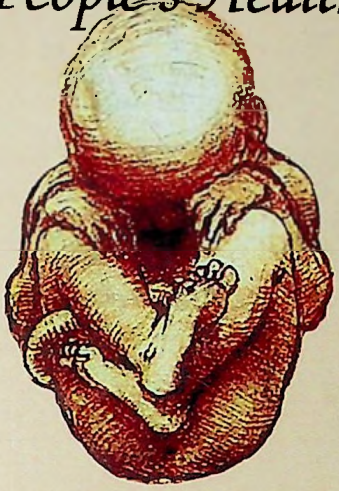
What Globalization does to People's Health !



Towards the People's Health Assembly Book—1

What Globalisation does to Peoples Health !

-Understanding what Globalisation is all about and how it affects the health of the poor

Prepared and Published by
The National Coordination Committee
for the

Jan Swasthya Sabha

Towards the People's Health Assembly Book-1

What Globalisation does to Peoples Health!

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Authored and Published by :
National Coordination Committee, Jan Swasthya Sabha

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- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- All India Women's Conference (AIWC)
- Bharat Gyan Vigyan Samithi (BGVS)
- Catholic Health Association of India (CHAI)
- Christian Medical Association of India (CMAI)
- Forum for Creche & Child Care Services (FORCES)
- Federation of Medical Representatives Associations of India (FMRAI)
- Joint Women's Programme (JWP)
- Medico Friends Circle (MFC)
- National Alliance of People's Movements (NAPM)
- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Ramakrishna Mission (RK)
- Society for Community Health Awareness, Research and Action (SOCHARA)
- Voluntary Health Association of India (VHAI)

Participating Organizations

Over 1000 organizations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Sabha campaign as participating organizations.

About the Jan Swasthya Sabha

Governments & international agencies have forgotten the goal of **Health for All by 2000 A.D.** But we, the people, cannot forget it. It is time to strengthen & expand people centered initiatives - to find innovative solutions & to put pressure on decision makers, governments and the private sector.

There is a need to reiterate that attaining **Health for All** means ensuring everyone has access to affordable quality medicare, safe drinking water and sanitation, adequate nutrition, clothing, shelter and employment and no one is discriminated against on the basis of class, caste, race or gender. People need to be made aware of the links between globalization and the worsening health of the people. When structural adjustment policies work to undermine the vision of Alma Ata, renewing the Health for All call is an imperative.

With this understanding a large number of people's movements across the country have jointly initiated a national campaign called the Jan Swasthya Sabha. This has three broad objectives:

- To re-establish health and equitable development as top priorities in policy making with primary health care as the strategy.
- To forge a local, national and global unity of all democratic forces to work towards building long term sustainable solutions to health.
- Reinforce the principle of health as a broad inter-sectoral issue

The campaign has a four-tier structure. 2000-3000 blocks in 200-300 districts mobilize people on **Health For ALL – Now!** and conduct block level enquiries into the state of health services. These enquiries culminate in block seminars highlighting the findings & helping formulate people's initiatives for primary health care. Then, each district has a district level mobilization culminating in a District Seminar. All this builds up to the Jan Swasthya Sabha to be held in Calcutta from Nov 30th – Dec 1st 2000. Four trains with representatives from various parts of the country will arrive at the National Assembly. The Jan Swathya Sabha – with over 2000 representatives – will call for a reversal of structural adjustment policies and a renewal of the *Health for All* pledge. The assembly will also send its representatives to the international People's Health Assembly being held at Dhaka from Dec 4th-8th, 2000 where similar representatives from other countries will gather. Following the Jan Swasthya Sabha, each interested block or district follows up with health intervention and advocacy.

The Jan Swasthya Sabha is being coordinated by a National Coordination Committee consisting of 15 major all India networks of peoples movements and NGOs. This book is the second book in a 5 book series brought out by the NCC for guiding the block, district and state seminars.

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About the Jan Swasthya Sabha

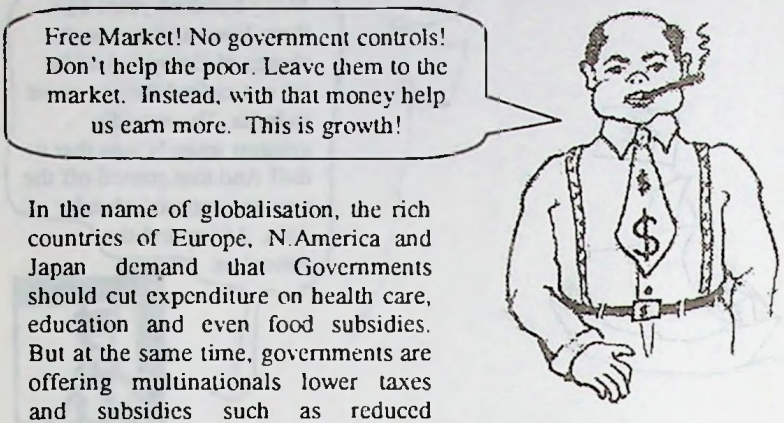
Chapter I

Globalization and People's Health

The British colonised India 250 years ago. The motivation of the western countries was beyond doubt greed. The capitalist "free market economy" has, even by its own stated understanding, only one goal – profit. This colonial loot was helped by the Industrial Revolution (development of machine based production), which began in Britain about 250 years ago. The new factories produced steamships and guns that made conquest unequal, easy and bloody.

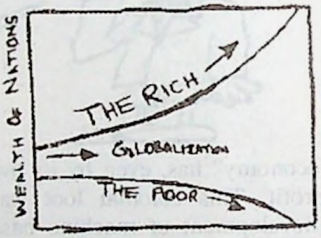
Today we hear the term 'globalisation' being used to describe the expansion of the global capitalist economy. In India, Pepsi, Coca-Cola, Western TV shows and movies, and foreign clothes like Nike, are common. India is opening up even more to the global market economy. But the history of the last 500 years shows us that globalisation is just another word for the continuation of that form of capitalist exploitation that is known as imperialism. Globalisation is a word that has been deliberately coined to raise false hopes among the poor of the world, that

the current processes in the global economy will allow them to approach the standards enjoyed by the rich in the countries of North America, Europe and Japan. While selling this false dream, these countries have mounted a fresh offensive to predate upon the resources of poor countries.



In the name of globalisation, the rich countries of Europe, N.America and Japan demand that Governments should cut expenditure on health care, education and even food subsidies. But at the same time, governments are offering multinationals lower taxes and subsidies such as reduced electricity rates. The "free" market economy is not free at all -- it is controlled to benefit only the rich at the cost of the poor.

Inequalities between countries have increased and the past decade has shown increasing concentration of income, resources and wealth among people, corporations and countries. The income gap between the fifth of the world's people living in the richest countries and the fifth in the poorest was 74 to 1 in 1997, up from 60 to 1 in 1990 and 30 to 1 in 1960. In 1996, the working class of the world received an average 3% increase in wages while the heads of multinational corporations received a 67% increase. The 5 largest multinationals, mostly American, together earn more in one year than all of the domestic earnings together of India, Pakistan, and Bangladesh.



By the late 1990s

The top fifth (20%) of the world's people have	The bottom fifth (20%) of the world's people have
86% of world GDP	Just 1% of world GDP
82% of world exports markets	Just 1%
68% of foreign direct investment	Only 1%
74% of world's telephone lines	Only 1.5%

"Thus, the concept of globalization has justified with ease a set of unequal relationship among peoples and nations.

But how did this process of globalization begin?

