dealt with unless a collective consciousness is built up among those who are willing to make sacrifices and to live without destroying and exploiting. It is only when enough people have cared and dared that changes have been enforced.

Source:** Mira Shiva, **'Environmental Degradation and Subversion of Health' 'Development Dialogue', (1,2), 1992.

The Hunger-Strike

The hunger-strike began in the morning and the women rallied round in substantial numbers. By mid-afternoon the village elders had conferred. The fact that the women were present in large numbers, the people from neighbouring villages had heard about the hunger-strike and some had visited Malshiras, the outside support that the MASUM activists had, made a dent; private had become public.

Under such pressure the village elders were finally compelled to call a *Gram Sabha*. It was a day of 'many firsts': — it was the first time that accounts of public money were given to the community. For the first time it was acknowledged that nobody had a monopoly over water and that drinking water would be given priority over water for irrigation.

It was for the first time that a Water Committee was formed consisting of MASUM members, one MASUM trustee and two villagers representing two different political parties.

The Water Committee was to fulfill the following duties :—

1) See to it that the women were allowed to fill water from wells where pipes had been installed with MASUM money.
2) Take a physical stock of the pipes and motors which were bought with MASUM money.
3) See that the fields were not irrigated till the drinking water problem was solved.
4) Discuss various workable solutions to find a permanent answer to the perennial issue of drought.

In the entire proceedings of the *Gram sabha* the local politicians all stood together in the rocking boat and supported one another. But this was a mere face-saving tactic since the villagers already knew who the culprit was and also the exact nature of the irregular actions. But on the part of those on the hunger strike, there were no recriminations or scape-goating. The aim had been to highlight the issue of water-scarcity and this was certainly achieved. Despite the fact that there would be many more struggles ahead before the issue is entirely resolved, the strength and resilience of the women came out forcefully during the experience of this hunger strike. In their own words: "We have to make do with one *handa* (pot) of water for three days" says it all.

The Backlash: lessons learned

Shalantai, a fiery MASUM worker, was a recipient of many threats. Fields were irrigated at night, so that in the morning less drinking water was left. The women were in a combative mood : they wanted to drag out the pipes, which they understood were theirs and hence they had a right to water. All separate events, but all direct results of the hunger-strike. So though social pressure had worked in the *Gram Sabha* a few loose ends still remained.

The Water Committee intervened; some villagers also pitched in and a new pipeline was dug. Through it the water was collected in a tank from where the women could fill water for two hours (in the morning as well as in the evening). The gushing water told its own story.

A dialogue has now begun and various alternatives to solve the water-scarcity are being discussed. But unresolved questions remain : the well from which the water is being brought by the pipeline is to be cleansed of impurities. Who will pay for the task? Will the villagers unite and contribute collectively? What will happen when this source dries up or the water level is reduced? If a percolation tank or an underground dam is to be worked on as a viable alternative, once again where will the economic resources come from?

The struggle for water and the following hunger-strike led to many

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STAKES OF MEDICAL PRACTICE

Maya Nirmala

In the past there have been a few articles in FRCH Newsletter focussing on various dimensions of the financing of health care services in India. One of the current studies in FRCH is looking into health investment and expenditure patterns in Ahmednagar district of Maharashtra.

In the first phase of this study we had prepared an inventory of all health-care resources including medical personnel and establishments. This inventory only confirmed the well-known urban bias in the geographical distribution of health-care-services. This disparity between rural and urban concentration of doctors (1885:1 and 343:1 population to doctor ratio respectively) is also stratified by trends among doctors trained in different systems of medicine. For example, about 60% allopaths and more than 90% dentists and specialists practice in the urban centres of the district. The reasons are obviously located in the socio-economic conditions available for medical practices and institutionalisation of those practices operating in our society.

During July-August 1992, FRCH had organised three one-day workshops — two in Ahmednagar and one in Shrirampur — with the doctors from Ahmednagar district, focussing on some regularities evident in the field of medical practices. Participants came from all over the district, representing medical practitioners of all pathies. There were also RMPs, and those who were part of the public health sector. The deliberations during these workshops mainly revolved around the economic dimensions of medical education as well as setting up and continuing medical practice; competition among doctors; role of the drug industry and patterns of charging fees. Doctors also raised the issue of consumer movement and talked keenly about their impressions regarding that. The following brief account is an attempt to skim through some aspects of these exchanges between our doctor-friends from Ahmednagar district and some colleagues in FRCH, in the context of some ongoing debates concerning community health.

Initial Determinants

State discrimination at the level of financing the training and research facilities, and at the level of health-care provisions and recruitment in the public sector, influence the status and scope of different medical practices. Priorities of the medical industry and the social images of various therapies have a strong hold on their relative marketability, despite a high degree of cultural advancement in the district. In fact, with the booming sugar economy and growing urbanization, the contrast between the hegemonic allopaths and the under-privileged non-allopaths is growing wider with each passing day.

When we consider the high profile therapy, allopaths have a better choice in deciding location, raising finances from institutional sources and repaying loans, etc. After paying an exorbitantly high price towards the cost of modern medical education and considering the increased cost of setting up a medical unit, taking loans is an indispensable factor except for those who inherit fortunes. Agencies like Maharashtra State Financial Corporation (MSFC) reflect the same discriminatory attitude in favour of allopaths. Doctors with M.B.B.S. or M.D. degrees can avail of the 'Medical Practioners Scheme' but non-allopaths have to enter into a contract with the allopaths for getting loans from MSFC. Hospital standards sanctioned by MSFC are difficult to achieve in the rural set-up having inadequate water and electric supply, inadequate sanitation and scarce qualified paramedical staff. Whether these standards should be relaxable as suggested by some doctors is a much complex issue to settle. Incidently, those who have availed of loans are also supposed to give an undertaking that their practice will grow every year, enabling a faster repayment of loans. Indeed, doctors exercise all rational, professional and irrational means to keep up the promise even after the repayment of loans. Everyday at least five X-Rays or three sonographies have to be conducted on the respective instruments not for any less obvious reasons.

The private health sector offers a wide range of medical services and specialities. The specialists and pathological laboratories are visited even for illnesses like minor ophthalmic or skin diseases. The status of the doctor as a family physician is fading away. About 50% patients move from doctor to doctor. Doctors beginning private practice face acute competition. The competition takes bizarre shapes among GPs and specialists, and among modern and traditional medical practitioners. Fifty years ago, superstitions and faith in 'unscientific' rituals had an adverse effect on allopathic practice. Now that the taste and desire for modern medicine has already been created, doctors no longer compete to retain monopoly, but to provide most advanced treatment, thus paving the way for new 'scientific' biases.

Unfortunately, with every specialized technique, the subtle intuitions supporting a therapy and its simple remedies are being forgotten. Many young doctors follow a certain 'pathy' without having sound faith in it. Medical colleges function as incidental launching pads into the profession. Even those doctors who carry the necessary conviction for practicing Homeopathy, Ayurveda or any other traditional system, resort to Allopathy dictated by patients' expectations or by the medical market. Only a minute stratum among the urban middle class, which respects the traditional medical knowledge, has the patience and luxury to await the recovery offered by these systems, against the backdrop of irrational allopathic treatment.

Cross-practice and CME

Cross-practice, mainly by non-allopaths has therefore become one of the major concerns of the state. With the recent legitimization of cross-practice, in Maharahtra (only for the ayurvedic practioners) which was still under consideration at the time of the workshops, ayurvedic doctors strongly advocated re-introduction of integrated approach in

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The author is a researcher at FRCH, involved in the study, 'Health Investment and Expenditure in a District'.

medicine, hoping to overcome limitations involved in following any one therapy exclusively. But the idea of multi-system short courses in medicine proposed by some doctors sounds problematic. Doctors fear that the idea of complementary therapies would be exploited by some of their fraternity merely to expand their practice. More compounders and nurses than those already practicing might want to treat people independently, on the basis of some working knowledge of medicines. At the same time we are also familiar with the image of a bare-foot-doctor or that of a village-health-guide. The attempts at demystifying medical knowledge and devices for assuring a rational medical practice should then be monitored in the same vein. Similarly the 'propriety' of continuing medical education (CME) per se is not being questioned. Doctors certainly need orientation programmes in order to acquaint themselves with new developments in medicine. But apart from lectures organised by local medical associations, most of the rural doctors rely basically on the literature distributed by pharmaceutical companies. This literature is designed for propaganda purposes rather than for the altruistic goal of educating doctors. Likewise, as Andrew Wear writes, "Cries for scientific medicine, for better medical education, more rigorous examination etc., (have) their altruistic side, but (are) also mixed with social and financial considerations". Pharmaceutical companies, being the pivotal forces operating in the medical market, influence the present day medical practice, determining the nature of diagnosis, treatment and charging pattern.

Role of the Drug Industry

Despite the Hathi Committee recommendations many ready-made combinations, non-essential tonics and protein preparations are flooding the market. Apart from the routine queries from the FDA there is no controlling mechanism. Drugs which are patented abroad escape the critical gaze of 'Central Drug Research Laboratory', Lucknow. This laboratory, the only national institute of its kind, scrutinizes the new Indian pharmaceutical products, most of which are ayurvedic preparations. Competition among pharmaceutical companies and the continuous flow of new medical products is mentally strenuous for the doctors. They have to choose the combinations and brands on the basis of a plethora of ready-made information. There is every possibility that the chosen drug would look dangerous or backward with the ever exploding new researches and higher drugs. However, these untimely professional scruples are eventually sobered up when about 40% of the annual turnover of the drug industry is distributed among doctors, druggists and distributors, as doctors themselves admit. Despite the fact that there are doctors who practice rationally or those who are conscious of the irrationality in their practice, medical professionals are, to a great extent, instrumental in further victimization of patients. Physician samples are tested out on poor patients in the name of charity. Patients are sent to specific drug stores with loaded prescriptions. And chemists push forward their pet substitute brands.

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Capitation Fee and the Right to Education

The Supreme Court issued the landmark directive in February that "There shall be no quota — reserved for the managements or for any family, caste or community which may have established the institution". As per the directive, all professional colleges will have at least 50 % of seats filled by the nominees of the government or university as 'free seats'. The remaining 50 %, called 'payment seats', shall be for those candidates who are prepared to pay the fee prescribed by a committee consisting of a Vice-Chancellor, the Secretary (or Jt. Secy.) for Education, and the Director of Medical or Technical Education as the case may be. The seats in both categories will have to be filled up on the basis of merit, or, in its absence, such criteria as may be determined by the competent authority — the state government or the university. Where the institutions have constitutionally valid social objectives and obligations to certain sections of society, as in the case of minority institutions, the state shall decide how much of this the managements are free to fulfil and under what criteria, again determined on the basis of merit.

Karnataka: The managements of private professional institutions in Karnataka are up in arms against the State Government implementing the Supreme Court directive on admission norms. But the Karnataka Government is in no mood to relent. In the 1960s Karnataka encouraged capitation fee-based colleges. Today it has 15 privately-managed medical colleges. With successive Chief Ministers sanctioning colleges, most of them on caste lines, today major communities like Vokkaligas and Lingayats, including the Backward and the Scheduled classes and Brahmins, own capitation fee colleges. This has resulted in strong ties between politicians and the college managements. In this background, enforcement of the law to curb the capitation fee menace remains difficult. Another sore point is the Supreme Court's decision under Article 30(1) of the Constitution to permit minority institutions to admit not more than 50 % of the candidates. This has caused much heartburn among other managements. This may prompt more colleges to clamour for minority status, either linguistic or religious. Interestingly, some minority institutions have appealed to the Supreme Court to allow them to fill up all seats.

Maharashtra: Till the current academic year, 80 % of the seats in private medical colleges used to be filled on the basis of merit, the remaining 20 % constituting the 'management quota'. Henceforth the Director of Medical Education and Research will allot seats in all medical colleges. With legal experts asserting that the dual fee structure violates the fundamental right to equality, the system is likely to be challenged in court. The Akhil Bharatiya Vidyarthi Parishad along with several senate members of Bombay University, while not condemning the fee hike outright, have asked that since market forces were being encouraged, consumer rights of students must be protected by making local public inquiry committee reports on all private colleges affiliated to the university.

Tamil Nadu: Interestingly, Tamil Nadu's education Secretary V. Sankarasubbaiyan corroborates the sentiment in Karnataka, when he points out that one positive feature of the Supreme Court directive is that it ensures that merit is built into the system of admission to professional courses. The other feature, he points out, is that it recognises the heavy investment made by the institution on the student and the need to recover it. Professor Peer Muhammed, director, Crescent Engineering College, Vandalur, explains that Article 30 of the Constitution provides for the right of minorities to establish and administer educational institutions of their choice. "In our college, about 30 percent of the total strength comprises Muslims.... that is our aim, to serve the cause of education in our community. With the new ruling, however, we would hardly get about four or five students a year".

— In the course of liberalization, while there is a probability that education will be looked at, more and more, as a commodity, the Supreme Court's directive comes as a hope for the deserving students from the poor and middle classes. But considering the vested interests, one cannot expect that it will curb the commercialization of education.

Sources: 1) Times of India: June 6, 1993. 2) Frontline: July 2, 1993.

DOCTORS 'COPE' WITH RISING DRUG PRICES

Audrey Fernandes

As a part of the New Economic Policy, the government has removed the price control on a large number of drugs. Consequently, last couple of years have seen a sharp rise in drug prices. This has been documented by Dr. Wishwas Rane's study 'Rising Drug Prices' in the *Economic and Political Weekly*, April 17, 1993. It is noteworthy that not only consumers but even the doctors have been affected by this price rise. This was revealed to us recently during our interviews with doctors in both the private and the public sectors in rural areas of Satara district. The interviews were a part of the study called 'The Supply, Cost and Use of Drugs and Pharmaceuticals in a District', being conducted by the FRCH. One part of the second phase of this study consists of analysing prescriptions of doctors in both the public and the private sectors to determine the degree of irrationality,and the other consists of in-depth interviews of doctors to probe into factors that influence their prescribing behavior.

The 'Family Doctor' : an obsolete concept

The general impression of the interviewers was: the nature of the doctors' practice (especially those practicing for a number of years) has been changing over a period of time. The concept of 'family doctor' who dispensed medicines seems to be fading out. When asked about the reason, the almost unanimous answer was: cost of drugs. Most doctors said that it is now a common practice for a doctor to prescribe rather than dispense drugs from his own stock. There are many reasons for this. When a doctor dispenses drugs, patients are reluctant to pay for both — the drugs as well as the consultancy. Some doctors said therefore that the only drugs they dispense are the samples left with them by the Medical Representatives. Earlier, a patient insisted that a doctor gave some medicine alongwith consultancy, but now patients are not so insistent. Just an injection is enough. The doctors say that a patient does not question the contents of a prescription, being under the impression that the more expensive the drug, the more powerful and hence better the drug. In the same logic the doctor who precribes such 'better'drugs is the better doctor. Some doctors on the other hand felt that not dispensing made patients lose faith in them — "Doctor only writes, does not give anything in hand". Doctors feel that it is not worth their while to dispense drugs though most of them know that patients, many times, have to travel to the nearest drug store to buy the drugs prescribed. This often means the nearest *taluka* town and in some cases even the district headquarters. There too the drugs prescribed are often substituted by the drug store. This occurs more often if it is the only store in the village (though this is not very common anymore, as most PHC villages have at least three drug stores and eight to ten private doctors operating). The substitute drug is generally more expensive. While some doctors ask the patients to show them what the medical store has given, very few insist on the prescribed drug, and still fewer check that the drugs are not 'Bombay Market'ones. Most of them do not bother at all. The general feeling is, "what can we do?". One doctor said that twenty-five percent of the patients take the prescriptions but do not buy anything because they do not have the money. Fifty percent buy only a part of those prescribed, and ninety percent take the prescription to the medical store only the next day. Though the doctors are concerned with the implications of patients taking only a partial course of medicine, e.g. resistance to certain antibiotics, they know that often a large part of what they prescribe might be irrational.

Drug Companies: marketing strategies

Most doctors when asked the reason for the increase in drug prices, attributed it to the marketing strategies of drug companies. Detailed explanations were given as to how the expenses on the visiting Medical Representatives, and particularly the large number of samples that they leave behind, increase the cost of drugs finally available in the market. A doctor showed us a set of five Ciplafloxacin injections that a representative had left with him that day. He said, "Each of these vials is sold for Rs. 60 to Rs. 70 at the Drug Store. I am only a small doctor practicing in a rural area. If they leave so many samples with me, can you imagine how many they would leave with a consultant practicing in Satara?" That this was done at patients' cost was a view expressed by many, and some doctors felt that this was bad ethics.