The Genesis of Globalisation

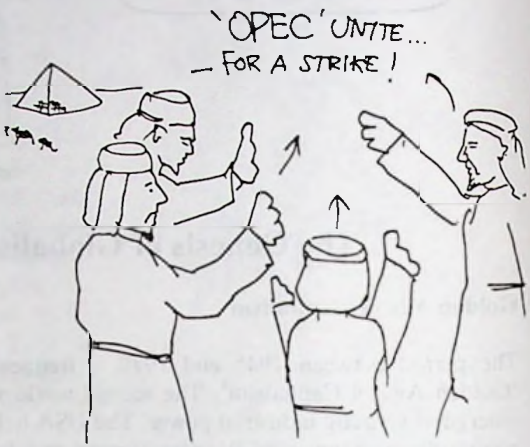
Golden Age of Capitalism

The period between 1945 and 1970 is frequently referred to as the 'Golden Age of Capitalism'. The second world war had seen the USA emerge as a strong industrial power. The USA helped to rehabilitate and restore the economies of Western Europe and Japan. It also helped to kick-start the industrialization of East and South East Asia (S.Korea, Taiwan, Singapore, etc.) -- as a bulwark against the spread of Socialism. During this period a large number of countries, like India, were liberated from hundreds of years of colonial rule. Many of these countries embarked on a path of rapid industrialisation, and saw significant progress in socio-economic spheres of development. In this, they benefited significantly from help that they received from the then Soviet Union and Socialist countries in

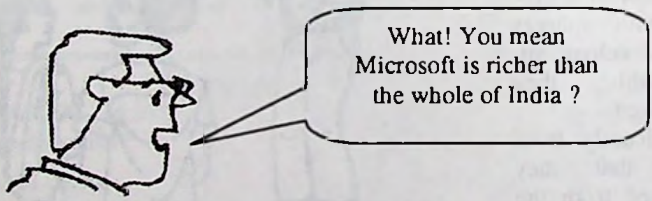
Eastern Europe. The interference in the development processes in these countries, by the Capitalist countries of Europe, N.America and Japan was relatively subdued.

Crisis in Developed Countries and Capital Accumulation

The Golden Age of Capitalism faltered in the seventies, following the shock of the sudden (and precipitate) oil price hike by the OPEC (oil producing countries, located mainly in the Middle East) in Nov. 1973. There followed a long period of crisis in all the developed countries (other than Japan, where the slump commenced from the early nineties), characterized by a slump in economic activity.

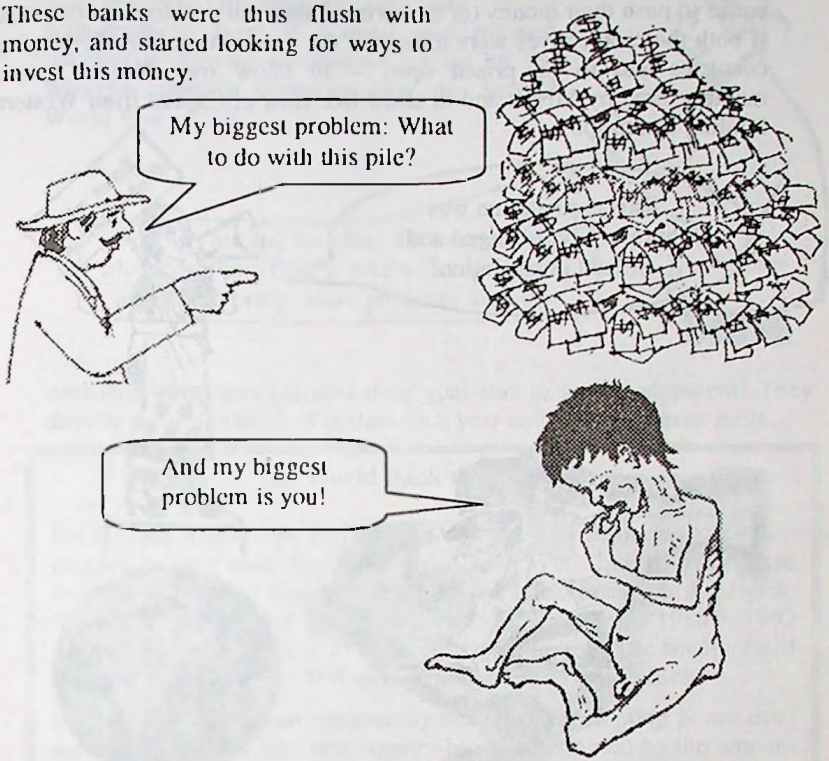


Alongside this, another new phenomenon emerged. There began an accumulation of money (or Capital - as economists call it) on an unprecedented scale in a few hands. A major source of this accumulation was due to the growing resources and influence of Multi National Corporations (MNCs). Their growth has been so phenomenal that several of them are bigger that the economies of entire nations. For example the sales of General Motors (164 Billion US$) is more than the GDP of Thailand (154 Billion $) and Norway (153 Billion $). The market value of Microsoft touched $507 billion, about Rs 21,92,267 crore - a value that is much higher than India's Gross Domestic Product (GDP) of about Rs. 17,70,000 Crores.



Over the years MNCs have grown larger and stronger through mergers amongst themselves, and acquisition of smaller companies across the globe.

Another source of accumulation was the huge profits made by oil producing countries, which they deposited into western capitalist banks. These banks were thus flush with money, and started looking for ways to invest this money.

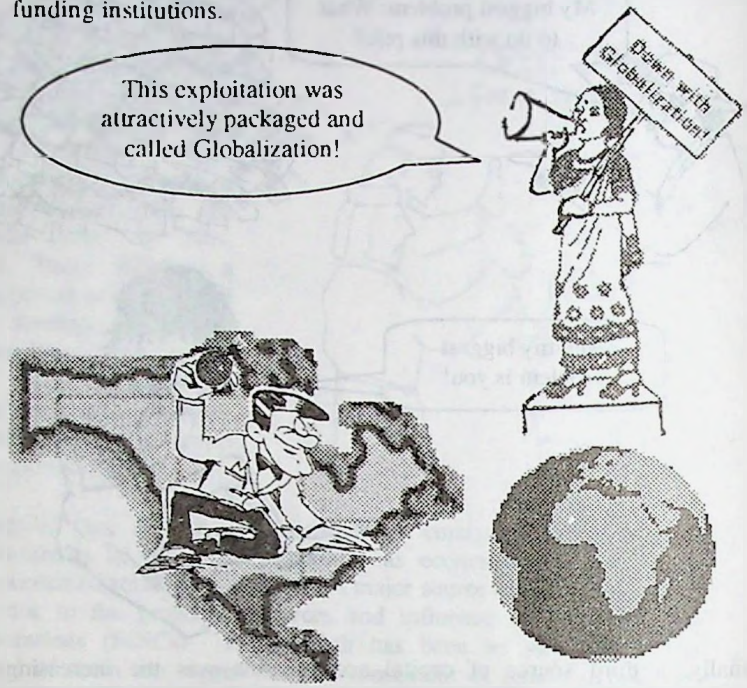


Finally, a third source of capital accumulation was the increasing volumes of illicit or illegal incomes from crimes of various kinds - ranging from drug smuggling and drug peddling to the plunder (by dictatorial rulers and others from the ruling elite) of the wealth of developing countries. Dictators like Marcos and Mobutu siphoned off large funds from otherwise poor countries. And respectable bankers of developed countries sweetly "laundered" all such ill-gotten gains.

Real Face of Globalization

Thus, the availability of "surplus" money in the global economy became enormous, and it came at a stage when the economies of the developed countries were facing a slump and were incapable of absorbing this money in production related activities. This produced the impetus for the process of

globalization, where avenues were sought, on one hand by MNCs to sell their products in developing countries, and on the other by capitalist banks to push their money (in the form of loans) in developing countries. If both these objectives were to be met the economies of the developing countries had to be prised open -- to allow free flow of goods manufactured by MNCs and to allow free flow of Capital from Western funding institutions.