Perhaps drug companies are also finding it difficult to maintain a force of Medical Representatives to promote their products. Companies such as Cipla, do not hire representatives anymore (at least in Satara district). They depend almost entirely on what doctors call 'Cipla Courier' for their promotion. This is sent to all private doctors as well as PHC doctors. This is often the only printed 'continuing medical education' that a doctor receives. To quote an example, 'Cipflox'- the anti-typhoid drug from Cipla, is to most of the doctors, the 'Wonder Drug'which is the result of the 'pioneering research that Cipla did in Thane district'. Some refrain from prescribing it only because it costs Rs. 24/- per tablet. At the time of interviewing most doctors were happy to convey that the latest courier from Cipla had announced a reduction in the price to Rs. 12/- per tablet.

Companies like Medicare do not approach doctors at all. They operate entirely through medical stores. A discussion with Medical Representatives revealed that they offered certain schemes to dealers, such as a percentage on the goods sold, or an offer like, "stock up Rs 40,000 of 'A' drug and we will send a washing machine to your house". Some companies still concentrate on doctors, giving incentives such as a trip to Singapore, after having prescribed a certain amount of a particular drug. A senior doctor in Medha PHC, in Javali *taluka*, which is a remote, under-developed, hilly and drought-prone area, said that at least three to four doctors had gone abroad on such trips in the last four years. He expressed alarm concerning the growing trend of this

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The author is a researcher at FRCH, involved in the study, 'Supply and Cost of Drugs & Pharmaceuticals in a District'.

unethical practice. He further added, "The new doctors entering practice fall prey to such unfair means because now, being in practice means being in competition with other doctors".

The Public Sector

Doctors in the public sector find their own way to deal with drug shortages, which, according to them, are the result of a stagnant drug budget on one hand and rising prices on the other. Not revising rate contract prices since 1988 has resulted in refusal by many companies to supply drugs, procrastination of delivery, etc. At one PHC, we were shown tubes of an antiseptic cream packed in cartons. Except for the tubes in the first layer all the rest were filled with air. This was perhaps the drug companies' way of retaliation against the low contract prices. In practice, this means long periods of time being spent without many essential drugs, and almost always, an acute shortage. For Primary Health Centre doctors this is a way of life and they do not expect any better, knowing that in the past they have many a time requested for a larger quota, but to no avail. Many doctors hold the view that the drugs available through the public sector are of sub-standard quality. Most of them cope by giving prescriptions for drugs to be bought in the open market. In larger hospitals, like Civil and Cottage Hospitals, samples left by Medical Representatives are collected even from private doctors, a 'drug bank' is maintained, over-prescription for rich patients is done and the surplus medicines are used for poor patients.

In one PHC, a doctor showed us with pride how he stamped every case paper at the top right hand corner. When any patient came to the OPD he / she was asked whether he / she had undergone a sterilisation operation, and if yes, after how many children. Patients who had undergone the operation were given Septran; or a more potent antibiotic, if the surgery was done after two or less children. These antibiotics are not available in large numbers. Those who had not undergone the operation were to be content with Aspirin, which was the only tablet available in plenty in all PHCs.

Usually, drugs required for National Programmes, particularly the immunization programme and sterilisation operations, were in adequate supply. But drugs for TB and Leprosy were sometimes not available. Some doctors rationalize this by saying, "anyway PHCs are not meant for curative care, our job is preventive care and the drug supply we get is adequate for that purpose". But others felt that this perpetual inadequate supply of drugs was an insult to their training and their esteem as doctors. But, most of them felt that when the drug budget needed to be increased, there were threats of it being slashed. The Medical Superintendent of one Cottage Hospital told us that the drug budget had been halved in the last year and they had received a GR again for another 25% cut. This was also accompanied with the threat that if he did not manage with the reduced budget, the extra expenses would be cut from his salary.

Time for Intervention

While rising drug prices were ultimately always directed at hapless patients, the recent liberalization trend has also alarmed the doctors. They find their esteem as healers being questioned by patients who cannot afford what they prescribe. It is well-known that doctors fall prey to the hard sell tactics of the drug companies, this being the largest influence on their prescribing habits. They are aware that drugs are increasingly being promoted, not necessarily for what they are worth, but only for profit. The rural doctors whom we met were well aware that most of their clientele was not able to afford prescribed drugs.

The problem of cost of drugs can be addressed on different planes. One of these is to convince doctors of a more rational practice e.g. prescribing less tonics / placebos etc. Of course this is very difficult. It has been tried time and again by the rational drug movement activists with partial success. Today, the country is facing the threat of the Dunkel proposals. This would result in an increase in drug prices on a much larger scale. It is possible that the impression of some doctors that the smaller doctors would be pushed out of business, might come true. This is perhaps the right time for intervention. In such a situation the doctors, particularly those practicing in rural areas, might pay more attention to the fact that 'rising drug prices' is an adverse effect of the liberalization policy and the globilization phenomenon may have frightful consequences on their lives.

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positive repurcussions.

Firstly it focussed on the issue of drought and water-scarcity from a women's perspective. Drought is inevitably linked with hunger, poverty, hazards for agriculture. But the lack of drinking water - a basic necessity - and the immeasurable hardships that the rural women undergo while filling this water get sidelined. This was sharply focussed on and the women narrated their experiences in detail. Also they became aware that the pipes were fixed for their benefit by MASUM. As the pipes belonged to MASUM and, by the same measure, to all the women, they could demand their right to draw water.

Secondly MASUM as an organisation succeeded in giving 'accountability', which is no longer a buzz-word in the day and age of stock-market scams, its rightful place of pride. MASUM, itself, displays its annual statement of accounts on the village notice board. Hence the expenditure of MASUM funds by the village should also have been explained to the community. Only when this was done was the fast broken.

Thirdly the formation of a Water Committee meant that the issue of water would be discussed democratically by the ordinary citizens who were members of the committee and the hegemony over water of the rich and landed members of the community would be questioned.

But if these gains are to be consolidated then sustained efforts on the part of the people of Malshiras along with MASUM will have to continue. So the struggle is not over yet.....

An Appeal to our Readers

During the last few months, we have been receiving letters / messages from our readers, informing us that they have not been receiving their copies of the "FRCH Newsletter" regularly. If you or any of your friends, have been facing the same problem, please write to us so that it will be possible for us to follow up the matter with the Post Ofice. Please check that you have received the following issues:

1) Six issues for the year 1992:
   - Four general Issues
   - Two Special issues:
     - Special Issue on the Handicapable
     - Special Issue on Children
2) Two issues for the year 1993:
   - Jan.-Feb. issue:Special issue on AIDS
   - Mar.-Apr. issue: A General Issue

Editor

LIBERATION FROM LIQUOR
a way to development

Abhay Bang

Dr. Bang, a friend of FRCH from 'SEARCH' (Society for Education, Action and Research in Community Health, district Gadchiroli, Maharashtra), shares his experiences of the movement for liberation from liquor with us, which we would like to share with our readers.

All liquor shops in Gadchiroli district were closed down on 29th March '93 effectively putting stop to the annual alcohol trade of Rs. 200 million. People, especially the women and children, are experiencing tremendous gains in their lives. This has further strengthened our conviction that liberation from liquor is a way to development.

When we faced the widespread problems of alcoholism in Gadchiroli on our arrival here in 1986, our first response was medical de-addiction. Twenty men were de-addicted in one year out of which fifteen relapsed into the addiction. And there were thousands of addicts in the district! Obviously the medical approach was extremely inadequate. So we decided to turn to people for the solution.

In the pilot work emerged a social model to control the availability and consumption of alcohol in the villages. Very rapidly the small public health work became a massive 'Liberation from Liquor Movement' which, in 1988, made two demands to the state government:

1. Stop the trade of alcohol in the district by cancelling the licenses.
2. The power to control alcohol should be given to the village.

In the last five years, 600 villages, 334 organisations and 40,000 people in Gadchiroli district participated in the movement forcing the state government to declare the district dry from 2nd October '92. A stay by the high court prevented the government from implementing the 'prohibition'. But, in a gathering of 10,000 representatives from 300 villages, the movement declared the programme of 'people's liberation from liquor'. In the subsequent six months 200 villages put effective community ban on the consumption and sale of alcohol using a wide variety of creative social and political techniques. Thus people have taken control of their lives with regard to an issue they considered very vital.

After a legal battle of six months, the highcourt finally declared the prohibition order valid resulting in closure of the licensed alcohol shops in the district. One goal has been achieved. The movement shall hereafter concentrate on the community control of alcohol, on preventive education of the individuals vulnerable to alcohol and on providing de-addiction services to the addicts.

The movement has already spread to the adjacent Chandrapur district. Women in Andhra Pradesh have successfully forced the state government to declare prohibition. The tide is definitely turning against alcohol in India. This heralds emergence of new frontier of public health and action — ***Action Against Alcohol !***

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The issue of 'Bombay Market Drugs' is a different story altogether. These sub-standard allopathic drugs which are provided in bulk at extremely low costs, seem to be the saviours of the GPs. Ayurvedic and homeopathic drugs have also not escaped the cutting edges of competition. Ready-made operations and steroids are commonly used for large-scale production of traditional medicines. There is no standardization for these products. Simple powders and potions prepared from locally available herbs being comparatively expensive, cannot really stand the competition of modern medicines. Certainly, the healing practices and their allied agencies are governed by a larger capitalist scheme.

Charging Patterns

Medical practitioners in Ahmednagar district unanimously claim that cut-practice and feed-back mechanism have not yet infiltrated into their towns so far. But there is a definite shift of focus from consultation to diagnostic tests and medication. Relevance of sharing pain and that of giving professional opinion / advice as an essential part of therapy is very often neglected. If the patients are made to realize this and also to pay for consultation, even by the GPs, the demand for injections and medicines would automatically come down. In this way, doctors would resume their legitimate professional function rather than being accomplices to the drug merchants. Doctors are divided over fixed or flexible charging system. Despite the tension between the professional commitment and cost of giving standard medical treatment and the humanitarian ideals about charging consessional fees, the conviction against charity towards patients remains unscarred. Nevertheless, in practice, rural doctors are forced to forego their charges in many cases. Patients too have contradictory feelings about paying charges. Rural patients, not necessarily poor, invariably expect concessions, credit, or free treatment. Yet, they would doubt the healing powers of a system or the knowledge of a doctor if inexpensive treatment is offered. Homeopaths are forced to charge more for the same reason, only to experience yet another disillusionment. People try Homeopathy only after all other therapies have failed. And they are not willing to pay even half of the charges that they pay elsewhere.

Impressions about Consumer Protection Act (CPA)

It is difficult to refer poor rural patients to specialists in the cities. Rural doctors have to therefore take greater risks and all important decisions for handling difficult cases with inadequate facilities. The issues of non-maintainable hospital standards, mistaken self-assessment of the doctor and that of medical negligence are closely

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LIBRARY NEWS

Books

1. Buck C. and Llopis A., **The Challenge of Epidemiology: issues and selected readings**, Pan American Health Organization, Washington, 1989, pgs. 989.
2. Channabasavanna S.M.and Shah S.A., **Affective Disorders: recent research and related development**, NIMHANS, Bangalore, 1987, pgs. 239.
3. DANIDA, **Essential Drugs Project Bangladesh: final report** (1986-1990), DANIDA, Dhaka, 1991, pgs. 248.
4. Dasgupta S. and Murty L.S.N., **Panchayati Raj Institutions in West Bengal**, NIPCCD, New Delhi, pgs.72.
5. Dunstan G.R. and Seller M.J., **Consent in Medicine**, King Edward's Hospital Fund, London, 1983, pgs. 128.
6. Ghai O.P., **Understanding and Managing Acute Diarrhoea in Infants and Young Children**, AIIMS, New Delhi, pgs. 25.
7. Ghosh R. and Zachariah M., **Education and the Process of Change**, Sage Publications, New Delhi, 1987, pgs. 301.
8. Govt. of India - Ministry of I. and B., **India 1992: a reference annual**, Publication Division GOI, New Delhi, 1993, pgs. 930.
9. Morris F.R. and Wilkins R.W., **Quiet Riots: race and poverty in the United States**, Pantheon Books, U.S.A., 1988, pgs. 223.
10. **ICMR Report on Research Activities During 1990**, ICMR, New Delhi, 1990, pgs. 162.
11. Isaac M.K. and Chandrashekar C.R., **Manual of Mental Health for Medical Officers**, NIMHANS, Bangalore, 1985, pgs. 210.
12. Jain A.K. and Visaria P., **Infant Mortality in India: differentials and determinants**, Sage Publications, New Delhi, 1988, pgs. 398.
13. Jarman H. and Scrivener B., **Sardar Sarovar**, Narmada Bachao Andolan Bombay and others, 1992, pgs. 363.
14. Mascarenhas M.M., **The Population Trap**, C.R.E.S.T., Bangalore, 1990, pgs. 41.
15. Misquith D., **System Analysis of Health Care Delivery in Plantations under United Planters Association of Southern India**, 1993, pgs. 303.
16. Rose G. and Barker D.J.P., **Epidemiology for the Uninitiated**, B.M.J., London, 1983, pgs. 59.
17. Sriram T.G. and Chandrashekar C.R., **Manual of Psychotherapy for Medical Officers**, NIMHANS, Bangalore, 1990, pgs. 60.
18. Thimmayamma B.V.S. and Menon K., **Use of Food Products in Supplementary Feeding Programmes in Andhra Pradesh**, NIN, Hyderabad, 1987, pgs. 76.
19. World Bank, **World Development Report 1992**, OUP, Oxford, 1992, pgs. 308.
20. **Partners in Health: the role of NGOs in health development**, WHO, New Delhi, 1988, pgs. 13.

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intermingled. Doctors argue that the fault does not always lie entirely with the doctor. Patients make very little attempt to understand the treatment and to participate consciously in the medical decision. But as Dr. Arun Bal of ACASH points out, "even the most uneducated, backward..... person can be communicated the facts of his / her illness if the will to do so is present in the doctor. At present such a will is conspicuously absent". The patients litigate doctors when things go wrong. In many instances doctors feel they are unjustifiably litigated.

Unnecessary litigations can certainly be minimized if, as Dr. Bal suggests, "Informal reconciliation machinery (is) formed with the help of consumer organizations". Instead, doctors are panicking over the issue of medical malpractices surfacing with the growing consumer interventions in this field. It is difficult to convince doctors about the usefulness of the CPA. Consumer movements are neither painting the doctor-patient relationship in black and white, nor limiting the scope of their action to just doctors and patients. They are aiming at medical malpractices in general, including offensive behaviour towards the doctors by insurance companies, dealers of medical equipments, big hospitals employing young doctors, etc. Consumer movements are looking forward to doctors' co-operation because even if the latter are trapped in the logic of the medical-market, they are better equipped to break out of it. Doctors are in a privileged position and hence capable of comprehending the socio-economic reality and also of exercising self-regulation.

The issues emerging from the discussions dwelt upon here have served as guidelines for the second phase of the present study. This phase would focus on the actual investment and expenditure patterns of a selected sample of health establishments in both, the private and public sectors.

References

1. Bal Arun, **Consumer Protection Act and Medical Profession**, *Economic And Political Weekly*, Vol. 28 (11), March 1993, pp.435.
2. Indian Express, 27th December, 1992.
3. Wear Andrew (Ed.), **Medicine in Society: historical essays**, Cambridge University Press, Cambridge, 1992, pp.7.

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COMMUNITY HEALTH CELL
326, V Main, I Block
Koramangala
Bangalore-560034
India

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HEALTH FOR ALL IN INDIA
A Long Way to Go

Ravi Duggal and Sonya Gill

This is the seventh and the last article in the series, "Health Financing and Costs: comparative perspectives". (No.1 - Japan; No.2 - Zambia; No.3 - China; No.4 - Brazil; No.5 - Sri Lanka; No.6 - Canada). We invite our readers to write to us regarding their impressions about this series. It will help us in planning our future series'.

Multiple medical systems, the fast growing private medical services, grossly inadequate public services, enormous differences in the availability and quality of services in urban and rural areas, and the neglect of public health and epidemiology are the central features of the Indian health care system. It is one of the largest health care delivery systems in the world and has grown at a remarkable pace in the forty five years since Independence. But as a result of the wide disparities India has made slow progress in meeting the health needs of its people and compares poorly with those Asian countries such as China and Sri Lanka that started at the same level of development.

Health Status

India's population of 844 millions is three-quarters rural and highly dependent on agriculture for its livelihood. Indians as a whole have experienced a major improvement in survival chances, with life expectancy rising from 31 years in 1947 to 60 years at present and general death rates falling from 27 per 1000 population to 10 per 1000 (Table 1). The decline in the rate of infant deaths (from 146/1000 births in 1951 to 91/1000 in 1989) and child deaths (currently 33 per 1000 in the 0-4 years age group) has contributed to the longer life span of the people, and itself reflects the small improvements in living standards, reduction in severe malnutrition and efforts to control communicable diseases. These overall figures hide, however, very large variations in health status across regions, between rural and urban areas and different socio-economic groups. Almost 39 % of all deaths are among children aged 0-4 years. The infant mortality rate crosses 120 per 1000 live births in rural Orissa, Madhya Pradesh and Uttar Pradesh, and is above 100 per 1000 births in rural areas of Bihar and Rajasthan. The excess female deaths in age groups upto 35 years and a persisting adverse sex ratio is another feature of health conditions. The poor female health resulting from widespread anaemia and malnourishment combined with very poor availability of maternity services manifests itself in a high maternal mortality of 500 per 100,000 live births, that rises to 800/100,000 live births in many rural regions. In sharp contrast to this mortality pattern is the experience of Kerala where all health indicators, including birth rate, have long surpassed even the targets India hopes to achieve by the year 2000 AD.

TABLE 1
HEALTH STATUS

State	Year	Crude Birth Rate (per 1000 pop.)	Crude Death Rate (per 1000 pop.)	Mortality Rate Infant per 1000 births	Mortality Rate Maternal per 100,000 births	Life Expect. At Birth (years)	Literacy Rate (%)
India	1951	39.0	27.4	146	---	31	16.7
	1989	30.5	10.2	91	500	60	52.1
Kerala	1989	19.8	5.9	22	---	70	90.6
U.P.	1989	37.0	12.6	118	---	54	41.7

Source: GOI, CBHI, Health Information of India (Respective years)

The highest toll of mortality and morbidity is from preventable and easily curable communicable diseases, amongst which pulmonary tuberculosis continues to be the most severe and widespread public

Sonya Gill was a co-researcher in the above FRCH study. She has written this article in collaboration with Ravi Duggal who was a senior researcher at FRCH, and contributed to this study.

health problem (9 million cases in the country and four lakh deaths every year). Tuberculosis, pneumonia, anaemia, gastroenteritis, dysentery and typhoid together account for nearly 20 % of all deaths. Since 1971 malaria has shown a resurgence, while filariasis, encephalitis and meningitis are currently on the rise. Along with communicable diseases, the chronic and degenerative problems particularly cardio-vascular diseases and cancers, associated with developed societies, are also rising as a proportion of all deaths.Underlying this public health situation are the large-scale poverty (40% below the poverty line), malnourishment and chronic hunger among the lower income groups, illiteracy, and the lack of environmental sanitation and clean drinking water supply for most of rural India. It is this failure to provide social inputs on a wide scale that is responsible for such modest achievements as against the significant improvements achieved by an average income state like Kerala.

Health Policy

At Independence, India inherited a very limited infrastructure of public health and organised health care services. Allopathic medical care and preventive and environmental measures were narrowly concentrated in centres of commercial activity and colonial military and civil administration. Ayurveda and other indigenous medical systems were the only available services for the mass of people, again largely in urban areas, while caste-based herbalists and healers were the main providers in rural areas. The nationalist vision of a new India responsive to the rural majority, the increased role for the State in social security and welfare in Western countries after World War II, and the 'right to health' approach of the USSR, all influenced two remarkable pre-independence policy documents — the Sokhey (1942) and the Bhore (1946) Committee reports. The Bhore Committee made a detailed survey of health conditions at that time and recommended an integrated national health service organised on a 3-tier model, which was to provide complete medical and curative care as close to the people as possible. It gave a detailed plan for developing the infrastructure for the primary and district levels which was highly suited to provide preventive and rural services, the time frame of 30 to 40 years for achieving this, and the resource burden that would fall on the government. It estimated that the State would need to increase its health expenditure by three times, from the existing 4.5% to 15% of the total government expenditure. The conceptual framework of the Bhore plan became the blue print for developing the public (government) health services sector in India but its specific recommendations were only selectively and minimally implemented. India's chosen path of development gave priority, in investment, to creating the socio-economic infrastructure necessary for the growth of private capital, and neglected and under-funded the social sectors. Initially two concepts from the Bhore plan were picked up for implementation — the primary health units and the programmes to control communicable diseases. The former, as it exists today, consisting of a 4-bed health centre with two doctors and some paramedic staff to cover a population of 30,000 is not even an apology of what was originally outlined. The latter, implemented as separate vertical top-down campaigns showed some initial success, particularly the malaria control programme. In the absence of basic health services in the rural areas, however, the impact of these programmes could not be consolidated and these too were increasingly marginalised within the government health services as increasing priority was given to the family planning activities and targets.The only target of the Bhore Committee plan to be achieved is the production of doctors, but this has only accentuated the imbalances, by concentrating health services in urban areas and the private sector. Viewed historically, the inequalities and imbalances in health care services have continued to grow over the past forty five years as a result of policy support and subsidies to the production of doctors for the private sector as well as subsidies for setting up private practice and private hospitals, the disproportionate concentration of medical services in urban areas, and granting permission for the large-scale migration of medical professionals and health personnel. The poor coverage of public services and the long-term under-funding of this sector has encouraged a rapid growth of the commercial health sector. Its accelerated growth since 1976, has occurred in the very period when the community health model was being projected as an alternative method for strengthening the public services and making them accessible to the underprivileged and rural majority with the help of paramedic staff and non-professional village health workers. This model, incorporated into the National Health Policy of 1983, has made little difference to the poor state of the public services in the rural areas.

There are thus two sub-systems in health care, the smaller public health care system and the dominant private health care system. The public services are constitutionally the responsibility of the state governments, but the Central government has played the more significant role by defining policy and influencing the choices in the health programmes through allocations of funds and grants. The private sector is estimated to control 70 % of all health resources but it has never been planned or regulated, and no policy document has ever looked at the private sector in order to arrive at a holistic picture of the Indian health care system.

Health Care Services

Around three-fourths of all routine illnesses, both in urban and rural areas, are treated by self-employed private practitioners. On the other hand public facilities are used for 60 % of all inpatient care. The private practitioners, who form the largest component of the private health services, are extremely diverse in their qualifications, practice patterns and the quality of care they provide. Almost 69% of qualified allopaths and 90% of non-allopaths work privately. A major policy concern should be the large numbers of unqualified practitioners among them, particularly in the rural areas. During a nation-wide survey of diarrhoea in rural India, it was found that 62% of practitioners had no medical qualification and 61% did cross-practice between different systems of medicine. In the absence of regulation and licensing of providers in India, a large number of helpers, compounders and assistants to other doctors have set up practice and dispense medicines.

TABLE 2
HEALTH DELIVERY

State	Year	Physicians (Allopaths) per 100,000 population		Nurses per 100,000 population		Beds per 100,000 population	
		R	U	R	U	R	U
Bhore Recommendations*		62.3		150.8		576.0	
India	1981	11.3	93.8	7.2	65.9	17.6	239.7**
Kerala	1981	18.8	81.5	48.7	107.4	192.4	425.9**
U.P.	1981	12.9	83.8	10.1	54.7	7.6	191.6**

Note: * *Uniform provision for the whole country*
** *1989 data*
Source: *GOI, Census of India, 1981;GOI Helath Information of India, 1990.*

According to the 1981 census data, 41% of all doctors (indigenous systems and allopathy) were in rural areas, but the actual proportion of qualified allopaths, serving approximately 76% of the total population residing in rural areas, was just 27%. Medical education, largely subsidised and provided by the government has grown rapidly from an annual out-turn of 2000 doctors in 1950 to around 20,000 at present. This includes around 15,000 MBBS graduates from 128 recognised colleges and the rest from the increasing number of private, unrecognised colleges. Additionally the admission capacity in other systems of medicine is approximately 10,000. The availability of doctors has as a result, increased markedly from 17 allopaths (43 doctors of all systems) for 100,000 population in 1950 to 43 allopaths/100,000 population (106 doctors of all systems) today. These are increasingly becoming concentrated in the urban private health care sector, with the result that the proportion of doctors working in rural areas has actually declined in the past 40 years or at best improved marginally in certain states. The weightage in public policy to developing highly trained doctors and specialist skills has meant that the rural (and even urban) public sector primary medical and preventive services have suffered acute shortages of both medical and paramedical staff. A further distortion of the health services is the low priority given to paramedical education and the training of nurses. In most states, barring Kerala, the number of doctors exceeds the number of nurses, and even the proportion of paramedics, especially nurses, in rural areas has declined between 1961 and 1981. The public services are organised differently in rural and urban areas, almost constituting two separate delivery systems. For the country as a whole, in 1989, there were 10,172 hospitals (31% rural), 28,304 dispensaries (45% rural) and 625,418 beds (17% rural). The distribution of inpatient facilities available to the rural population has hardly changed since 1956. From a mere 10.9 beds per 100,000 rural population the availibility has increased to 17.4/100,000 today, whereas in the urban areas it has increased from 165 to 239.6 per 100,000 urban population. Despite the greater severity of health problems in rural areas, good curative care in the public sector is concentrated in urban areas in the form of city civil, specialist and teaching hospitals. This urban concentration is further accentuated by the huge private sector consisting of diagnostic centres, nursing homes and super specialist corporate and trust hospitals. Rural areas on the other hand are served by a rural hospital for 500,000 population, primary health centres for 30,000 population and paramedic-staffed sub-centres for 5000 to 6000 population. These rural public sector institutions have selective focus on certain preventive and promotive services such as detection and treatment of communicable diseases, immunisations and family planning.

The Minimum Needs Programme launched in 1974 within the Fifth Five Year Plan gave a thrust to the expansion of rural health services. Subsequently, the new population-based norms for developing primary health care infrastructure laid down in the National Health Policy of 1983, led to a rapid expansion of a network of public facilities. Yet while the coverage at the lowest level — the sub-centre, has physically expanded, the referral and support services needed to ensure good curative care have not kept pace. On an average no state has met the norm of having a CHC or small rural hospital for 80,000 to 120,000 population. A large number of vacancies for posts of doctors and supervisory paramedic staff exists and the quality of care suffers from acute shortages of crucial inputs, especially drugs. Despite a large physical infrastructure PHCs are not meeting the demand for curative services and are hence underutilised in the majority of states. Since 70% of the time of paramedical staff is spent on identifying and motivating eligible cases for family planning, the rural population is not motivated to utilise the primary health centres.

Health Financing

Health expenditure in India amounts to an estimated 6% of GDP which is fairly high spending for a low-income country. The public share of this spending is however, just 1.6 % of GDP, while 4.5 % of GDP is spent privately. This ratio of public to private expenditure is contrary to the trend in health spending in countries with more efficient, comprehensive and better quality health care systems. The trend worldwide is towards publicly controlled or publicly regulated health financing methods which ensures that health care is accessible to individuals when they need it irrespective of their capacity to pay. In sharp contrast, in India, the private expenditures not only constitute 75 to 78 % of total health spending, but three-fourths of this private spending itself is the direct expenditure made by households. This large volume of private health expenditure and its rapid growth in the past 15 years has hardly been documented, but constitutes an enormous burden on lower income groups. Various household surveys have shown that per capita health care spending ranges between 7 to 9 % of total consumption expenditure and on an average the per capita annual health spending could be Rs. 178/- (Kerala), or Rs. 183/- (Maharashtra) or as high as Rs. 299/- (Madhya Pradesh). It is obvious that almost half the country's population which lacks sufficient resources to meet even its food requirements, is not going to utilise health services or only take intermittent treatment due to the costs involved. The costs of travelling to distant public health centres in rural areas and the out-of-pocket expenditure on drugs in short supply as well as poor quality of care, means that public services are free only on paper.

The latest estimate for government (both Central & State) health expenditure is about Rs. 60/- per capita per annum, (Rs. 80/-, if expenditure on water supply and sanitation that does not come under the perview of the Ministry of Health and Family Welfare is included). The public expenditure on health has declined from 4% of total government expenditure in the First Plan period to 3.8% in the Seventh Plan. The Bhore Committee had recommended raising it to 15% by the early '80s. The developed states like Goa, Maharashtra, Punjab, Haryana and Gujarat have higher per capita public expenditures than the backward states of Bihar, Orissa, UP and Rajasthan. Low-income Kerala is once again the exception.

The spending on curative (medical) care, though still the single largest component of public expenditure, has declined from 43% in 1951 to 37% in 1985. Given the growing demand for medical care, the vacuum has been filled by private services. Much of the curative care expenditure is on urban hospitals and dispensaries. The rural health system, such as PHCs and sub-centres, is funded by the other components of the government budget, namely Communicable Diseases Control Programmes (between 12 to 13% of total public health spending) and Family Planning (16% of the total). The latter programmes indicate the bias towards preventive services for rural areas, while curative care is better available in urban areas. The urban areas also gain from public spending on teaching hospitals (10% of total spending is for medical education), statutory insurance for organised workers, and municipal services.

The acute under-funding of rural health services is evident from the fact that just 25% of total curative care expenditure is spent on rural facilitates, i.e Rs.9/- per rural inhabitant as against Rs. 65/- per urban dweller. Salaries have absorbed an increasing share of this small budget (between 66 to 80%) leaving just 25% of the funds for medical supplies and material inputs. The under-supply of drugs has reached such a crisis point that 58% of PHCs and 80% of sub-centres were found to be

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LESSONS FROM LEPROSY FOR AIDS

N.H. Antia

The present unrealistic fear of contracting AIDS is nothing new to those who have worked with leprosy patients for the past three decades. Even when leprosy was no longer an incurable disease due to the availability of Dapsone, and though it is not contractable through casual contact, the stigma attached to leprosy was as intense as it is at present to AIDS. This stigma was reinforced by the medical profession who continued to treat it as a disease apart from all other diseases. Leprosy patients were not admitted to general hospitals and the sufferers were confined to distant leprasoria generally run by missionaries. It was hardly fair to expect the public to accept cured patients, when the doctors, even in leprosy institutions, sat behind barriers and refused to handle the certificates of cure and rehabilitation once issued by themselves.

No amount of health education can succeed in the presence of such an attitude of the profession to whom the people look for advice and opinion regarding all their health and disease problems. And yet it is the changed attitude of the same profession which has brought about a transformation in the attitude towards leprosy patients during the past three decades. The first leprosy patient was admitted to the plastic surgery department of the J.J. Hospital in 1959 for correction of a deformity of the face. It proved to be a myth that this would lead to refusal by doctors, nurses and wardboys to work and other patients to be treated in the same department, for not a single objection was raised by anyone. Those who had propagated this myth had now to accept this as a *fait accompli*. Thousands of patients have since been accepted in various departments of general hospitals all over the country and researchers handle live germs of this disease like any other pathogenic microbe. The stigma could not have been reduced by mere slogans like 'Leprosy is Curable', without actual demonstration by the professionals. Strange as it may seem the integration of leprosy into medicine and health services has been opposed by leprologists themselves who have a vested interest in this disease. This is true of specialists in almost all fields.

The AIDS Stigma and the Western Media

The stigma attached to AIDS is following a very similar pattern even though it is a relatively new disease. Unfortunately being a disease which has originated and spread from the Western societies, it has received media coverage more in conformity, with the needs of Western media, than with its medical and epidemiological reality in this country. Within a decade this has led to stigmatization of the disease of an extent which has taken centuries for leprosy. The power of Western media to influence human behaviour is revealed by the way it has instilled this unrealistic fear even in the medical profession, for it needs a Shabana Azmi to bring sanity to the scene.

Dr. N. H. Antia is the Director, Foundation for Research in Community Health, Bombay and Pune.