The Numero Uno Globe Bomber

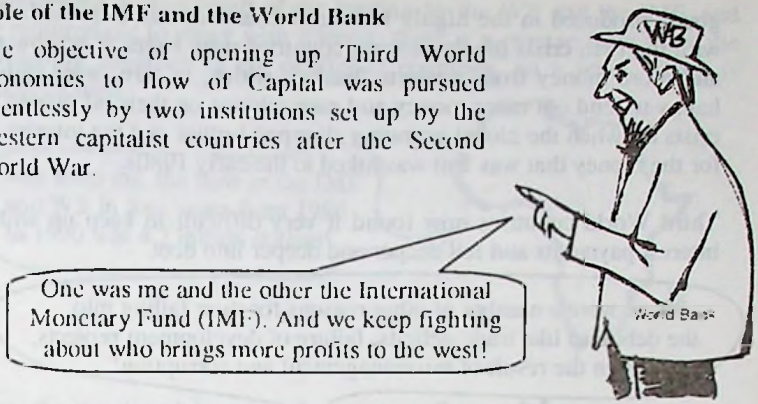
Essentially it meant that the economies of developing countries were forced to open their markets to MNCs and their economies to free flow of Capital from Western institutions.

One glaring effect of globalization has been the explosive growth of MNCs across national borders. Capitalism identifies nations not as nations but as "markets" and countries like India and China are the vast, untapped markets. 2 billion unshod feet is a tantalizing opportunity for Bata, Nike, Reebok and their ilk. Even if only 10% of these can afford shoes, this means a 200 million person market which as large as all of Western Europe!

As a global slump in productive activities creeps across the world, developed countries seek to expand their markets beyond their own boundaries and the obvious targets are nations such as India. Never mind that the majority in these countries can barely make ends meet.

Role of the IMF and the World Bank

The objective of opening up Third World economies to flow of Capital was pursued relentlessly by two institutions set up by the Western capitalist countries after the Second World War.



And that while they claimed their goal was to aid development! They directly control billions of dollars each year and indirectly even more.

The World Bank and the IMF

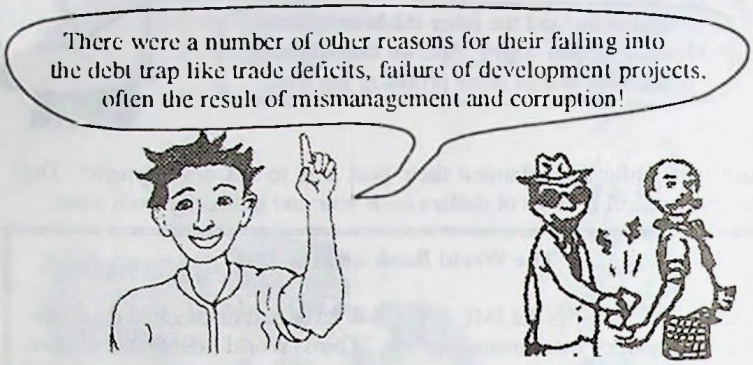
For the last 50 years the IMF & the WB have had unchecked decision-making powers over managing the "Third World" debt. They have secured guaranteed flows of reserves from the South to the North. Since 1947 the WB has made profit every year. Between 1980 & 1992 its net earnings rose over 172% to over $1.6 billion. The accumulated retained earnings of the WB alone amount to over $14 billion.

Both the IMF & WB are structurally undemocratic. Voting power does not operate on one vote one country but is determined by the amount of money invested by each member country. While more than 150 countries are members of the IMF five of them (USA, Britain, Germany, France, Japan & Saudi Arabia) control 44% of the votes. The USA alone controls 19% of the vote. In the case of the WB, the 24 OECD countries control more than two thirds of the votes. Clearly this gives the rich countries a great deal of power.

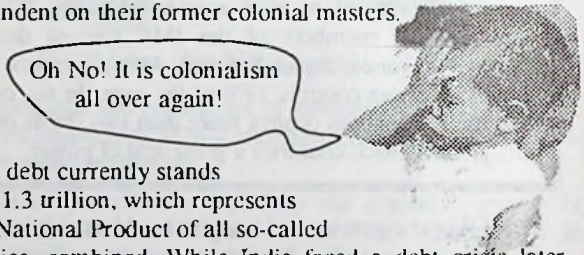
Third World countries had been hit hard by the hike in oil prices in 1973. Further, in the 1970s developing countries faced increased economic problems as a result of unfair trade. Their economies were designed around the export of raw materials and agricultural products, the price of which was manipulated on the world market by developed countries. Over the last few decades the price of these commodities have declined sharply while the import of manufactured

goods produced in the highly industrial countries has increased. Faced with the twin crisis the developing countries were eager to borrow more and more money from western banks, which, in turn, were only too happy to lend out more money and earn interest on their oil money. The crisis hit when the global economy slumped further and the interest rates for the money that was lent was hiked in the early 1980s.

Third World countries now found it very difficult to keep up with the interest payments and fell deeper and deeper into debt.



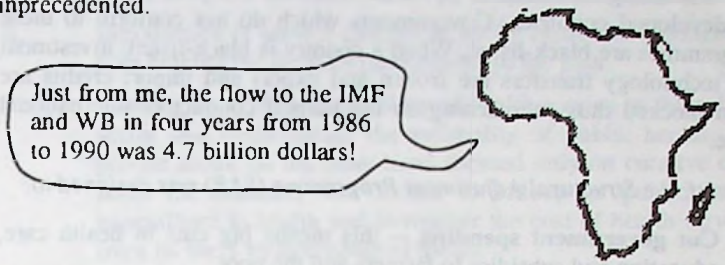
Further loans were given to "help" create conditions for the repayment of loans, and in the process creating a vicious debt trap, i.e. a situation when poor countries have to spend a very higher percentage of the national product just to pay the interests on the loans taken. Third World countries had achieved political independence but they were now in debt to the big western "moneylenders" and were, therefore, more and more economically dependent on their former colonial masters.



The '*Third World*' debt currently stands at approximately $1.3 trillion, which represents 44% of the Gross National Product of all so-called developing countries, combined. While India faced a debt crisis later than many other countries, in the late 1980s and 1990s, India today owes almost Rs. 400 thousand crore to the World Bank, IMF and other foreign banks. This is Rs. 4,000 for each man, woman and child in India.

The ultimate result of the massive loans given by institutions like the World Bank and the IMF has been a massive loss of capital from the poor countries to the rich countries in the North - an estimated $50 billion in 1985 alone. In 1990 there was a net transfer of $156 billion from the "third world" to the developed countries. In other words, what

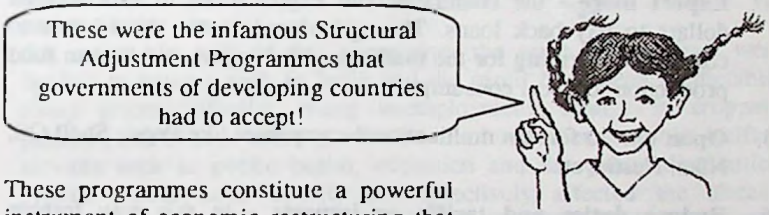
is happening is, as a result of the lending by the WB and the IMF, and the requirement to repay with interest, there is a reverse flow from the developing countries to the developed countries, on a scale, which is unprecedented.