While none should underestimate the consequences of AIDS to the 'need based' countries, it must be realized that while AIDS may be a major consideration in the Western society, it is only one more major hazard to the health of the poor of the world where millions die annually from diseases like gastroenteritis, acute respiratory infection, malaria and tuberculosis — for which we have knowledge as well as simple and cheap technology for their prevention, cure and control. Tuberculosis affects nine million people in India at any one time, of whom, 4,00,000 have died annually for the past three decades. Western media, through channels like Star TV choose to ignore this while blowing up the danger of its spread via AIDS, relying chiefly on the testimony of Western experts which is based on poor epidemiological data.

The $100 million loan given to India by the World Bank to combat AIDS, is further distorting the approach to this disease which should be based on detailed countrywide epidemiologic data and scientific information about this disease, and not on a knee-jerk response. The almost entirely urban approach of the World Bank based on urban data collected by urban doctors and urban social workers seems to ignore the fact that 70% of our population is rural. As a result of the urban-rural nexus there will soon be a larger problem of rural AIDS as predicted by the epidemiologist Roy Anderson, a WHO consultant epidemiologist on AIDS. The injection of vast sums of money is leading to a 'run' on this new Bank account with everyone wanting a piece of the cake.

Changing Attitudes: an uphill task

The chief method for containing its spread lies in changing the sexual habits rather than devoting excessive attention to blood transfusion or protection of the doctors. This needs a predominantly anthropological and sociological rather than a medical approach for both understanding the problem as well as solving it. It is unfortunate that the role of the social scientist is seldom adequately appreciated in the field of health and disease and is generally converted into a techno-managerial one by the medical profession and the health bureaucracy. Lack of understanding of social, economic and cultural factors, generally leads to a failure in achieving the desired results. Social workers cannot replace sensitive social scientists who are prepared to live with the people they study. These are unfortunately a rare breed, same as epidemiologists.

The study of the problems of sexuality among the rural population needs attention, as revealed by the high rate of promiscuity and prevalance of sexual diseases in a study by Dr. Rani Bang, of the tribals of Gadchiroli. It is rare to find such urban trained researchers living for prolonged periods in rural communities, without which little can be gained in a subject requiring both intense personal and cultural rapport as well as high technical and analytical skills.

Changing of attitudes and practices in such a highly private and personalized subject cannot be achieved merely through the use of mass media which in any case are not the media of the majority,

especially the rural population. For them, meaningful communication is the oral communication - through interpersonal and small group discussions.

Deeply ingrained cultural practices cannot be changed in a subject like sex, merely through television, radio or even through health education, that is, lectures or group meetings. The professionalised techniques of social marketing for goods and commodities have not proved effective, even when employed extensively, as in Family Planning.

The high illiteracy rate especially in the BIMARU states is also a handicap in using many of the mass media.While changing the attitudes and practises may pose difficulty, mass media can be more effective in creating fear. Unfortunately, as in the case of drug addiction, it may not only prove of limited value in AIDS but its association with tuberculosis may revive the stigma to the latter disease.

The Need for the Right Approach

Leprosy also teaches us that fear leads to concealment and delay in early detection of the disease, which in turn helps the spread of infection. Early voluntary reporting and treatment compliance showed a marked improvement with the decrease of stigma. As in the case of leprosy, the control of AIDS will require a prolonged massive effort at the grass root level where the problem like most other health problems lies. A hysterical response, dictated by Western advisors who provide loans and termed aid will not do, because it leads to further indebtedness and there is a failure to understand the entirely different culture and ethos of the majority of our people who are at the greatest risk. Urban industrialization dictated by imported Western models of development is not only responsible for creating the conditions for prostitution and spread of sexually transmitted diseases (besides many others) but is also responsible for its spread to rural areas when urban workers visit the families left behind in the villages.

THE NEEM CAMPAIGN

This is an appeal made by the following organisations, to join the campaign against the theft of common intellectual property of the Third World People by Transnational Corporations, which is being given international legal sanction by the GATT Agreement.

* *The Research Foundation for Science, Technology and Natural Resources Policy,*
* *Karnataka Rajya Raitha Sangha,*
* *Azadi Bachao Andolan,*
* *All India Drug Action Network, &*
* *People's Health Network*

It has come to our notice that the bio-pesticidal properties of the Neem have been patented by one Robert (Tony) Larson from the US (Patent No. 4,556,562). The claim for the patent wilfully ignores the fact that Larson has patented and made his private property what is the common natural/cultural and intellectual heritage of the people of India who have selected and used the neem's biopesticidal properties for millennia. Larson has further sold his patent to W.R. Grace & Co., USA for a sum of $150,000 cash, 5% of the royalties and 50% of the foreign license fees. Larson however has taken W.R. Grace to the court for breaking the agreement. The neem has also been patented by Dr. James Klocke in the U.S. (Patent No. 5,047,242) in 1991. This patent too may be owned by W.R. Grace. W.R. Grace is setting up a plant in Antarasanahalli, Tumkur Dist., Karnataka, in collaboration with P.J. Margo Pvt. Ltd. The plant will initially process 20 tonnes of seed per day for export to the US. W.R. Grace is producing and marketing the neem pesticide internationally under the names MARGOSAN-O and BIONEEM. The latter is marketed by their subsidiary, Ringer. W.R. Grace & Co. claim that their Tumkur plant is the world's first commercial scale facility specially designed and built for producing neem-based pesticides. This claim is totally false. Neem based pesticides have been commercially produced and marketed in India by the small-scale sector under various brand names.

Patenting the active principle of the neem is :

- **a direct attack on the intellectual contribution of a Third World country;**
- **open theft of common intellectual property of the people of a Third World country;**
- **an arrogant statement that the intellectual contribution of a person/organisation from the First World has a hand in developing it.**

The issue of the Neem further makes clear that the individual, the community and the Third World countries have no rights of safeguards against piracy by Transnational Corporations. This piracy is being given international legal sanction by the GATT Agreement on Trade Related Intellectual Property Rights.Succumbing to the US Super 301 clauses, the government of India is betraying the people of India and those of the Third World by signing the GATT Agreement in secrecy. By doing so, it is signing away the sovereignty of India and the human and national rights of its 800 crore people.

THE NEEM CAMPAIGN demands that:

- **the US patents on the neem granted to Robert Larson and James Klocke be withdrawn.**
- **unequivocal rejection of the US patent laws by the Indian government and other Third World countries.**
- **rejection of the GATT Agreement on Trade Related Intellectual Property Rights.**
- **protection of Third World Biodiversity and Third World knowledge through the effective interpretation and**
- **implementation of the Biodiversity Convention.**

THE WORLD BANK REPORT ON HEALTH-CARE STRATEGY
A Critical Discussion

Anant Phadke

The World Bank, for its annual World Development Report (WDR) for the year 1993, chose 'health care' as its subject. This report, titled "Investing In Health" was released in July 1993 and the World Bank decided to release it in India this year.

A hundred thousand copies of this report are being distributed all over the world. A series of meetings were organized by the World Bank in some of the major cities in India, to launch this report. The FRCH organised one such meeting at the request of the Bank, on 10th of July in Bombay. About forty prominent health workers and health researchers, mostly from Bombay, were invited to participate. The researchers from the FRCH and the FMR were also present.

The World Bank Recommendations

Prof. T. Jamison, the Staff-Director of the World Bank team which has prepared this report, had specially come to India to launch this report. He, along with his colleague R. Skolnik presented the background and the chief recommendations of this report. They argued that the international experience showed that the investment in health-care was extremely cost-effective and hence the Bank's interest in health-care.

The report argues for a three pronged strategy to improve health:

1. "Foster an environment that enables households to improve health": This includes growth-oriented economic policies, expansion, investment in schooling especially for girls, and promoting rights and status of women.

2. "Improve government spending on health": This includes reduction in government expenditure in tertiary care facilities, increase in governmental spending on highly cost-effective package of Public Health Interventions, improvement in the management of government services through measures such as decentralisation and "contracting out".

3. "Promote diversity and competition in health services": This means that apart from the government financed "package of essential health services" there should be social or private health insurance.

4. "Encourage suppliers to compete": One of the implications of this policy, as the report itself further says, is that "the domestic suppliers should not be protected from international competition".

The Criticism of the World Development Report (WDR)

The impressive look and the sophisticated language of the report did not seem to impress the participants. This was partly because of the image of the World Bank as the agency for promoting foreign interests and the privatization to which most participants were opposed. The report was criticized without inhibitions by most of the participants. The fact that such a big report was made available hardly a week before this meeting, was also criticized.

The following major critical points were raised :

1. Neglect of socio-political reality: Just the pumping of more money into "cost effective public health services" is not going to produce the desired results. The experience of last forty years, as to why different schemes did not work, has to be analysed. The structural maladies which result in the dysfunctional public health system, have to be corrected. The WDR does not talk about this important problem. The tertiary hospitals, like the J.J. Hospital in Bombay, serve mostly the poor patients and are the bases for training new doctors. If they are further starved of funds, the poor will have nowhere to go and the standards of medical education will decline. The tertiary hospitals in the private sector would grow but the teaching public hospitals would be degraded.

2. Private sector not touched: "Greater reliance on private sector" shows a misplaced faith in the private sector. The reality is that the unregulated private sector is too costly, wasteful, substandard and exploitative. A number of examples were quoted to illustrate the nature of the unregulated private sector in India. The drug industry is the biggest example of how national resources are wasted on unscientific drug combinations. It was therefore forcefully argued that unless the drug industry and the private sector are radically improved through strict rational regulation, mere pumping of more resources into public health services (if at all this is actually done) is not going to change the health scenario in India. It was pointed out that all interventions must be seen within the context of the ground reality in India. Only 1.3% of the GDP is spent on Public Health Services and 4.7% is spent on Private Health Services. Public Health intervention in the context of a major, irrational private sector, has been ineffective.

3. Fragmented approach: There has to be a comprehensive approach in public health interventions. Isolated vertical programmes in the absence of basic comprehensive services are ineffective. Secondly there has to be integration within different social sectors. Increasing the budget in education and reducing it by 20% in health shows a disjointed approach. Fears were expressed that Structural Adjustment Programme (SAP) would affect adversely the poor and the women. In the context of worsening socio-economic conditions, all the talk about women's empowerment and social upliftment sounds empty. What about the degradation of environment and the consequent diseases caused by the 'green revolution'? What about the impact on health status of increased poverty due to SAP?

4. No mention of non-allopathic systems: Non-allopathic systems have firm roots in our tradition, are cheaper, effective and decentralised. They have lagged behind partly due to their systematic neglect. Yet, they are very much there. Herbal medicines, in particular, offer a bio-mass based, decentralised source of medical care, which

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The author is a medical doctor, active in the Medico Friend Circle and the people's Science Movement. He is presently associated with FRCH on the project "Supply and Cost of Drugs & Pharmaceuticals in a District."

has a strong basis in people's culture. But the WDR does not even mention it and hence there is no programme to upgrade and use these pathies. A homeopathic doctor made a strong plea to give serious thought to this "modern system of medicine which is popular all over the world".

5. Absence of people's control: It was argued that "scientific interventions" at the behest of international agencies do not leave any scope for indigenous, grass-root initiatives. The Bhore Committee, which recommended comprehensive basic health care services; Gandhiji who aimed at developing decentralised, self-reliant rural communities; the experiments like Ralegan Siddhi which show that the rural development can occur without international finance or advice — all these have been forgotten and a dependent, fragmented, centralised model of development is being fostered. This approach to development, itself, has to be basically questioned.

In his response to the above criticism, Prof. Jamison argued that this report does not argue for privatisation of health services; on the contrary, it has argued for a far more expenditure on essential health services in the public sector — from the current level of $ 4 (US) per capita to $ 12 (US); and that the Bank's lending in Public Health facilities has increased from 1% to 5% of its total lendings in the past few years. He clarified that according to the World Bank, in case of education and health, relying on private sector was not enough and the government had to have a leading role. Prof. Jamison claimed that the World Bank was not in favour of vertical programmes, but favoured the strengthening of district level health structures. He further claimed that the SAP had helped many countries to come out of economic chaos. These claims would not have impressed the participants, but there was no further discussion as the time allocated was over and the meeting concluded. Dr. Ms Armaity Desai, Director, T.I.S.S. was in the chair and Dr. M.W. Uplekar delivered a note of thanks on behalf of the FRCH.

The WDR - 93 is not a plea for privatisation; it takes a much more balanced view of the role of the private sector. It has argued for a much higher spending on essential health services. It does talk about the need for social development, increase in the level of education, especially of women, in order to improve the health of the people. It has gathered impressive data from all over the world to estimate the global burden of diseases and has worked out a prioritized list of "cost-effective health interventions". Towards this end, it has brought forward a novel concept — DALY — Disability Adjusted Life Years — to measure the burden of diseases. This concept enables us to take into account losses due to morbidity and thus to go beyond mere mortality statistics by combining the human years lost due to both morbidity and mortality. Secondly it does not measure impact of morbidity or mortality in money terms, but in terms of years of human life wasted. (It is a technical concept, yet vulnerable to ideological prejudices and hence will have to be used very carefully.) Despite these positive features, this report suffers from some basic weaknesses and these were very well brought out in this meeting. But would the decision-makers listen?

Neem : The *Kalpavriksha*

The neem, widely called *Kalpavriksha* (the tree of imagination), belongs to every facet of Indian life — housekeeping, religion and ceremony, agriculture and medicine. Its use may well be taken for granted as a commonplace event in many Indian households. A "grows-in-my-backyard" toothbrush; nature's very own naphthalene balls; the mosquito-repelling smoke from its burning leaves - almost every part and product of this tree has long found some use or the other in Indian society.

A number of neem-based products have been in the Indian market for some years now. Among them are ***"Margo"*** soap, ***"Neem"*** toothpaste and ***"Wellgro"*** pesticides. Neem oil is a widely-used raw material for the soap industry, and neem cake is a good fertilizer. Neem extracts are known to have anti-malarial properties.

Pharmaceutical products :*Galakol* : tablets as galactogogue; ***'JK 22 Tablets'*** : against diabetes mellitus; ***'Neembola'*** : Neem oil capsules against diabetes; ***'Olosyn'*** : soothing action on the nervous system; ***'Loquin'*** : antimalaria tablets; ***'Neem Cure'*** : antiseptic bactericidal skin ointment; ***'Sensal'*** : a herbal medicinal liquid contraceptive.

Medicinal Uses of Neem

Anti-Tubercular activity: Neem oil inhibits the growth of all the three strains of Mycobacterium. **Anti-Fungal actvity:** Nimbidin, Nimbin, Nimbidol and Neem Oil are very effective against various fungi like Tinea rubrum, ring worm fungus, Trichophyton interdigitale, Coccidiodes immitis and other species of Trichophyton at comparatively very low concentrations. **Anti-Protozoal activity:** Nimbidin and Sodium nimbidinate kill paramaecium candatum. **Anti-Allergic activity:** Nimbidin is reported to be effective against eosinophilia with marked symptomatic relief.

Dermatological Diseases: Nimbidin is also effective against various skin diseases such as furunculosis, arsenical dermititis, eczema, scabies and seborrhoeic dermatitis.

Dental Diseases: Nimbidine gargle and dentifrices have been found to be effective in bleeding gums and pyorrhea, etc.

Piracy by the MNCs

While Indian Policy makers and a section of the press may object to the violent mode of protest by the Karnataka Rajya Raitha Sangha, against the seed processing complex of the US multinational subsidiary, Cargill Seeds India, at Bellary some time ago, very few among them appear to understand the full implications of the introduction of seed patents in Indian agriculture at the behest of the multinationals.

If the operations of Cargill Seeds at Bellary appear too distant and esoteric to the average Indian citizen, a similar experiment being undertaken, again by a US firm in Karnataka, should cause concern to every Indian. It involves the processing of the familar 'neem' seed.

A time may come when the seed processing firm - for its increasing requirements for export, may encroach more and more on the the 'neem' trees which till now have remained the common property of villagers all over India. (Similar private commercial encroachments on common property have eroded the access of our people to their traditional food resources, like fish, in the coastal areas.) Further, the MNC attempts at the hybridisation of neem (for greater profits from faster and higher production as had happened in the case of wheat and other seeds) may lead to the gradual decrease and final disappearance of the original 'neem' breed. That this is no idle speculation is evident from the fact that new hybrid high yielding varieties of wheat had driven out the numerous diverse traditional varieties that used to grow in different parts of the world.

Sources: *1. Frontline, August 13, 1993.*
*2. **'Note on Neem'**, compiled from the literature on neem by C.M. Ketkar.*
*3. **Piracy by the MNCs.** ,E.P.W., Aug. 7-14, 1993.*

LIBRARY NEWS

Books

1. Borlaug N.E., **Population: a challenge to contemporary development strategies**, Family Planning Foundation, New Delhi, 1990, pgs.24.
2. David L.H., **Project as Instrument of Change: the DANLEP experience**, ASCI, Hyderabad, 1992, pgs. 40.
3. Desai A.V., **Human Energy**, Wiley Eastern Ltd., New Delhi, 1990, pgs. 139.
4. Gopalan C. and Kaur S., **Women and Nutrition in India**, Nutrition Foundation of India, New Delhi, 1989, Pgs. 378.
5. Gupta R.B., Verma M.M. and Jayakrishnan B. **Baseline Survey in Himachal Pradesh under IPPVI and VII**, IIHMR, Jaipur, 1992, pgs. 200.
6. ILO, **How to Read a Balance Sheet**, Universal Publishing Corporation India, Bombay, 1988, pgs. 214.
7. Jitatmananda, **Holistic Science and Vedanta**, Bharatiya Vidya Bhavan, Bombay, 1991, pgs. 156.
8. Jussawalla J.M., **Art of Healthy Living**, Vikas Publishing House Pvt. Ltd., New Delhi, 1993, pgs. 162.
9. L.S.H.T.M., **An Evaluation of WHO's Action Programme on Essential Drugs**, London School of Hygiene and Tropical Medicine, U.K., 1989, pgs. 137.
10. Mitra A., **Population Stabilisation Strategies in India: an assessment**, Family Planning Foundation, New Delhi, 1992, pgs. 36.
11. Nagi B.S., **Review of Ongoing ORT Programme in India**, Council for Social Development, New Delhi, 1990, pgs. 143.
12. OECD, **Financing and External Debt of Developing Countries** OECD, Paris, 1989, pgs. 217.
13. Puri R.K. and Sachdev H.P.S., **Secular Trends and Determinants of Under-Five Mortality Components in India**, Maulana Azad Medical College, New Delhi, 1991, pgs. 291.
14. Purohit B.C., Juyal R.K. and Siddiqui T.A. **Socio-Economic Case-Mix of Patients Utilising Public Health Services**, IIHMR, Jaipur, 1992, pgs. 188.
15. Ruben M. and Ruben S., **Diagonostic Picture Tests in Ophthalmology**, Wolfe Medical Publications Ltd., London, 1987, pgs. 128.
16. Sood M., Swaroop N. and Batra A. **Voluntary Organisations Working for Children and Women: some profiles**, N.I.P.C.C.D., New Delhi, 1992, pgs. 326.
17. Swaminathan M.S., **Population and Environment: how to meet the twin challenge in India**, Family Planning Foundation, New Delhi, 1991, pgs. 28.
18. Tata J.R.D., **Population, Poverty and Environment**, Family Planning Foundation, New Delhi, 1992, pgs. 31.
19. WHO, **Our Planet, Our Health: report of the WHO commission on health and environment**, Oxford University Press, Delhi, 1992, pgs. 282.
20. WHO, **Women's Health and Safe Motherhood: the role of the obstetrician and gynaecologist**, World Health Organisation, Geneva, 1989, pgs. 22.

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without antibiotics by a recent national survey. On the other hand Family Planning funds, almost wholly provided by the Central government, are spent mostly in rural areas with the result that the entire rural health infrastructure and personnel get diverted into fulfilling family planning targets. Acute shortages of inputs and the obsession with family planning has completely eroded the credibility of the rural public health services. The only credible public sector facilities today are the government hospitals.

Conclusion

Ensuring access to an affordable and decent level of health care services for the large majority of people remains the major challenge even today. Ironically, instead of arresting the long term decline of public spending on health in response to the commitment to achieve Health for All by 2000 AD and of raising investment to ensure the effectiveness of services in the rapidly expanding rural primary health infrastructure after 1983, the share of government spending on health further fell during the Seventh Plan period. The burden of cuts was borne mainly by the disease control programmes which account for 60 % of PHC funds. With the economy undergoing the IMF and World Bank mandated structural adjustment programmes, public spending on health will continue at current low levels. In fact, accelerated privatisation of health care and medical education, raising charges in public hospitals and their eventual disinvestment, and narrowly targeting public funds on a set of selective services and backward regions is likely to be the emerging trend in the Indian health sector. At a point when the Indian health sector is once again at policy crossraods, changes in the direction of universal health coverage need urgent attention. Taking the cue from worldwide trends, India too can create a single, publicly controlled financing mechanism such as a national health service or social insurance programme, or a combination of both, that will pool the enormous private resources along with the tiny public funds. It would also create the framework for integrating the private and public systems and ensure the regulation of the system as a whole. Given the size of the country and its uneven regional development, the organisation and provision of services and the administration of the funds could be the responsibility of invigorated local governments and *panchayat* institutions.

Select Bibliography

1. Antia N.H., **A Disastrous Prescription**, *The Economic Times*, August 21, 1993.
2. Duggal R , **Health Care Services and Financing in India**, FRCH, Bombay, 1992.
3. Special Issue on Bhore Committee, *FRCH Newsletter*, Vol IV (1-2), Jan.-Apr. 1990.
4. ICMR, **Evaluation of Quality of Family Welfare Services at Primary Centre Level**, New Delhi, 1991.
5. Jesani A. & Anantharam S., **Private Sector and Privatisation in the Health Care Services**, FRCH, Bombay, 1993.

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THE RELEVANCE OF HERBAL MEDICINE
Problems Encountered

Marie D'Souza

To most lay persons the word 'Herbal' immediately brings to mind the shampoos and face-packs so much advertised lately — and an import from the West. To most allopathic doctors Herbal Remedies are associated with quacks and charlatans and they ask: "Can an allopath practise or promote Herbal Remedies and still be called a doctor?"

In the present day, I would say that Herbal Medicine, if properly practised, is very much relevant. N.H.Antia in his article, 'Functional Classification of Diseases', suggests that diseases could be divided into five categories according to the knowledge, skills and facilities required for their diagnosis, treatment, etc... and I would like to say that Herbal Medicines can be used in the categories 'B' and 'C'. People should be able to treat themselves and should not necessarily depend on doctors or pharmacies especially if remedies are easily available in and around their homes, and the diseases are self-limiting and not life threatening. Today, people are trained for independence and self-reliance. Why should this not be in the field of health? Is treatment with herbs really a new idea that we are introducing into our country? Or is it rather an old truth, done away with by vested interests, and now rejuvenated?

The Herbal Tradition: misconceptions

Re-introducing the idea of Herbal Remedies to the younger generation is a difficult task, especially in rural areas. The younger generation is 'educated' or rather I would say 'literate' and looks down on those who are not. Why should they learn from their fathers or grandmothers? The middle generation has experienced the 'magic' of injections rightly or wrongly given by doctors more interested in making money than catering to the real needs of the patient. And tablets / capsules come in attractive colours, syrups taste so very good. Why go back to remedies which are unattractive, bitter and take time to be effective? Besides, the herbal remedies have to be prepared before they can be used while the tablets and syrups can be bought from the market ready-to-use. It matters little that time and money have to be spent in going to town to buy them. Of course, in some villages the tablets are available with the VHWs, very well trained by NGOs and well provided too, unlike the government VHWs poorly trained and inadequately provided in most areas. The VHWs are also trained to reject / forget the 'superstitious practices' of their forbears who are supposed not to have known better.

In some cases Herbal Remedies have been misused by people not at all trained in the preparation or correct use of the remedies. They have 'heard' about a remedy and advise it incorrectly with disastrous results, thus earning a bad name for a valid tradition. Another harm done to Herbal Medicine is the indiscriminate destruction of forests, leading to the non-availability of herbs needed for treatment.

In fact, the herbal tradition is a sound one, especially when practised by persons who are properly trained and not interested in monetary gain. The *vaidus* have been chosen and they choose others because of their integrity, ability and willingness to undergo a rigorous practical training under the *guru.* The remedies they use have proved their effectiveness over a period of time. Also these *vaidus* do not limit themselves to the old remedies alone. They learn from others and with newer plants being introduced into the area they use the new remedies, always taking at least one dose of the new remedy themselves before giving it to a patient in order to be sure that there are no ill-effects. They treat the diseases included in categories 'B', 'C', and some of those in 'D' of N.H.Antia's classification. Some psycho-somatic diseases (though the *vaidus* may not call them so) are also treated by them with good results.

The author is an allopathic doctor. She moved out of a hospital thirteen years ago because she realised that health was linked to the social, political and economic conditions of the people. She wanted to work with tribals and help them fight against exploitation. She joined the Janaseva Mandal because it was working in that direction. She believes that Herbal Medicine is effective and can help tribals to be self reliant.

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The Role of Janaseva Mandal and other NGOs

Fortunately for the Herbal Tradition, some NGOs have become aware of the need of preserving and re-vitalising this tradition, though this effort is very meagre considering the vast ocean of knowledge existing in the country.

The Lok Swasthya Parampara Samvardhan Samithi (LSPSS) is an organisation attempting to co-ordinate and encourage the activities of various NGOs through training camps/workshops on:

a) Identification, uses and properties of medicinal plants.

b) Methods of processing, in order that medicines can be preserved for a certain length of time, to be available for immediate use by the patient.

c) Diagnosis and treatment of common ailments.

It has also taken up the task of creating village nurseries, village herbal gardens, medicinal forests, etc.

We at Janseva Mandal, Nandurbar are attempting in a small way to correct the wrong done in the past. Having observed the effectiveness, initially of a few herbs, we came to realise the potential that indigenous medicine had in developing a better self-image and a greater independence among the tribals who have been exploited for centuries. Deprived of their lands and forests, marginalised by a capitalistic society, they are gradually being made to forget their very culture and traditional knowledge, in the process of absorption into a money economy.

Of course, we needed to have a better base for this activity, and it was just then that a meeting was called, at Academy of Development Sciences, Kashele, of people interested in re-vitalising the Herbal tradition. It was then that we discovered that *vaidus* in other parts of India used the same herbs for treatment of similar illnesses. Thus, an empirical base for continuing our efforts in promoting and strengthening this tradition, was established. The *vaidus* from this area met and exchanged information with those from other areas, through the camps organised by LSPSS, further confirming their own knowledge and learning from others.

This knowledge limited to *vaidus* alone, we felt, was not enough. We prepared photographs and slides of trees, shrubs and weeds of medicinal value. These slides are being shown by our Tribal Animators in the villages. The turn-out for the slide shows is very good as the people learn the usefulness of the plants for common ailments and simple methods of preparation of the remedies. The slide shows have also helped re-generate a respect for trees and a desire to grow a few in their fields. The literate keep asking for written material about the same as they say they are not able to remember all the information given. At the moment a book is being printed in Bhili and English, to satisfy this expressed need. In it is recorded information, collected from the *vaidus*.

Women's Contribution

Recently we turned our attention to the problem of women's health, which is rather neglected. Meetings are organised once a month in the villages at a time convenient for the women. Herbs which are useful specifically for women's ailments are dealt with at these meetings and a mention is made of the other possible uses of the plant. The women are very happy to be able to treat themselves, where earlier they bore up with their illnesses rather than explain their problems to a male *vaidu*.

An interesting development has been that the women have now started discovering treatments on their own. The use of *Aloe barbadensis* for menstrual pain and leucorrhoea was explained to them, together with its other uses for cuts, wounds, burns, abscesses, etc. A child had parotitis and her mother, Chamubai, decided to tie *Aloes*. The swelling subsided the next day and by the third day the child was free of symptoms. The mothers and children of two neighbouring families also went down with the disease and Chamubai advised tying of *Aloes* with similar good results. She related to me later, "It is not enough to tie it for only one day. Even if the swelling subsides, it must be tied for at least another two days till the symptoms disappear completely".

We encouraged the women to grow plants around their homes and then realized the difficulty they had in doing so. Many homes had only rocky ground around. Others who had a little useful strip of land found that infants, allowed to roam freely around the home, destroyed the seedlings, while bigger shrubs were destroyed by cattle. The problem was finally solved by giving them plastic pots to hang from their roofs — an idea given to us by a woman. This idea has caught their fancy, for it not only provides easy availability of a remedy, it also adds beauty to the house.

Government Policy: doublespeak ?

The government may speak of Health For All by 2000, a target which does not seem feasible. Rural India, comprising seventy percent of the population, is the area where the need is the greatest. And however much government spends on training in allopathy, or for that matter in ayurveda (on the latter the amount is relatively little), the doctors tend to gravitate towards the towns and cities, where a more lucrative practice is available. If, however, it had made more efforts to promote and revive this dying tradition and helped strengthen it with fresh inputs, we would, perhaps, have a healthier nation. China, with its barefoot doctors trained also in traditional medicine, is a case in point.

Efforts have been made by LSPSS to help NGOs interested in promoting the Herbal Tradition get funding from government organisations. But it has run into difficulties. One government organisation wants all the reports submitted in English! Even Hindi, the *rashtra--bhasha* will not do. It was difficult for NGOs existing in rural areas with members speaking the local / regional language to submit reports in English and as a result funds were stopped. Another organisation had given funds for 'involvement of women in indigenous health practices' and 'cultivation of medicinal plants'. A new director says that this organisation is meant for research and is not willing to sanction funds to future applicants wanting to involve women in indigenous health practices. Are only 'degree holders' capable of research and adaptation of technology? Is an illiterate incapable of thinking and adapting technology to her / his needs? Or is it that adaptation of complex technologies alone is acceptable?

Most persons in government bureaucracy and in city-based NGOs come from an urban background with a Westernised training. They are constantly looking to the West for guidance and norms. They find it difficult to accept that any 'new technology' can come from the Indian country-side. So also, most of the rural-based NGOs look up to the city-based ones as if they have a 'better' education. And as long as this attitude remains, the wealth that exists in the land, specifically with the rural population, will be lost — to the detriment of the well-being of the nation.

References :

1. **Antia N.H.**, Functional Classification of Diseases, *FRCH Newsletter*, Vol.7(2).
2. LSPSS Pamphlet.

SCIENTIFIC VALIDATION OF AYURVEDA

Urmila Thatte

Ayurveda, literally translated, means 'knowledge of life'. Some call it a philosophy, some say it is a scientific description of facts, some say it is a way of life, while others relegate it to the class of folk medicine. Amidst this confusion emerges the fact that almost eighty percent of our population looks to ayurveda for remedies and has been staunchly loyal to this system. Because of its continuous interaction with Indian Ethnomedicine, the ayurvedic formulary has become rich and diverse. Over the years, ayurveda has grown and matured in the soil of India. An uninterrupted contact with the folk medicine has enriched the materia medica of ayurveda.

The primary aim of ayurveda is promotion of health, and removal of disease. The therapy is therefore directed at protection of cells from endogenous and exogenous stress factors and preserving their functions. Several therapeutic approaches are advocated including Prakritisthapani Chikitsa, Roganashini Chikitsa, Rasayani Chikitsa and Naishthiki Chikitsa. The procedures used to achieve these aims are : Vyadhiharanam, diet and drugs.

In this paper, I shall restrict myself to drugs — especially plant drugs used in ayurveda, although the horizon for research in ayurveda is far wider. We shall see how modern tools can be used to explore ayurvedic concepts, so that useful drugs can be picked up for general use.

Traditional Remedies: an unexplored treasure

Man has looked toward nature for remedies ever since the dawn of civilization and scientists have delved into the 'grandma's pouch' for the magical cure. There are several examples in Western medicine that illustrate the usefulness of this approach. In 1785, William Withering published his famous treatise describing the usefulness of foxglove in dropsy. His observations were based on the folk use of the plant. Subsequent diligent research led to the identification of the active ingredient 'digoxin', and its use in congestive heart failure and atrial fibrillation. Perhaps the story of reserpine comes closer home. The publication, in the British Heart Journal, of the usefulness of *Sarpagandha* in hypertension, by Dr. R.J.Vakil led to the isolation of reserpine and validation of its efficacy in patients.