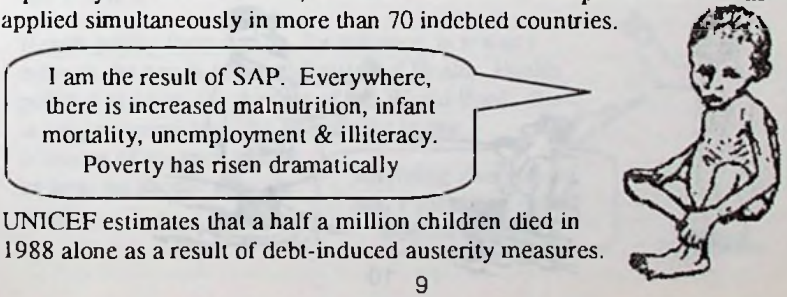
Thus, the developed countries have been able to transfer the crisis of their own economies on to those of poor developing countries.

Structural Adjustment Programmes (SAPs)

The story does not stop here. In the face of the debt crisis banks and other financial institutions saw the need to safeguard their own interests, i.e. to ensure that they get back the money that they had lent to the developing countries. They developed tough conditions on loans to "Third World" countries to ensure that there would be no defaulting on their debt repayments. Stringent conditions were imposed on further loans.



These programmes constitute a powerful instrument of economic restructuring that affects the livelihood of millions of people. The same prescription of reduced government spending – especially on social sectors, trade liberalization and privatization was applied simultaneously in more than 70 indebted countries.



UNICEF estimates that a half a million children died in 1988 alone as a result of debt-induced austerity measures.

The application of SAPs in a large number of indebted countries favours the globalization of economic policy under the direct control of the IMF and WB acting on behalf of powerful financial and political interests in the developed countries. Governments which do not conform to these programmes are black-listed. When a country is black-listed, investment and technology transfers are frozen and export and import credits are often blocked thus encroaching on the normal conduct of international trade.

In brief, the Structural Adjustment Programme (SAP) was designed to:

1. **Cut government spending** -- this means big cuts in health care, education and subsidies to farmers and the poor.

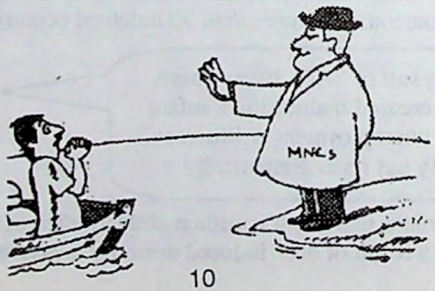
2. **Privatize** -- state owned industries and services must be sold off to private corporations. Often foreign multinationals are the buyers. Many workers lose their jobs as government industries close down. Services like transportation and power become more expensive.

3. **Devalue the local currency** - for example, in India the rupee should be worth less and less compared to the American dollar. The World Bank and IMF demand this so that what the country exports is cheaper in the international market. The World Bank and IMF say this will increase the country's exports so it can earn foreign dollars - and pay back the loans! But farmers and local industries get less for their goods. And prices of imports go up!

4. **Export more** - the country should export more to earn foreign dollars to pay back loans. The agricultural sector should turn to commercial farming for the market and for export, rather than food production for local consumption.

5. **Open up**: to foreign multinational companies like Pepsi, Shell Oil, Nike, Nestle, etc.

6. **Reduce duties and tariffs on imports** - in this way foreign multinationals can more easily sell their products in a country like India. Local industries find it hard to compete with cheaper imports.



Specifically, in the Health Sector it meant:

i. A cut in the welfare investment, leading to gradual dismantling of the public health services.

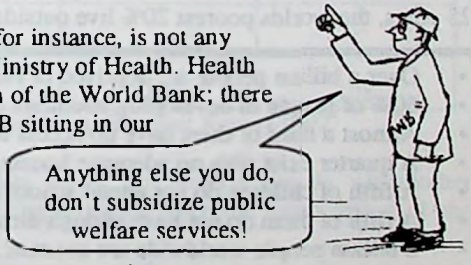
ii. Introduction of service charges in public institutions, which has now making the services inaccessible to the poor.

iii. Handing over the responsibility of health service to the private sector and undermining the rationality of public health. The private sector on the other hand focused only on curative care. India for instance, was forced to reduce its public health expenditure in health and to recover the cost of health services from its users by international banks.

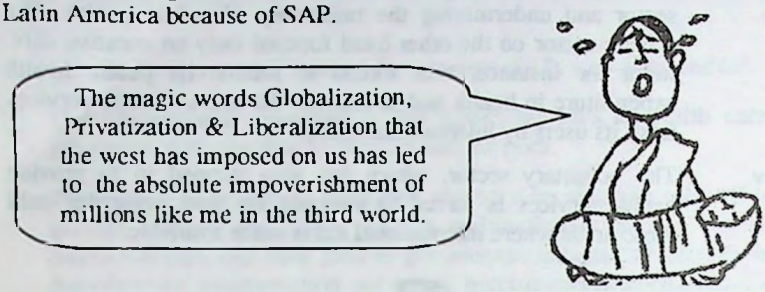
iv. The voluntary sector, which has also stepped in to provide health services is forced to **concentrate and prioritize** only those areas where international aid is made available.

SAPs were initiated in many countries in Latin America and Africa in the 1970s. Recorded information proves that SAP has been detrimental to nation states in that region. In spite of this experience, the same prescriptions were applied to nations such as India and the result have been predictable: rising prices, inflation, rising unemployment, change in cropping patterns, loss of food security, withdrawal of subsidies on public welfare services such as public health, education and the public distribution system. These have directly and selectively affected the already 'disadvantaged' in our country. Combined with this is the larger issue of loss of sovereignty since our Parliament can no longer make policies favoring our people but is bound by conditions agreed to and dictated by the WB/IMF.

Health policy formulation, for instance, is not any more in the hands of our Ministry of Health. Health policies are now the domain of the World Bank; there is a representative of the WB sitting in our Ministry of Finance telling us how we should allocate funds.



The impact of SAP on the third world is manifold. In seven African countries the infant mortality rate, which previously declined, increased from 4% to 54%. A steep increase from 3.1% to 90.9% of mortality rates of children under 5 years was observed. The nutritional status of children has deteriorated in around 8 countries out of the 10, which went through SAP. It has also been estimated that at least six million children under five years of age have died each year since 1982 in Africa, Asia and Latin America because of SAP.



The number of people living in poverty continues to grow as globalization proceeds along its inherently asymmetrical course: expanding markets across national boundaries and increasing the incomes of a relative few while further strangling the lives of those without the resources to be investors or the capabilities to benefit from the global culture. The majority are women and children, poor before, but even more so now, as the two-tiered world economy widens the gaps between rich and poor countries and between rich & poor people.

- The State of the World's Children 2000

The Marginalized in the Present Scenario

The policies have been disastrous for the third world and more so for the poor in the third world. After SAP, mal-distribution of global income has attained unacceptable levels. During the period 1960-70 the poorest 20% received 2.3% of the global income. In 1990, they received a minute 1.3% of the global income, a reduction by half. Meanwhile, the richest 20% of people in the highest income countries account for 86% of the total private consumption expenditures. While consumption has steadily increased in the industrial countries by about 2.3% annually over the past 25 years, the worlds poorest 20% live outside the consumption market!

- Over a billion people are deprived of basic consumption needs
- 60% of people in developing countries don't have basic sanitation
- Almost a third of them have no access to clean water
- A quarter exist with no adequate housing
- A fifth of children do not attend school to grade 5.
- A fifth of them do not have enough dietary energy or protein
- 2 billion people worldwide are anaemic.

Table 1
Percent share of the poorest 20% of the World Population in Global Opportunity

	% of Global Economic Activity	
	1960-70	1990
Global GNP	2.3	1.3
Global trade	1.3	0.9
Global domestic investment	3.5	1.1
Global domestic savings	3.5	0.9
Global commercial credit	0.3	0.2

Source: Human Development Report 1993

It is very clear that the poor are increasing and more so after the intervention of international financial institutions. The distribution of the world's poor showing their concentration in the developing nations is given in the following table:

Table 2
Distribution of the World's poor 1985-90

Region	Number of poor in millions	
	1985	1990
All developing countries	1051	1133
South Africa	532	562
East Asia	182	169
Sub Saharan Africa	184	216
Middle East & North Africa	60	73
East Europe	5	5
Latin America & Caribbean	87	108

Source: The World Development Report 1992

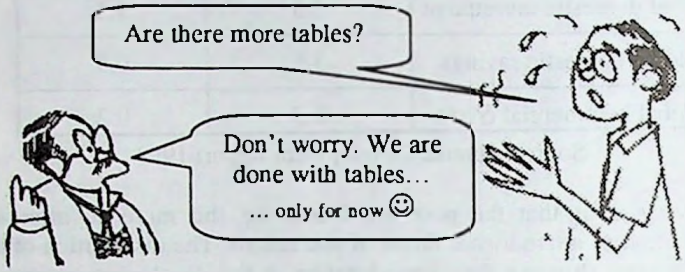
The percentage of population below the poverty line is yet another indicator to show the appalling situation after the intervention of the international agencies.

Table 3

Percentage of population below the poverty line 1985, 1990 and 1998

Region	Percentage of population below poverty line		
	1985	1990	1998
All developing countries	30.5	29.7	32.2
Latin America & Caribbean	22.4	24.9	23.8
South Africa	51.8	49	-

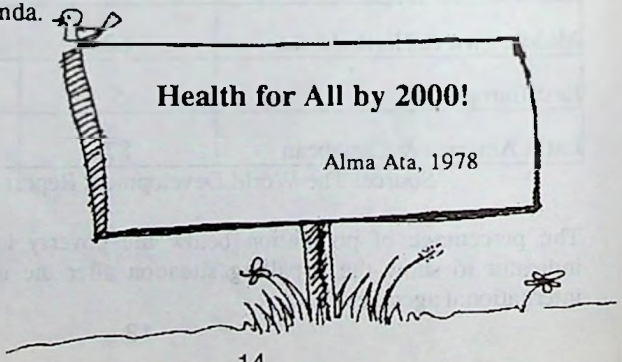
Source: Human Development Report: 1998



The World Health Organization has estimated that infant mortality rate has increased in sub-Saharan Africa, maternal mortality in Latin America and malnutrition levels in India since the implementation of SAP. In sum, the debt war declared by the WB and the IMF completely reversed the gains that the developing nations attained so meticulously in 15 years. The World Trade Organization (WTO), which is in the forefront of the drive to globalize world trade, is poised to complete the work done by the IMF/WB combine. It is estimated that when the World Trade Organization is fully operational, 2 to 6 billion people will lose their jobs and much of their land too.

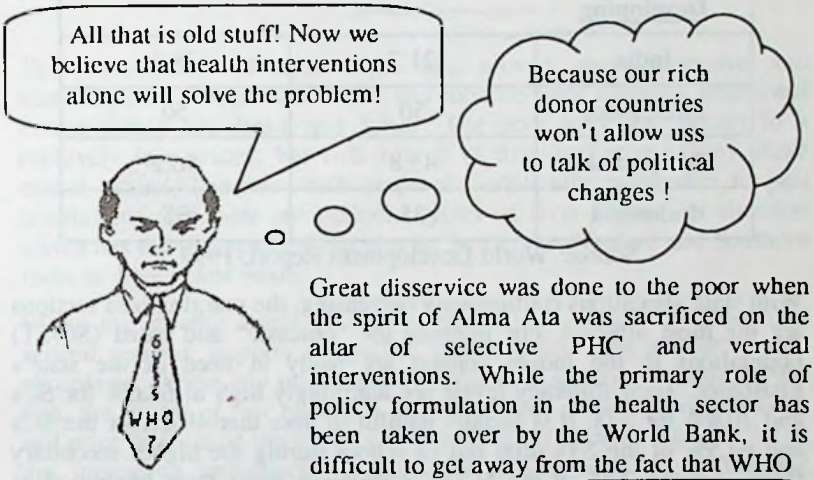
The PHC approach

The Primary Health Care approach was advocated emphatically at the Alma Ata Declaration of 1978, which has declared Health for all by 2000 as their agenda.



They had in their agenda stated among other things a complex set of strategies to improve people's livelihood and their quality of life by aiming to reduce the morbidity and mortality rates. The PHC approach did not deliver its goods for many reasons. Firstly, it was a vertical programme and failed to include the necessity of incorporating local health skills -- like treating diarrhea with rice water rather than spending one fourth of a daily income in buying the ORT packet. Secondly, the introduction of SAP had its own effects such as imposing user fees, freezing farm wages, freezing farm produce prices and thereby making public services inaccessible to the majority who are poor and needy. Thirdly, the World Bank's increasing role in dictating the health policies of developing countries prevented the implementation of the PHC approach.

> Health is Politics!
>
> - Halfdan Mahler
> Ex-Director General. WHO



Great disservice was done to the poor when the spirit of Alma Ata was sacrificed on the altar of selective PHC and vertical interventions. While the primary role of policy formulation in the health sector has been taken over by the World Bank, it is difficult to get away from the fact that WHO exists to soften the ugliness of globalization and is busy putting band aid on cancer. If the WHO does not start functioning at the political sphere and address fundamental issues such as resource redistribution, debt service cancellation and such, it will continue to remain largely irrelevant to the majority in the world.

The World Bank now prescribes health insurance, in place of free health services by the government. Private health insurance can in no way help the ordinary citizen in a developing nation who cannot afford to pay the premiums,

especially when they are not ill. Large members of people in the informal sector cannot afford the system. Some are only seasonally employed and are therefore more vulnerable. While the developed nations have increasingly had state support for their health services, the same nations are advocating lesser allocations in the developing countries where we have seen those below the poverty line increasing in absolute numbers:

Table 4
Financing of the health sector

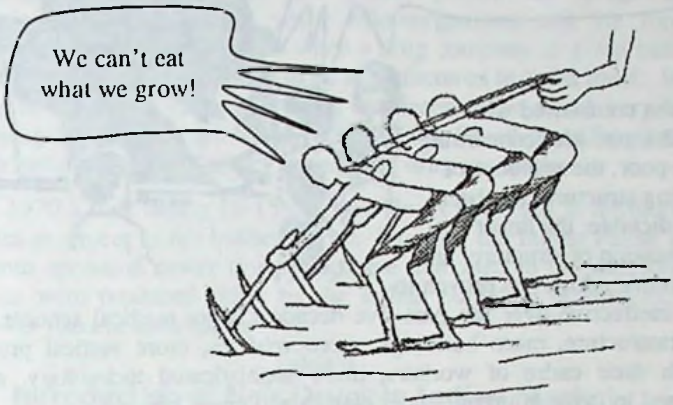
Country	% of Govt share	% of Pvt. Share
Developed		
Canada	74.7	25.3
Sweden	89.8	10.2
UK	85.2	14.8
Developing		
India	21.7	78.3
Philippines	50	50
Bangladesh	43.8	56.2
Indonesia	35	65

Source: World Development Report, 1993.

With state allocations continuously decreasing, the marginalized sections are the most affected. For instance the "outcaste" and tribal (SC/ST) populations in the Indian context are badly in need of the state's assistance. Their illiteracy levels are alarmingly high at 62.6% for SCs and 70.4% for STs. It is equally painful to note that 49.6% of the SCs and 64.5% of the STs drop out of school during the higher secondary stage. Around 70% of the SC/ST population earns their livelihood as agricultural laborers.