Today, the National Institute of Health in Bethesda, USA, has launched a massive multi-million dollar programme to identify, from ethnomedicines all over the world, drugs that may prove useful in AIDS and cancer. The Chinese and the Japanese have not lagged behind. The development of Artemisine from Quing Hou sou for malaria, and gossypol as an antifertility drug, are fine examples of how a scientific merging of the two streams — modern and ancient — has led to the discovery of useful new drugs.

The story of the development of guggulipid is an illustrative example of how ayurveda can contribute to the modern pharmacopoeia. Inspired by a *shloka* from Sushruta Samhita, Satyavati and Dwarkanath explored the utility of gum guggul in hyperlipidimia. Dr. G.V.Satyavati, (currently the Senior Deputy Director of the ICMR) first published in 1966, the hypolipidemic action of *Commiphora mukul* in her thesis, 'Effect of an indigenous drug on disorders of lipid metabolism with special reference to atherosclerosis and obesity (*medoroga*)', submitted to the Banaras Hindu University. Since then, guggul has come a long way. A complete phytopharmacological workup followed by exhaustive experimental and clinical studies has led to the drug now being on market as an effective and safe hypocholsterolemic agent.

The Central Drug Research Institute, the Indian Council of Medical Research and Central Council for Reasearch in Ayurveda and Siddha are actively involved in exploring the ayurvedic pharmacopoeia in order to develop new drugs.

In the Ayurveda Research Wing of the Dept. of Pharmacology (Seth G.S.Medical College and KEM Hospital) we are engaged in the study of Indian medicinal plants for different indications. Our first clues are from Charaka and Sushrut Samhita. We take these hints, use the principles of ayurveda but try to fit them into a lattice woven with modern technical strings.

The Tc Story

Perhaps the most interesting story we have, is that of *Tinospora cordifolia* (Tc). A plant extensively used by *vaidyas* and found even more widely among the constituents of 'over the counter' brands of 'herbal' or the so called ayurvedic drugs marketed today, Tc is prescribed as a *rasayana*, usually in fevers and post-fever convalescence. At that time we felt it likely that this use of the drug could be based on its effects on the immune system. And since then, the story of Tc reads like a fairy tale.

Our initial studies showed that Tc protected animals against infections induced by a variety of organisms. The animals withstood the onslaught of bacteria or fungi and survived. This happened in normal as well as those animals whose immunity was depressed.

Logically the next step was to identify the mechanism of action of the drug. We looked for, but found no antibacterial activity. How, then, was Tc working? Tc was proven to have immunomodulatory actions when its protective effects against the myelosuppressive effects of cyclophosphamide (CP) were confirmed in mice. Tc not only increased the counts, but also stimulated immune cells to function better. This meant that Tc would be a useful adjuvant in patients receiving chemotherapy for cancer. All these were experimental studies. There was a need, at this point, to prove its efficacy in clinical situations.

The Safety Studies: a continuing debate

A very widely debated issue regarding ayurvedic herbal remedies is the need to conduct safety studies on them. Protagonists for this believe that with the changing ecological environment, use of pesticides, new

The author is an Associate Professor in the Department of Pharmacology, Seth G.S. Medical College, Bombay.

smanufacturing techniques, modern formulations and combinations of herbs not prescribed in ayurvedic texts, there is a pressing need for looking at ayurvedic herbal drugs as 'new drug entities'. Opponents feel however that herbal remedies are 'natural' remedies and are beyond conventional toxicity studies.

We, in our laboratory, conducted toxicity studies on the aqueous extract of Tc and satisfied ourselves regarding its safety. We then went to the clinic and evaluated Tc in patients with obstructive jaundice. These patients tend to develop biliary sepsis and were found to have significantly depressed immune functions. They were administered Tc in a dose of 16mg / kg for 15 days before and following definitive surgery. It was observed that treatment with Tc significantly reduced mortality and this was associated with increased immune function. We are currently evaluating its usefulness in several clinical situations where chronicity associated with immunosuppression is the hallmark of the disease. These conditions include tuberculosis, tropical pyomyositis, malaria, etc.

Thus we see that in Tc we have a potent immunostimulant which is orally effective, indigenously made and without major adverse reactions. Drugs like Tc will be of great importance in conditions like AIDS, chronic infections, antibiotic therapy etc., where the immune system is at its lowest ebb. Multicentric and large scale clinical trials are required to evaluate the efficacy of this promising drug. It may prove useful as an adjunct in malnourished children, in tuberculosis patients and in patients with fevers of unknown origin. Still several questions remain. For example, what is the active ingredient and the exact mechanism of action of Tc? Although such questions are mainly academic.

Rasayana is a term which is used to describe rejuvenating effects. Tc, Ar and Eo *(Tinospora cordifolia, Asparagus racemosus, Emblica officinalis)* have all been described as *rasayanas*. We studied them in a 'cold immobilization stress model' and found that pretreatment with these drugs protected rats against stress induced gastric damage, increase in serum cortisol levels and inhibition of macrophage function. The protective effects of the drugs were found to be mediated through macrophages. These results prove that there is a strong scientific basis for using these drugs in 'anti-stress' preparations so commonly found in the market.

The Need for Genuine Efforts

What then are the problems that face us? What has prevented us from being far ahead in the global scene vis a vis health care? One of the major reasons for the setback that ayurveda faced is the language. Sanskrit is a very rich language. But the stanzas, which are short and to the point, can be interpreted in different ways. The subject tends to be looked at from different angles, without making a unified effort at identifying the real message. This scenario brings to mind the story of the men who were blindfolded and asked to identify an elephant. Are we doing the same with ayurveda? Can we all not work out a policy of teaching, utilising and researching ayurveda which is mutually acceptable and above all applicable to the society at large? Can we not all communicate freely and on a large scale?

We have seen that a lot can be achieved by using modern techniques to explore usefulness of ayurvedic drugs. We have a rich tradition in ayurveda,however, ways that are well thought out have to be evolved to incorporate its colours into the canvas of our lifestyles so that the picture that emerges is not confused but clear and beautiful. In 1940, Zimmer said, "There lurks a secret truth from which modern research might take its flight toward a new insight". Let us hope, then, that our country will take the lead in integrating new and old, in building upon the grand traditions that we already have inherited — all in an attempt to alleviate human misery and perhaps to put India back on the world map of medicine.

If the readers want to correspond with the author, the address is available with us. — Editor.

Private medical colleges are sprouting all over. The resultant imminent spread of modern health care to remote rural areas, so far untapped by doctors, has raised several issues. It would surely work as a death-blow to already withering indigenous health care. In fact, it is likely to be replaced by irrational 'modern' health care soon, as the young doctors start exploiting the rural health market in order to recover the cost of their expensive education at the earliest. With this new development, it is now an urgent need to think and act accordingly, so as to preserve at least the time-tested indigenous remedies.

Many of these remedies have not been systematically tested in the field and are likely to be shrouded with mysticism, claiming total cure and total safety. Dr.Anant Phadke, while training the health workers in villages near Pune, decided to test some of these remedies in a more systematic manner. He asked the health workers to name the traditional medicines which according to their experience were very effective. Then he selected a few of these medicines which were confirmed as being effective by health workers from other villages. He encouraged the health workers to use them and keep a record of the results. Dr. Phadke is at present collecting the data which he will analyse soon. But the initial results are very impressive. For example, one of the time-tested remedies, *Aloe* - a fleshy xerophyte- locally called *'Korphad'*, is found to be extremely effective in the treatment of infected wounds. The cut-surface of the fleshy leaf is tied to the wound for two to three days. The slough drops off and fresh healthy granulation tissue appears. Powder of *'Avali'* leaves is found to be useful in treatment of fresh wounds. *'Shikekai'* roasted to brown-black and then powdered and mixed with coconut oil can be used for the treatment of infected scabies and bacterial scalp infections. Asafoetida when applied to the skin affected by ringworm is quite effective.

Similar exercise is being undertaken at the four training centres, where *ashram* - school teachers are being trained in health care by the FRCH team. Although there is enough empirical evidence as to the efficacy of such remedies, here is an attempt to systematically collect data from the field and re-establish the commonly available, useful and cheap health care in a de-romanticised manner.

— Mohan Deshpande, researcher, FRCH.

TRADITIONAL HEALING
A Dying Practice

Manisha Gupte and Ramesh Awasthi

Two extreme views categorize our attitude towards traditional healing: either that such healing is all hocus-pocus or that it is sacrosanct. While some of us will believe that no such arts (or sciences) exist anymore, some others will shudder at the so called superstitious behavior of backward rural or tribal people. Furthermore, all traditional healers are clubbed together, often making no distinction between ritualistic and secular healings. Overtly, or covertly, urban biases about having to redeem the local healers surface even amongst well-meaning individuals, the 'dangerous practices' of traditional practitioners are sought to be curbed and new 'scientific methodology' is sought to be imparted to them.

Is there a middle path in the understanding of traditional healing? As we stayed in Malshiras area for some years, and saw that our neighbours and friends practiced traditional healing in various forms, we thought of documenting their actual experiences and perceptions without interference of our own preconditioned biases. The findings were interesting, to say the least.

We found that though healers practise a multitude of arts together, there is a distinction between religious and medicinal treatment. In an atmosphere of suspicion, most healers feel insecure and become secretive; this in turn accounts for the death of knowledge and wisdom.

Of the various healing processes documented, we are herewith presenting four representative case-studies.

Treatment of Scorpion Bites

We could identify twelve persons in the 30,000 population (eighteen villages) who were publicly acclaimed as being able to treat scorpion bites. Very possibly, there are many more such persons. The twelve individuals were interviewed in detail about their socio-economic background, their skills and mode of treatment. The healers come from all castes, with none of them educated above matriculation. Except one, all are above forty years of age. All healers are males.

Seven of the practitioners are 'specialists' in the sense that they treat only scorpion bites. However, one reportedly is a bone setter and treats guinea-worm infestations, too. Another gives medicines for headache. Two persons also treat pneumonia in children. One treats jaundice.

All except one (the only Muslim practitioner being the exception), reported very similar methods of being inducted as a healer. In some cases, an older healer 'chose' them: "You only have to look at somebody once, to know that he is your successor". In other cases, the present healer approached a senior and requested him to pass on the '*mantra*' (chanting) to him. In all such cases, the seniors approached were either family elders (father, uncle) or close family friends. The senior, who was now the '*guru*' asked the novice to wait until the night of the forthcoming eclipse. On that night, the *guru* took the young entrant to a body of water (well or pond), and asked him to undress entirely. Then he whispered the sacred chanting in the latter's ears and asked him to repeat it the whole night, staying partially immersed in water all the time. The *guru* advised him to revise the chanting at least a thousand times in an overnight session each year, during an eclipse. Then he ought to bathe and change into fresh clothes; that would keep his magical strength intact.

Now certain taboos have to be observed by the new healer. For all his life, he must not eat stale food; not even a small portion of it. He should avoid eating in large gatherings. At no cost, should he touch or come in contact with a menstruating woman. He should never eat food cooked by women during the four days of menstruation. The most important taboo is the woman in the post-partum period. He cannot share a roof with a woman for forty days after child-birth; if and when child birth takes place in his household, he should stay elsewhere. If he is defiled, his chantings cease to have effect. Similarly, he should never repeat the secret and sacred chanting to anyone, because that causes instant loss of magical power. Only in old age, when his powers start failing naturally, should he identify a successor, or wait for a prospective successor to approach him, and then, should pass on his chanting (and power) to the new initiates. After this transfer, he should content himself by living as a *guru* of his new initiates, rather than as a healer.

An ageing healer gets distinct signals when his power starts receding. One old man treated a patient with a scorpion bite and sent him home. The patient and his relatives, however, returned in an hour, saying that the pain had resurfaced. The old man at once understood that someone else was challenging his powers and that he was incapable of retaliating. He sent the patient back, with apologies, and sat down quietly for a long while. Then, all of a sudden, he asked his twenty-five year old son, if he wanted to inherit his magical powers. The son was only too happy, and so, he became the successor on the subsequent eclipse night. The son has now been practising this skill for the past twenty years and is confident of carrying the art for many, more years.

The mode of treatment of scorpion bites by most healers is quite similar. Some ashes (and sometimes a little kerosene) are applied to the site of bite; and the healer keeps on mentally uttering the *mantra*, whilst slowly and repeatedly moving his hand from the point of bite to the extremeties; thus directing the ill effect out of the body. One healer gathers herbs and roots (he won't tell their names) and asks the patients to bite on them while he utters the secret chant.

Healers are not supposed to ask for any material benefits from their clients. This is necessary if one wants to preserve the magical power. However, people do give some money or a coconut or grains on their own, sometimes.

The exception to this general story, as mentioned earlier, is the forty-three year old Muslim practitioner, who along with *balutedari* owns

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The authors are reseachers at FRCH who were living at Malshiras while coordinating the Health Education Project.

a small mutton shop. "There are no spirits in Islam", he says. He learnt this art of treating scorpion bites from his mother, when he was twenty-five years old. His mother had started to lose her touch because of old age and she taught the son how to make a betel-leaf '*paan*' with herbal medicine.

When a patient arrives, this healer makes some tea for him, and then he prepares the *paan* with lime, betel-nut, catechu, leaves of the '*sher*' tree, and one more herbal ingredient, the identity of which he cannot reveal. He said that he had accepted his mother as his *guru*. He does have a secret chant, but the real remedy is the medicinal *paan*. As the *paan* dissolves in the saliva, the palliative effect starts taking place.

Most healers treat between 5-10 patients each, per month, the figures rising to 25 or 30 in the summer months. They derive immense satisfaction from the fact that they are being useful to the community. "A particular God has given me the third eye which I use carefully in the benefit of all people", said one healer. The response from their families is positive, they say, in spite of the fact that patients arrive even at night; and the community regards them with respect and affection. Most of the healers are very religious. One of them is a *sanyasi* who has left his family and lives in Rajuri surviving on the flour that people give him every day.

The Bone Setters (Human and Veterinary)

Five bone setters, all male, were identified, one each from Malshiras, Vanpuri, Pondhe, Rajuri and Guroli villages. The socio-economic details of the five practitioners revealed that all healers were above forty years of age, none had attended school beyond the fourth grade and that most of them had some close contact with animals and cattle.

Bone-setting and treatment of sprains is a secular art, learnt with perseverance and keen observation. Except one healer, none use any chants or *mantras* while they treat their patients. One healer amongst them however said, "If you believe in God, the cure is faster".

All the five bone setters learnt this art by observing, and originally treating animals. Of the five, two were famous for their goat / shepherding skills, and the third was very attached to his own cattle. Eventually, these healers start attending to humans; yet they are still called upon to treat cattle, sheep and goats, especially when the animals are in obstructed labour.

To ease a cow or buffalo in delivery, a healer gives an internal examination to ascertain the position of the calf. If the presentation is breech, the cow is made to lie on her back, legs up, with region of the head being lower than the rest of the body. This helps the calf to turn around. Then the cow is again made to stand erect. The calf then slips out of the birth canal, easily.

If a bullock loses a shoe and there is an infection at that spot, a mixture of molasses and the Korphad plant is cooked and the warm slurry is poured on the animal's feet. The adhesive quality of this mixture seals the shoe to the foot pads and the 'poisonous' qualities of Korphad kill the invading germs and maggots. This action is not accompanied by any magical chants.

Fractures of limbs in the cattle are treated by immobilisation of that limb. A young bamboo is tied tightly around the leg and left there for some days, until the animal is able to walk on its own, without limping.

Sprains, whether in humans or in animals, are treated alike. If the sprain is muscular, the area is massaged with warm groundnut oil. Some healers use their feet or a rolling pin if the back muscles are sprained. If there is a swelling because of fracture, a hot mixture of transformer oil and castor oil is dabbed on the area. In case of dislocation of joints, the healer massages the area slowly, engages the patient in conversation and when the patient relaxes, a sudden jerk is given, to set the bone in its place. "When the limb is pulled, the *sheer* (nerve?) that has climbed over another, gets back to its original position,also".

The healer recognises a fracture by the accompanying depression in the flesh, studies the direction of the jutting bone and massages the bone into its own position.

Four bone setters said that they did not charge anything for their services; though occasionally they may recommend that the patient break a coconut for some God. One healer, who is a sixty-three year old poor labourer, said that he charges Rs. 20/- plus travel expenditure, because he has to compensate for the loss of his daily wages. On an average, a bone setter treats 5-7 patients (human and animals) every month.