In the context of liberalization and globalization, the state is gradually abdicating its responsibilities to society. This forces the marginalized sections to compete

in unfavorable conditions, more so since globalization has displaced traditional occupations and agriculture with several mechanized activities. Orissa's worst affected district Kalahandi produces more than the national average of rice but very few of the poor there can afford to buy it.

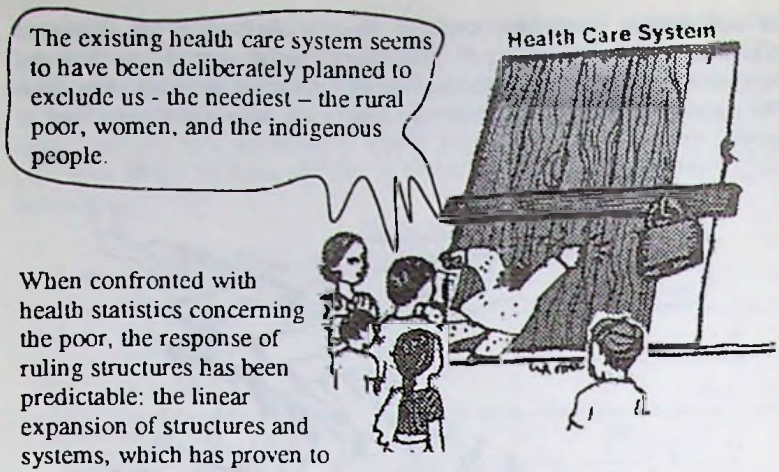


The introduction of cash crops has proved very expensive and unmanageable. Crops like cotton and tobacco have replaced traditional coarse grains like Bajra and Jowar. The poor have lost access to a relatively low priced, but rich source of nutrition provided by these coarse grains. The new cash crops are especially vulnerable to pest infestations and there are periodic cycles of crop failure - a situation which has led to a spate of suicides by farmers in Western and Southern India in the last few years.

While the income levels go down, prices tend to go up because of several reasons: imports of specific commodities such as fruit juices, chocolates, cheese and other luxury products to satisfy the wants of the rich, the export of raw materials and other cash crops to pay for these, and price fixation on the imports by international agencies like the WTO, the increasing imbalance in trade and the weakening of national currencies with devaluations and currency fluctuations and the resultant inflation. In all this, the role of Multinational Corporations (MNCs) has been central. While it may appear that the poor are peripheral to this process, it has been demonstrated that they feel the ultimate effects.

Issues in the Health Sector

In Asia, as elsewhere in the third world, budget allocations continue to be made not based on the real needs of the majority but needs as seen through the eyes of the of the ruling elite. Specifically health and education seem to receive step-motherly treatment while defense allocations on the other hand are steep.

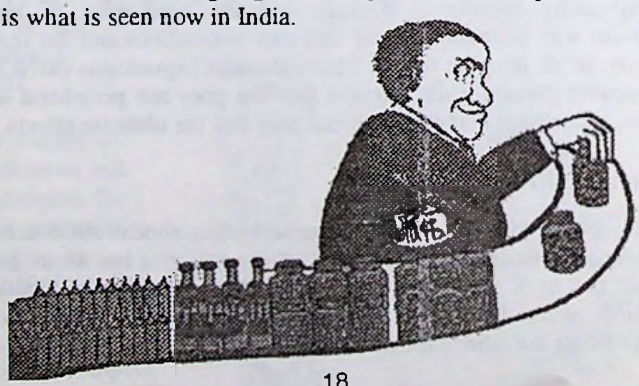


When confronted with health statistics concerning the poor, the response of ruling structures has been predictable: the linear expansion of structures and systems, which has proven to be ineffective over the past five decades. More medical schools, more infrastructure, more buildings, more vehicles, more vertical programs with their cadre of workers, more sophisticated technology, always biased in favor of urban, upper classes and upper castes.

India needs more para-medical staff instead of this system, which, with its many post graduation institutes, has produced more doctors and specialists. This makes the health organization-management set-up insensitive to the health needs of the majority of the poor. The health services, as it stands today, is badly in need of a strong village-level and people-centered organizational focus. Historically speaking, the poor were always denied effective public health services and today, with the onslaught of globalization, we are in a definite mess.

The Pharmaceutical Sector

The major impact of the WTO provisions especially the Trade Related Intellectual Property Rights is in the pharmaceutical sector. A good case in point where TRIPS is going to destroy a self-reliant pharmaceutical sector is what is seen now in India.



India has one of the most progressive patent laws passed by the parliament in 1970. The major features of the Indian Patent laws are that it is based on process patents rather than on product patents. This means that when a new drug is marketed anywhere in the world, we can manufacture the drug in India through a different process using indigenous capabilities. Also the patent period for drugs and pharmaceuticals is only 7-14 years. Microorganisms and life forms cannot be patented in India. Also when a drug company is given patent rights in India the drug will have to be manufactured in India itself. It is because of the Indian Patent that India has become one of the very few developing countries in the world (others being Brazil and China) that has attained near self-sufficiency in essential drug production.

Before 1970 it took nearly 10-15 years for drugs marketed in developed countries to appear in the Indian market. But after the Indian Patent act came into operation newer drugs that were marketed in the developed countries were produced either by the Indian public or private sector within 3-5 years or even earlier.

Table 6

Introduction of New Drugs in Indian Market

Drug	Production in Foreign Countries	Production in India
Before 1970		
Sulfadiazine	1940	1955
Penicillin-G	1941	1963
Streptomycin	1947	1963
After 1970		
Salbutamol	1973	1977
Rifampicin	1974	1978
Norfloxacicin	1987	1988
Mebendazole	1977	1978

It is because of the indigenous production capability that Indian drug prices still remain one of the lowest in the world.

Table 7

Drug Price: Comparison (In Indian Rupees)

Country	Ranitidine 150 mg x 10	Diclofenac 50 mg x 10
India	7.16	5.64
UK	320.85	125.88
USA	739.60	505.68

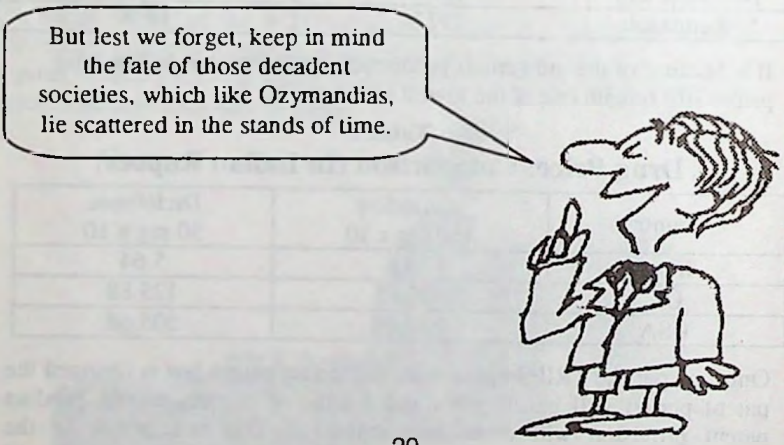
Once, as per the TRIPS agreement, the Indian patent law is changed the patent period will be 20 years and instead of process patent, product patent provision will come into existence. This will result in the dominance of the multinational drug companies in India and will

completely destroy our self-reliance in drug production. Drug prices will explosively rise and since the government health expenditure is already being cut down as per SAP, health care in effect will be denied to more and more sections of the people.