All the healers pride themselves about being useful to the village through their diligence and hard-earned skills. Their esteem in the community has increased over the years. Family members often prevail upon the older bone setters to give up the practice. One forty-eight year old farmer (whole family has high social status in spite of being unprivileged *balutedars*) said that his family and friends pressurise him to abandon bone setting because "it is below one's status". The family want him to pay more attention to farming.

Most of the existing bone setters are very old (four out of five are above sixty of age, two being over eighty) and there are not enough successors. "Nobody wants to learn this art anymore. Years of observation and practice are required to achieve this skill. Who wants to waste their time?" says one sixty year old bone setter. The others echo his concern. "If nobody wants to learn, we won't teach them", is what one says. The oldest bone setter in the area (reputed to be over a hundred years of age!), who started his career as a medicine seller (oils from the *Dhakal* plant for massages on sprains), has taught his second son some of his skills and hopes that the son will want to learn more. The other old healer, eighty-one years of age, says that he started treating animals and humans when no one else was doing this work. Now the villagers say, "When you are dead and gone, this skill will be lost to all of us".

Treatment of Jaundice

Four male persons, one each from Pargaon, Rajuri, Pimpri and Naigaon were interviewed for their skills regarding treatment of jaundice. Three healers were between fifty to fifty-five years of age and have been practising this art for more than twenty years. The fourth healer, a young Muslim aged twenty-two years learnt the art eight years ago.

Some socio-economic details of the healers (treating jaundice) are presented here:

A. Caste:	
1. Maratha	2
2. Unprivileged *balutedars* & Scheduled Tribes	1
3. Muslim	1
B. Education:	
1. Nil	2
2. Upto 4th std.	2
C. Occupation:	
1. Farming	1
2. Labourer	1
3. Masonry	1
4. Bharadi/Gondhali (religious folk performers)	1

Only one out of the four uses a *mantra* to cure jaundice. Twenty years ago, this healer met a *maharaj* who was travelling through his village. The *maharaj* told him about his religious abode where they performed *yagnas* and *homs*. During this occasion, various *mantras* were passed on to new-comers. When our healer went there, the *maharaj* wrote down the chant and whispered the same in the former's ears five times. Ever since then, he is able to cure jaundice.

Whenever a patient comes to him, the healer asks him to come back on a Saturday morning, as soon as the patient wakes up, without touching any water. He then sprinkles ash on the patient five times, each time repeating the *mantra*. Then the patient has to offer a coconut in a nearby temple. He gets 3-4 patients per month. His son, who is a school teacher advises him to give up the practice. "I know you can cure patients, but if ever someone gets worse, they will blame you", he says. No fees are charged, for fear of losing the magical power.

The other three healers did not use any *mantra*. Two of the three persons tied a string of roots around the patient's neck, and one gave a betel leaf with a herbal ingredient. Interestingly, treatment is always given on Saturdays by all four healers; and a coconut offering, to some God, is a regular feature in all their healings.

Two healers learnt the art from family members (father and elder brother, respectively). The third healer had an interesting tale to narrate, as to how he learnt the skill. "In 1972, during the drought, I was thirty-five years old and we had gone to the outskirts of Pune city for our survival. There, I suffered from jaundice. It was taken to a healer, who put a string of some roots around my neck. When he wasn't looking, I picked up a small twig of that plant and preserved it, very carefully. I would carry it on my person, each time I went into the woods. One day, I found the plant that I was searching for. Later on, our neighbour suffered from jaundice and I tied the string around his neck. He was cured, and that's how I became a healer, myself". Asked, if he would teach someone else the skill he had acquired so ingeniously, he vehemently refused.

The healer who gives the betel-leaf (*paan*) with the herbal ingredient, also refused to divulge the identity of the plant. He calls a patient on a Saturday, asks him or her to chew the special *paan* and if there is no effect he repeats the same treatment on the forthcoming Saturday. He gets around 2 patients each month.

The fourth healer, a fifty-five year old person, whose livelihood is *balutedari* and religious folk performances, was very candid. He learnt about the herbal string from his father ten years ago. But he had not practised the art on anyone until four years ago, when a family member was ill with jaundice. When he successfully treated the patient, more and more people started coming to him. He now gets 8-10 patients each month.

Whenever anyone with 'yellowed eyes' is brought to him, he asks for some string and makes a sort of necklace with the roots of the "Pandhara Vasai' plant. This string is tied around the patient's neck tightly. Over the next one week, the string starts growing. By the time the string reaches the abdomen of the patient, he or she is fully cured. Then a coconut has to be offered to Siddheshwar. His family members are very cooperative and his esteem in the village has enhanced since he started this practice. He is ready to tell anybody the identity of the herb (Pandhara Vasai) if they ask him.

All the other three healers were very indifferent to the community's response to their skill. None of them felt that their status had improved because of this special skill. As mentioned earlier, all the three healers (like most other healers) were reluctant to pass on their knowledge to anyone else.

Removing Foreign Particles from the Eyes

Two male healers, one a Kumbhar (potter) aged sixty years from Malshiras and a Ramoshi Naik (a scheduled tribe) aged sixty-five from Rajuri, were interviewed about their skill in removing foreign particles from the external eye. Neither of them used any ritual or chants, and had learnt the skill around twenty years from the same elderly practitioner in Rajuri village. Both were eager to demonstrate their skill and were very willing to teach anyone who was interested. Neither had any formal education.

Whenever a patient arrives with a foreign body in the eye, the healer takes a bit of clean cotton, makes a very fine and thin curtain of this soft cotton, places it on the iris of the patient while holding on to one end of the cotton piece. He then asks the patient to close his eyes and then gently moves the cotton film all around. Occasionally, he removes it from the patient's eye and checks it for the irritant particle. When the patient feels relieved, the operation is complete. Each month, a healer gets between 10-30 patients, whereas in summer (when the strong breeze blows dust all around) and during pre-monsoon periods, the figure rises to 50 persons each month. No fees are charged for the service rendered.

The esteem of the healers in the community is positive and family members do not object to them continuing with the practice. One healer, mentioned somewhat skeptically, "Sometimes, if the cotton film gets caught in the eye, people get upset and angry. The entire procedure is very delicate and requires patience on the healer's part and cooperation on the patients' part. These days no one wants to learn this skill and many call it a fraud".

Conclusions

1. The more perseverance the acquisition and practice of a skill involves, the more secular is the skill. Conversely, those skills which involve religious chanting, do not involve rigorous pursuits like observation, reiteration and improvement.
2. Skills involving ritual depend on taboos (most being a guard against being defiled or polluted) for the preservation of the skill. Many of these taboos are directed against women, especially during the menstrual and post partum period.
3. Those who use *tantras* or rituals are more reluctant to teach others as compared to those who have learnt through hard work.
4. Taboos about purity exist only among those who treat scorpion bites.
5. When healers use ritual, they see their predecessor as a "*guru*". The others (secular skills) say that they have learnt the skill themselves through hard work.
6. All bone setters originally started as veterinary healers.
7. 'Saturday' features as the day of choice for treatment of jaundice.
8. The Muslim healers are less inclined to practise ritual than their Hindu, Scheduled Caste or Scheduled tribe counterparts.
9. Women healers are absent (except the one case in which a mother, a Muslim, taught her young son, the art of administering a medicinal "*paan*" to treat scorpion bites), or they have been missed (this is rather unlikely) through this survey. In the next round, and when we cover gynaecological healers and abortionists, women healers should, in all probability, feature prominently.

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THE REALITY OF AYURVEDA MEDICAL PRACTICE
With Some Observations from the Field

Manjiri Sule and Shirish Kavadi

The VIII th Five Year Plan in its strategy for promotion of the Indian Systems of Medicine and Homeopathy (ISM & H) emphasizes —

1. The provision of adequate facilities for graduate and post-graduate education and research in these systems.
2. Integration of the practitioners of these systems in the mainstream health care delivery system.
3. Encouragement of research and standardization of indigenous drugs and their production.
4. The utilization, conservation and regeneration of medicinal plants.

The VIII th Plan reiterates the policy regarding the Indian Systems of Medicine that has evolved from the recommendations of various committees appointed right from 1920. At that time, the Indian National Congress, leading the nationalist movement, had resolved to regenerate Indian Systems of Medicine, (this excludes homeopathy) the role and status of which had declined under colonial rule. But attempts at promoting ISM have never been wholehearted. Though the 'populist' model with its emphasis on the development of indigenous system gained government's increasing acceptance during late 1960s and early 1970s, the 'professional' model representing the interests of the allopathic system dominated the policy of health personnel development. (Rushikesh M. Maru, 1985). In spite of the rhetoric of developing Indian Systems, financial support in terms of the percentage share of ISM in total health outlay decreased substantially from 4.34% in the IVth Five Year Plan to 1.12% in the VIII th Five Year Plan.

Against this background of attempts at regenerating interest in ISM this article looks at the ground reality and the role of ISM ('*shastric*' or institutional and not 'folk') as an alternate form of healing in health care delivery. The reality suggests a downward trend in the role of ISM in health care delivery as reflected in the declining utilization of these systems in rural areas, precisely where policy makers seek to extend and justfy its promotion. An inter-related factor contributing to this trend is cross-practice on a large scale by traditional practitioners.

Utilization of ISM

It is claimed that traditional medical practitioners are the "basic providers of health care, to 80% to 90% of rural population, in countries in South Asia and Africa" (Philips D., 1990). For instance, 80% of population in Tamil Nadu is said to be covered by traditional / indigenous practitioners (Ramesh and Hyma,1981, as referred by Philips). This wide use of indigenous medicine is attributed to factors like inaccessibility to modern medicine, the cultural acceptability based on the indigenous notions of body, physiology, diet and aetiology of diseases.

The authors are researchers at FRCH, presently working on the project, 'Health Investment and Expenditure in a District'.

But findings from some other studies contradict these popular notions about the utilization of traditional medicine. A study by Dr. Banerji on the health behaviour of rural population in India, and that by T.N. Madan on the utilization of modern medicine, reveal that the use of Indian Systems is second to that of modern medicine. According to Banerji the Indian Systems are used either side by side with allopathic medicine, or after allopathic medicine fails to give benefit, or when allopathic services are not available or accessible due to various reasons, or most frequently when the illness is of a minor nature. T.N. Madan points out, that for the majority, the first preference is allopathy (Gupta G.R. 1981). According to a recent report, the bed occupancy rate in the Patiala Ayurvedic Hospital declined from 100 percent in 1978 to 32 percent in 1991-92. From 1967 to 1991-92, the daily outpatient number declined from 200 to 60 (Hindustan Times, 10-6-93).

The NCAER studies covering all parts of India show that there are no regional variations in the utilization pattern. Eighty percent of the illness episodes in the urban areas and 75% cases in the rural areas were said to be treated by allopathy. Only 8% of cases were treated by ayurveda in rural areas. In case of 60% cases treated by allopathy, the perception was that the allopathic treatment was fully effective. According to the KSSP study in rural Kerala the utilization of allopathy is 72% compared to only 10% of ayurveda. Our own observations during our field study in Ahmednagar district appear to corroborate some of these findings.

Ahmednagar District: field experience

Impressions gathered during a study on 'Health Investment and Expenditure in a District', being conducted by FRCH in the Ahmednagar district, demythify the widely held notions about the use and popularity of traditional medicine. The census of health resources conducted in the district, a series of workshops on health economics involving urban and rural practitioners of all systems, two rounds of postal surveys, and the actual investment and expenditure study — all combined, threw light on issues concerning education and research facilities for traditional medicine, its utilisation, the problem of integration of ayurveda practitioners in the primary health care delivery system, and the practice of ayurveda medicine.

Our observations relate specifically to the low utilization of Indian Systems, the high proportion of cross-practicing among ayurveda practitioners and the preference for setting up practice in urban or rural areas. The impressions gathered from the field experience are that economic factors determine the practice of ayurveda medicine and the geographical location of ayurvedic practitioners. Economic and popular demands lead to cross-practice among ayurveda practitioners. The rural location of a majority of ayurveda practitioners is also the result of the open and tough competition from allopaths in a market economy.

Ahmednagar district has an ayurveda college established seventy six years ago. Yet we faced great difficulty in selecting samples of

'ayurveda practitioners' to study their pattern of investment and expenditure in the provision of medical care. During our visits to the district and *taluka* places, we found that medical shop owners, officials in government health services and even medical practitioners could not provide reliable information about the qualifications of doctors practicing in their locality. Why was this so? One of the reasons appeared to be the rampant cross-practicing by ayurveda trained practitioners.

Cross - practice

Several ayurveda graduates were stated to possess allopathic qualification. The confusion arose from doctors practicing allopathy instead of the system of medicine they were formally trained in. During the sample check to verify our census list not a single doctor practicing Indian Medicine could be found. None of the eight BAMS doctors interviewed practiced ayurveda.

Out of the thirty-one ayurveda graduates contacted for the investment study, only five claimed that a certain proportion of their practice was of ayurveda. Only two of them were found to be advocates of pure ayurveda pracatice. One ran an ayurveda hospital while the other owned and operated a manufacturing unit of ayurveda drugs. Both had plans to establish bigger institutions and plantation schemes for ayurveda drugs. Noticeably all the pure practitioners were situated in the two towns of Ahmednagar and Kopargaon. This suggests that the increasing trend from metropolitan and larger cities, of seeking alternate systems of treatment, has reached smaller urban areas. A few of the practitioners from our overall sample told us that they used ayurveda to treat certain chronic illnesses but resorted to allopathy for the survival and continuation of their practice.

The response to the questionnaires mailed to 3000 and odd doctors listed with us was seventeen percent. From amongst these respondents, a total of 221 had degrees in ayurveda, of which 147 were graduates in pure ayurveda and 74 had degrees in integrated medicine. Of the total, only twenty-two percent claimed to practice ayurveda alone. The remaining practiced only allopathy or allopathy in combination with other systems (Table I). We had no means of verifying the claims of all those who said they practiced ayurveda alone. From amongst those practicing a combination of systems, the proportion of ayurveda practice to that of allopathy was not known.

One of the reasons cited for decline of ayurveda was that the system appeared stagnant and was perceived as being not based on modern scientific principles. But there was also the problem of limited facilities and opportunity for research in the system. Dr. Arun Shitre, an ayurveda academician from the district lamented that the research being done in ayurveda was quite limited in spite of great potential. One of its practical reflections was the relatively small scale of drug production resulting in high costs of drugs. On the other hand, because of a large scale production and even the circulation of sub-standard drugs, allopathic medicine is relatively cheap, hence economical and therefore preferred by the practitioners. It also gives a quick relief to the patients especially in rural areas, who cannot afford to lose their working days because of illness. Because of this demand for allopathic treatment from the patients, the non-allopathic doctors lack the opportunity to prove the efficacy of their particular system of medicine. Economic pressures and market competition force non-allopathic practitioners to submit to cross-practice. This was the general reason given by the participants in the workshop for cross-practice by traditional doctors.

TABLE 1
SYSTEM OF PRACTICE

Degrees	Nos.	System of Practice			
		Ayurveda	Combination		
			Allopathy & Ayurveda	Allopathy & Ayurveda & Homeopathy	Ayurveda & Homeopathy
Ayurveda	147	45	99	2	1
Integrated Medicine	74	3	71	-	-
Total	221	48 (22%)	170 (77%)	2	1

Note: This information relates to the ayurveda respondents to mailed questionnaires

It was also observed that some medical qualification was primarily sought to gain legitimacy. Any valid or even suspect and doubtful degree, would do to start medical practice. In the majority of cases this practice was of allopathy. This explains the spurt in non-allopathic medical colleges in the district over the last few years. To set up a non-allopathic medical college is much cheaper and easier than setting-up an allopathic medical college. The non-allopathic medical education is in demand because it is cheaper than allopathic medical education but in no way a hindrance to allopathic practice and money-making. This is a serious menace to the future development of ayurveda as an alternate system of medicine, with a status of its own.

The threat to traditional practice is aggravated when attempts are made to legitimize cross-practice. In spite of the Supreme Court's recent decision, overruling the verdict of Kerala high court allowing allopathic practice by non-allopath practitioners, the Maharashtra Government issued an order on 25th November 1992, allowing ayurveda graduates to practice allopathy. No arguments can be put forth in favour of the Maharashtra Government's decision which is detrimental to the survival and cause of Indian Systems of Medicine as an alternate form of treatment.