From Gamma to Gates

Historically the problem started with the arrival of Vasco da Gamma on the west coast of India on 28th May 1498. The spices and other natural resources with which India was well endowed then were the lure. Gamma was merely the first of the adventurer-merchant princes, the latest being Bill Gates. Only the nature of the goods being traded has changed but from the beginning, the key characteristics associated with globalization have been greed, profit maximization, exploitation of nature and human beings, unequal trade, control by any measure - either through the East India Company or through the WTO. In capitalism, it is the survival of the fittest, the strongest, and the most cunning. It is a jungle where the weaker ones get eaten up. Globalization is a systematically planned process of capitalism for the domination of this Unipolar world where the rules of the game are drawn up by the rich, codified by the World Bank and International Monetary Fund and implemented by WTO, all forums in which the voice of the poor goes unheard because they are indebted.

This is not entirely out of the blue. Historically, right from the time of the Greek city-states through the Roman Empire and through the later centuries, as attested by biblical incidents, slavery has formed the basis of capitalistic accumulation in the past. Globalization is but an extension of the concept of slavery and is the ugliest face of capitalism yet.



The World's Priorities

(Annual Expenditure)

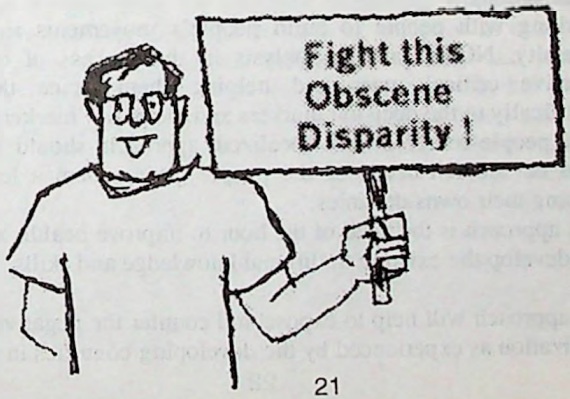
Basic Education for all	**$6 billion**
Cosmetics in the USA	$8 billion
Water and Sanitation for all	**$9 billion**
Ice cream in Europe	$11 billion
Reproductive Health for all Women	**$12 billion**
Perfumes in Europe and the USA	$12 billion
Basic Health and Nutrition	**$13 billion**
Pet Foods in Europe and the USA	$17 billion
Business Entertainment in Japan	$35 billion
Cigarettes in Europe	$50 billion
Alcoholic Drinks in Europe	$105 billion
Narcotic Drugs in the World	$400 billion
Military Spending in the World	$780 billion

Source: Human Development Report, 1998

Consumption Patterns in the World

Consumption Item	Richest 20%	Poorest 20%
Total private consumption expenditure	86%	1.3%
Meat and Fish	45%	5%
Energy	58%	4%
Telephone lines	74%	1.5%
Paper	84%	1.5%
Vehicles	87%	1%

Source: Human Development Report, 1998



What is to be done now?

There are certain steps that need to be catalyzed in order address the situation. Strategies should be developed so that the poor are able to handle the immediate effects of globalization. Long term solutions will depend up empowering peoples organisations which can effectively plan for there needs and also have a major role in national governance and policy formulation -- including policies that actively resist the forces of globalization, which are detrimental to the conditions of living of the poor and marginalized.

Strategies have to be centered around:

- Improving conditions for good governance, involvement of people in local governance irrespective of class or caste, community participation in identifying priorities, making financial allocations and management of resources, both material and human.
- This will mean devolution of power to lower, local levels and result in decentralized management of all sectors, specially the public health sector.
- A redefinition to "public health" i.e. from the old government type, giver-receiver type of relationship to placing the local community at the center of the scheme, where the poor have the capacity to make decisions that affect their lives.
- There is a definite need to develop a workable infrastructure to implement policies and strategies, which affect major health problems in providing curative and rehabilitative health services including health promotion.
- In the twenty-first country the 'Health for All' proclamation should no longer remain a mere slogan but be put to effective action.
- A periodic consultation and dialogue with peoples organisations, government and the international agencies is a must at global regional and national levels.
- There should be large alliances and networks among peoples organisations.
- Working with people to build people's movements is a definite necessity. NGOs can be catalysts in the process of creating an effective critical mass and helping them voice their rights specifically to the decision markers and the policy markers.
- This people-centered and localized approach should effectively build on the felt-needs of the people giving them a lead role in shaping their owns destinies.
- This approach is the need of the hour to improve health, and protect and develop the existing traditional knowledge and skills.

Such an approach will help to expose and counter the negative elements of globalization as experienced by the developing countries in particular.

People's knowledge systems and skills must be preserved, refined, built upon and propagated so that they do not have to rely on global forces for services.

The Role of NGOs and Peoples Movements

Globalization as a force cannot be countered by the 'disadvantaged' in a straightforward manner. But there is still a lot that they can do. Consider the fight against Cargil in Karnataka or against Monsanto in Andhra and elsewhere. People's power is immense. It just needs to be harnessed. It is in this that NGOs and peoples movements have a vital role to play.

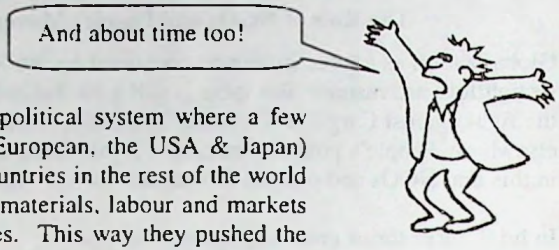
In brief, three thrust areas suggest themselves:

- **An Advocacy Role**: whereby relevant information is placed in the public eye. This information, to a large extent, already exists. It only needs to be 'interpreted' in favor of the poor and where no information exists, it may have to be generated. This is the age of information and information leads to knowledge and knowledge is power.
- **A Training Role:** which equips activists, trainers and communities with the knowledge and capacity to strategies and fight against forces of oppression.
- **A Networking Role:** which enlarges the community of believes and practitioners and brings about a critical mass that can effectively fight on the side of the barricades, in the poor for justice in health care.
- **Building Resistance:** Above all peoples organisations can join together to build a resistance, both against the philosophy of globalization and in its actual manifestations that touch the lives of common people in thousands of ways.

Global strategies of poverty alleviation have all aimed at maintaining the status quo by providing for example, minimum wages as opposed to living wage, mid-day meal for children of the poor as opposed to just wages, reservations and quotas instead of equality and justice, ORT instead of potable drinking water and so on. But history has proved time and again that a people, even the most supine of them, can be pushed only so far and no further. Existing disparities have been sharpened and have gone from mere inequality to the inhuman. The developed nations of the North can discount this only at its peril. At the turn of the millennium, unless structural problems are addressed urgently, humankind will be headed for a prolonged period of unrest and violence. If we are silent observers, we will stand indicted by posterity as having colluded with this process.

Chapter II

Understanding the Jargon !



Colonialism: The political system where a few countries (mostly European, the USA & Japan) conquered other countries in the rest of the world and used their raw materials, labour and markets to enrich themselves. This way they pushed the colonized countries into poverty.

Imperialism: The advanced stage of capitalism characterized by the emergence of large monopolies. The world is in this stage divided into spheres of influence and the export of capital is the major feature of this stage.

Food Security: A policy that ensures that all the food needed for a country is grown and stored within the nation, thus ensuring security from famines in the event of a natural or human-made disaster. Having such food security also means that as a nation our sovereignty is safe for if we needed to beg for food in a famine we would be forced to capitulate to their dictates.

Gross Domestic Product (GDP): This is one measure of a country's wealth. It is derived by adding up everybody's income. Equivalently, it is the total value of all products and services in the year. The problem with this index is that if a few persons increase their income/production considerably, even if there is a decline in the majority's income, the GDP would still go up! This figure hides inequalities.