As if to further lower the status and esteem of ayurveda the Health Secretary of Maharashtra, Mr. K.S. Sidhu, is reported to have said that the government is 'compelled' to appoint the 'non-allopathic' qualified personnel to fill up the posts of class II medical officers in the state (*Sakal*, 13.8.93). This is an account of the reluctance on the part allopathic graduates to join government health services. The specifics of how integration of the systems can take place in the health service, while still retaining the autonomy of ISM have never been outlined by the advocates of integration. There appears to be some confusion about the concept of integration. The emphasis is on co-opting the traditional practitioners into the health services without any clear understanding of how traditional medicine would meet the demands of basic health care.

The VIII th Plan for instance says that one way to overcome the backlog of Sub-Centres, PHCs and CHCs is, "Re-organisation of the Indian Systems of Medicine and Homeopathy (ISM & H) dispensaries / hospitals in rural areas to create ISM & H health centres ..." and that "the training of doctors of ISM & H will also be reviewed and reoriented to make it congruent with the needs of national health programmes and primary health care." It is difficult to fathom how this approach is likely to regenerate interests in indigenous medical science and redeem its declining status. The oft-repeated argument which finds place in the Plan that, "These practitioners are close to the community not only in geographical proximity but also in terms of cultural and social ethos and as such they can play significant role in primary health care delivery", shows an astounding lack of understanding of the actual conditions.

A recent report says that an experiment is underway to integrate the three main systems of medicine in health care delivery without affecting adversely the autonomous status of any of the systems. This experiment is being tried out in some hospitals in Kerala. The hospitals are

attempting to integrate the different systems in the provision of medical care through joint panels. These panels of doctors from different systems examine the patient thoroughly and later provide the most appropriate treatment from the relevant system (*Times of India*, July 1993).

Geographical Distribution

We observed that socio-economic factors lead ayurveda graduates to set up practice in rural areas. According to our census, 52% of a total of 1275 Indian Systems practitioners in the district are located in the rural areas as against 37% of 959 allopathic practitioners. This shows the clear preference among allopathic graduates to be located in urban areas and a higher tendency among ayurveda graduates to practice in rural areas.

A point of clarification for the data in Table II is required. Migration to urban areas has taken place mainly from rural areas, although a few may have moved from one town or city to another. The migration of allopathic practitioners to rural areas can be explained as of doctors who are employed in rural government health services, health units run by missions or trusts or in some cases where those who were earlier employed by these agencies later retired or resigned to set a practice in rural areas where they were posted. A few amongst these had a rural background. In the case of ayurvedic practitioners who migrated from their native places to set a practice in rural areas, most had a rural background. Only a few were earlier residents of urban areas.

Participants in the workshops discussed the reluctance of allopathic graduates to setting - up practice in rural areas as against compulsions amongst the graduates of non-allopathic systems, to be based in rural places. The participants with allopathic degrees from rural and semi-urban areas cited various reasons for their preference for urban areas, namely, the rise in their material expectations corresponding with those of their urban colleagues; knowledge of their market potentials in the urban areas and that a high standard of living, unavailable to them in the rural areas, is within their reach. Non-allopathic practitioners complained about the poor standards of educational facilities, available to them as as compared to those available in the allopathic colleges. The accommodation, mess and teaching facilities, they said, are so poor that as soon as a student gets his degree he prefers to go back home, even if it is in the rural area.

The more practical and economic reasons for this tendency were also mentioned. In the towns, with the availability of allopathic practitioners, the demand for non-allopathic graduates practicing allopathy was relatively low. In the urban areas their status would always remain second to that of allopathic graduates. Ayurvedic graduates choose to work in urban hospitals for a short duration, to gain experience in allopathic treatment. On the basis of this experience gained, they return to their rural homes to practice allopathy and to earn fullfledged status and prestige of a 'doctor'. They also have the advantage of family contacts to carve out their clientele. They have the additional advantage of supporting their income through agriculture or inherited business. Besides, clientele is assured to them as the people in rural areas, as mentioned earlier, prefer allopathy for quick results. Considerations such as ancestral or agricultural property do not appear to compel allopathic graduates to return to their rural homes and set up practice. But the general observation was that a very few allopathic practitioners came from an agricultural family or a rural background. In the case of ayurveda graduates the general finding was that the majority had a rural background. This suggests that people who have no access to allopathic education, take up non-allopathic education, and only as a second preference. Thus the medical education system itself has given a secondary position to the non-allopathic system.

TABLE 2
GEOGRAPHICAL DISTRIBUTION

Practitioners		Place of Practice					
Degree	Nos.	Overall		Native		After Migration	
		U	R	U	R	U	R
		%		%		%	
Allopathy	132	60	40	28	19	32	21
Ayurveda	221	37.5	62.5	23.5	34.5	14	28

Note: This information relates only to the respondents of our mailed questionnaires.

Conclusions

Much more, than a mere reiteration of the same old policy over the years, needs to be done to save ISM from degenerating into a 'dead science' or mere quackery. Perhaps it can be done in terms of providing substantial material support, or perhaps in terms of a more honest implementation of the policy. For too long, has the government taken for granted, the natural cultural affinity of the people for ISM, ignoring that the traditional medicine is holistic and organically linked to social and economic conditions of a different kind and time. Planners and policy makers have turned a blind eye to the socio-economic and political factors which have no less significance for the development of ISM.

The Indian government, under the dictates of the World Bank and the IMF, has undertaken a structural adjustment programme to liberalise the economy. Austerity measures have included a substantial curbing of government expenditure in the social sector while the VIII th Plan clearly states, "In accordance with the new policy of the government to encourage private initiatives, private hospitals / clinics will be supported ...". It is too well-known that any private initiative in the face of cut-throat competition in an open market will resort to survival tactics, compromising principles. The opening economy, which will further commodify health, is hardly conducive to the practice of traditional medicine, indeed to its very survival. This is so, considering that its utilisation is declining, and that the practitioners themselves have a weak commitment to their own medical science. They also appear to suffer from a low esteem regarding their own status in the health care delivery system and the wider society itself. Obviously there is a gap between rhetoric, popular beliefs and ground reality.

References:

1. Banerji D., **Historical and Socio-cultural Foundations of Health Services System,** Main Currents in Indian Sociology, Vol. IV., Vikas Publishing House, Sahibabad, 1981.
2. **Policies Making Ayurveda Extinct,** *Hindustan Times*,10.6.93.
3. Kannan K.P. et al, **Health and Development in Rural Kerala: a study of the linkages between socio-economic status and health status,** KSSP, 1991.
4. Madan T.N., **Who Uses Modern Medicine and Why,** Main Currents in Indian Sociology, Vol. IV., Vikas Publishing House, Sahibabad, 1981.
5. Maru R.M., **Policy Formulation as Political Process: a case study of health manpower, 1949-75,** Public Policy and Policy Analysis in India, Sage Publishers, New Delhi, 1985.
6. NCAER, **Household Survey of Medical Case,** NCAER, New Delhi, 1992.
7. *Sakal*, 13.8.1993, Pune.
8. **Selected Chapters From the 8th Five Year Plan Document of the Govt. Of India,** VHAI, New Delhi, 1993.

YOGA AND HOLISTIC HEALTH

Shashank Oak

A new approach has become popular among cancer patients and therapists in the United States in the past ten years or so. This 'new' approach is the result of the path-breaking study made by Dr. Carl Simonton with Dr. Stephanie Simonton and the publication of their book, 'Getting Well Again', in 1978. Cancer patients saw a ray of hope in Simontons' work and thronged their workshops in large numbers. The work done by voluntary support groups like ECaP ('Exceptional Cancer Patients' is a voluntary self-help group formed by cancer patients in the U.S. under the guidance of Dr. Bernie Siegel) and the best-selling books written by Dr. Bernie Siegel (Love, Medicine and Miracles, 1986; Peace, Love and Healing, 1990) and by Dr. Deepak Chopra (Quantum Healing, 1989) further highlighted this approach and made it even more popular among people. As a result of this, it has become quite common to see cancer (and now AIDS) patients meditating seriously; special programmes being shown on closed - circuit TVs in hospitals teaching patients the art of relaxation and visualisation; patients carrying audio-tapes in operation theaters to be played during the operation giving positive, healing messages to the anaesthesised patient; etc. In other words, it became a fad with the Americans and has made a number of doctors and writers extremely rich.

Conceptual Basis of the 'New' Approach

Any serious student of yoga will notice a number of things immediately, if he examines this approach. First of all, this so called 'new' approach is not new at all. The principles which these people have 'discovered' have been known to us for a considerable period of time. (In fact, the American doctors and scientists came to think about it after witnessing the miracles performed by some Indian *yogis*. They developed the new technique of bio-feedback after interviewing these *yogis*). It will also be obvious to a serious student of yoga that the visualisation exercises designed by these Americans are extremely complicated and difficult for the patient to practice. We, the Indians, with our knowledge and understanding of yoga, will be able to design exercises which are much more simple and effective (as I have done over a number of years). Unfortunately, all this is being given serious thought in the United States and is being ignored or ridiculed in our own country. But this cannot be helped. We can only hope that as problems become more severe and as the effectiveness of this approach gets demonstrated, people will be forced to open their eyes to these age-old techniques and utilise them for their physical, mental and spiritual well-being. The idea behind this approach is very simple to understand, though it may be a little difficult to practice. The basic idea is that everyone of us participates in his health or illness at all times. A person does not become ill because of some accident or because he is unlucky. A disease does not catch people — they catch it by becoming susceptible to it. This idea is not new. Hippocrates had once remarked that he would rather know what sort of a person has a disease than what sort of a disease a person has. Louis Pasteur and Claude Bernard argued throughout their lives as to whether the most important factor in disease was the 'soil' — the human body — or the germ. On his death-bed, Pasteur admitted that Bernard had been right, declaring, 'It is the soil'.

It is recognised nowadays that an illness is not purely a physical problem, but rather a problem of the person as a whole. It affects not only a specific organ or a system, but the entire body and mind. Emotional and mental states play a significant role in making a person susceptible to disease and in his recovery from it. A disease, thus, is only an outward manifestation of some deeper problem in a patient's life. These problems result in an emotional state which triggers a set of physiological responses which suppress the body's natural defenses and make it susceptible to illness. This change takes place through the central nervous system, the endocrine system and the immune system.

Now, if the state of the mind changes the state of the body, then it can be a double-edged sword. If it cuts one way, it can be made to cut the other way. In other words, if a patient participates in the process of getting well, then he will certainly improve his chances of getting well. If the mind gets involved in the healing process, a miraculous healing can take place. This can be achieved through simple visualisation exercises.

Yoga Techniques and Visualisation Exercises

The patient is first taught simple relaxation exercises and meditation. This prepares him to be able to relate to and communicate with his body effectively. Then he is taught to visualise his disease in some form. For example, he forms a mental picture of his malignant tumour as a black mass of weak and disorganised abnormal cells. At the same time he is asked to visualise his therapy in a positive way. If he is undergoing radiation therapy, then the process is seen as millions of tiny, silver, bullets of energy which would hit all the cells in his malignant tumour, destroying them. Then the patient is taught to form a mental picture of the most important process — his own white cells coming in, swarming over the cancer cells, picking up and carrying off these dead cells, and flushing them out of his body through his liver and kidneys. Then he is supposed to 'see' his tumour decreasing in size and his health returning to normal.

All this sounds very, very simplistic; but the results are so fantastic that one cannot ignore it. This has opened totally new possibilities for the treatment of, not only cancer but any disease. Once the basic idea is understood, similar visualisation exercises can be designed for any other disease and it can be used with a considerable degree of success.

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The author is a lecturer and has written a book on 'Industrial Democracy' and a novel in Marathi. He is a keen student of yoga and a yoga therapist - presently concentrating on treating the cancer patients.

LIBRARY NEWS

Books

1. Bhatia J.C., **Dynamics of Contraceptive Use: a study in Karnataka State, India**, IIM, Bangalore, 1991, pgs.44.
2. Chakravarty S., **Selected Economic Writings**, OUP, New Delhi, 1993, pgs. 580.
3. Dabreo D.A., **Ideology and Process of Participatory Evaluation**, ISI, New Delhi, 1993, pgs.121.
4. Dreze J. and Sen A., **Hunger and Public Action**, OUP, Delhi, 1993, pgs.373.
5. Jolly D. and Gerbaud I., **The Hospital of Tomorrow**, WHO, Geneva, pgs.55.
6. Kananaikil J., **Scheduled Caste Converts in Search of Justice, Part 3**, I.S.I, New Delhi, 1993, pgs.80.
7. Nayak R., Boal B.M. and Soreng N., **The Juangs: a handbook for development**,I.S.I., New Delhi, 1993, pgs. 226.
8. Padmanabhan A., **Mandal Commission Judgement and the Scheduled Castes and Scheduled Tribes**, ISI, New Delhi, 1993, pgs.45.
9. Prabhu K.S. and Chatterjee S., **Social Sector Expenditures and Human Development: a study of Indian states**, R.B.I., Bombay, 1992, pgs.73.
10. Puri R.K., Sethi G.R., and Ramji S., **Early Childhood Mortality and Perinatal Period Management in Urban Poor**, MAMC, New Delhi, 1991.
11. Ramachandran L., **Handbook of Management for Primary Health Centre Personnel**, Vikas Publishing House Pvt. Ltd., New Delhi, 1993, pgs.108.
12. Ramchandran L. and Dharmalingam, T., **Health Education: a new approach**, Vikas Publishing House Pvt. Ltd., New Delhi, 1993, pgs. 278.
13. Rohde J., Chatterjee M. and Morley D., **Reaching Health for All**, OUP, Delhi, 1993, pgs. 524.
14. Saxena E.D., **Child Abuse: a growing concern**, VHAI, New Delhi, 1993, pgs. 36.
15. Sehgal P.N. and Singh V., **HIV and AIDS: what everybody should know**, VHAI, New Delhi, 1993, pgs. 24.
16. Sengupta S., **Proceedings of the National Seminar on Sustainable Agricultural Development**, VHAI, New Delhi, pgs. 146.
17. Singh K., **Intellectual Property Rights on Biotechnology: a status report**, Biotech Consortium India Ltd., New Delhi, 1993, pgs. 130.
18. **Training needs Assessment of Indian Systems of Medicine and Homoeopathy Practitioners for Delivery of Health and FW Services in Bihar**, ORG, Baroda, 1992, pgs.59.
19. WHO, **Health Research Methodology: a guide for training in research methods**, OUP, Delhi, 1993, pgs. 252.
20. Wishwakarma R.K., **Health Status of the Under-previleged**, Reliance Publishing House, New Delhi, 1993, pgs. 283.

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The reason why this approach becomes so effective is very simple to understand — it helps the patient to tap the infinite healing energy at his disposal that lies dormant in his unconscious mind. Modern medicine places such a great emphasis on technology that the inherent healing powers a patient has; often go unnoticed. Of course, this does not mean that we should dismiss the advances medical science has made. It must be remembered that the conventional methods and these so called 'alternative' techniques are not mutually exclusive. These 'alternative' techniques are not to be used at the expense of or to the exclusion of the conventional methods. They should, however, complement them and enhance their efficacy. This is to be done by teaching the patient not to receive the treatment being given passively, but to become active in the process of getting well and to assume the responsibility to cure himself. He is to be encouraged to mobilise his internal resources, so that true healing can occur.

I came across Dr. Simonton's work due to my interest in yoga therapy. Thereafter I have developed a number of exercises and have helped a number of cancer patients with considerable success. However this work was done on a personal level, and it will require the foundation of methodical research on a bigger scale to arrive at definite conclusions. A lot of research is being done in the West and the results are available. The results are mostly positive. But nobody has undertaken a similar study in our country. If research in this area is done in our country, there is a possibility that the results will be better than those in the West. This is because, we have more effective and penetrating techniques at our disposal — due to our knowledge of yoga. It is time that somebody takes the initiative to base these techniques on a scientific foundation. ◙

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10. Most healers are getting old and there is not an adequate replacement by younger persons. The formal education level of most healers is very low..

11. It is universally felt that magical powers are instantly lost if one actively seeks for material gain through this service. Powers are lost, if one prematurely teaches anyone else, the art.

12. Most healers say that their esteem in people's eyes is positive because of this service that they render to the community; the reaction of their family members is also usually positive. Family members seem to be more in awe of those skills which involve rituals. When hard work requiring long hours, or menial work like attending to animals is involved, they are sometimes resentful.

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