Globalization: Refers to a set of economic and political policies that believes in taking down all barriers to the creation of a single global market as the best prescription for prosperity. Multinational corporations welcome this and so do all large, rich and powerful companies everywhere. For them the removal of national barriers means that they have a much larger market. However in most countries small producers and even small industries that cannot compete with the larger companies oppose this. In a free market they claim, the rich are free to do what they want, but the poor are pushed out. Globalization does not only create a global market by removing trade barriers. It also creates a homogenous global culture. Technology development, the creation and control of knowledge and information and the structure of social institutions are also shaped to favor the domination of the few multinationals.

Inflation: An economic trend in which the value of paper money falls. Therefore the prices of all goods rise. Inflation robs the worker of his/her wages - for it means his/her (effective) wages are lowered regularly. For property owners however it means no change in real value or that cash value of their property goes up.

International Monetary Fund (IMF): An international financial institution floated by the powerful countries of the West to help manage the international financial situation. It lends to developing nations. When nations are forced to plead for loans or are unable to repay loans it demands that these nations change policies to suit the interests of rich nations in return for the loans.

Liberalization: A political policy where state controls over production and trade are removed or are decreased considerably. The understanding stated for removing these rules is that the market is a better judge of people's needs than the government. Critics of liberalization point out that social goals of production especially to meet the needs of the majority who are poor and the goals of employment generation are bypassed by such liberalization and only the rich benefit.

Liberalism: Refers to an economic philosophy that believes in abolition of government intervention in economic matters. No government restrictions to manufacturing or trade. Such free trade was supposed to be the best way for the economy to develop. It was expected that when free trade was allowed, competition between producers would ensure both the best quality and quantity of goods and jobs for all. However by the middle of the last century this was challenged and during the nineteen thirties much of this was given up. Capitalism instead came to follow the theories of Keynes who challenged liberalism and called on governments to intervene to ensure full employment, stating that this was necessary for capitalism to survive and grow.

Multinational Corporations (MNCs): These large companies span many countries & continents. Most of them have huge assets, often more than the total budgets of many poorer countries put together. They do not come under any one country's laws. Their decision making process is totally invisible and they are not accountable to anyone but their own board whose only criteria is profit. Yet because of their tremendous resources they can influence the policies of governments with ease.

Neo-Colonialism: This refers to policies of rich countries that force developing countries to export their raw material at relatively low prices & become a market for their industrial goods and manufacture, without direct rule as in the colonial period. Through indebtedness, unequal treaties and through trade terms the rich countries maintain control over

the poor and extract as much profits from them as possible. Often the amount extracted is more than what happened during colonialism.

Neo-Liberalism: This is the revival of liberalism in the 80s and 90s. Its main content is that an unregulated market is the best way to achieve economic growth that benefits everyone. Though the rich would benefit more, some benefits would trickle down to the rest. Whereas liberalism foresaw a role for the state in social services and some activities called "public good", neo-liberalism tries to find market solutions even for these. In areas like health, education and social security the poor have to fend for themselves and if they fail it would be "because they are lazy."

Privatization: This is the policy by which, a government hands over all public sector undertakings and services provided by it to private hands.

Recession: An economic crisis caused due to insufficient demand, when goods manufactured fail to sell. This means big losses to industrialists and restricts industrial growth. This in turn means workers are laid off, resulting in high degrees of unemployment.

Structural Adjustment Programme (SAP): The IMF and World Bank impose these policies on indebted nations as a condition for deferring their loan repayments or giving them a fresh loan. These conditions, which are usually kept secret, dictate to the indebted country how the economic structure and certain aspects of government laws and regulations must be changed.

World Bank (WB): This is an international bank whose largest shareholders (and therefore effective owners) are the rich nations of the world, mainly the USA. Like any other bank it accepts deposits and lends money. Its depositors are the rich nations of the world. It lends largely to developing nations, supposedly to help development. But it will lend only when it can determine what development the money is going to be used for. Also, it lends only to support development as understood in the west. In the area of health, it even works out in detail the health programmes for which it lends. These are not grants or aid. These are all payable back with interest.

World Trade Organization (WTO): This is an international body composed of all the nations of the world who have signed international trade agreements (most of which are against the interests of developing nations) and have been admitted into it. It is meant to lay down the rules, settle disputes and police the implementation of trade agreements between nations. It is dominated by the west, but since all nations have some representation, they can also put forth their views and bargain before this body.

Chapter III

What Every Indian Should know About the Financing of Health Care in India!

Do You Know?

1. Indians spend less on health (as compared to expenditure on food, clothing and entertainment) than other nations.

True / False

2. Compared to other nations, especially the west, India has a larger % of public health expenditure (compared to pvt. expenditure).

True / False

3. Compared to other nations, Indian government expenditure on defense as compared to expenditure on health and education taken together is one of the lowest.

True / False

4. Govt. expenditure on health has steadily increased over the years.

True / False

5. Most government health expenditure goes to rural areas.

True / False

6. States with worse health status spend more on health care (as they should).

True / False

7. Family planning (FP) is a major part of govt. health expenditure.

True / False

8. Maternal & child services take up a major part of FP expenditure.

True / False

9. The per-episode out of pocket expense for in-patient health care in 1986 was Rs. 886. In 1996, the expense was double this, which is what we can expect at 10% inflation per year.

True / False

10. In 1986, the extent of utilization of the public health system for inpatient care was about 60%. This decreased to 45% in 1996.

True / False

11. Mostly, expenditure by poor households on curative medical care goes to essential drugs and basic health care.

True / False

12. Western aid, including from the World Bank, accounts for only a small part of government expenditure on health.

True / False

13. Since our country is cash strapped and the money is going to a vital area, we should be thankful for this aid.

True / False

Answers on the next page.
Score yourself ten points for every correct answer

Answers

1. **False**: Indians spend about 6 percent of their GDP on health care. (This is inclusive of both private and public expenditure). This is comparable to most developed nations (only the US is higher) and more than almost all developing countries. See the graph below. figure 1

However in absolute terms this is low. For example an Indian spends on an average Rs 250 per person per year, whereas in England it is Rs 2500 per person per year and in all Asian countries taken together it is Rs 1000 per person per year. figure 1

Figure 1.1 Income and health spending in seventy countries, 1990

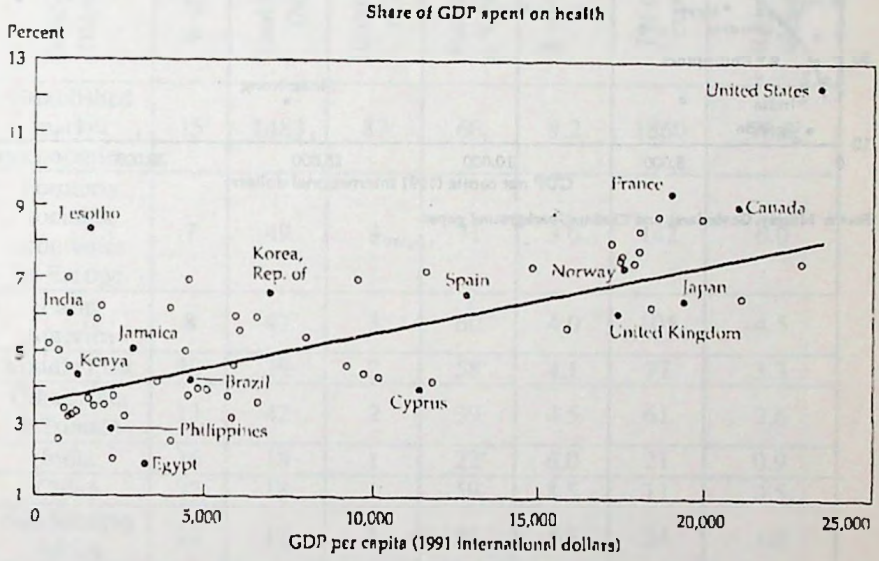
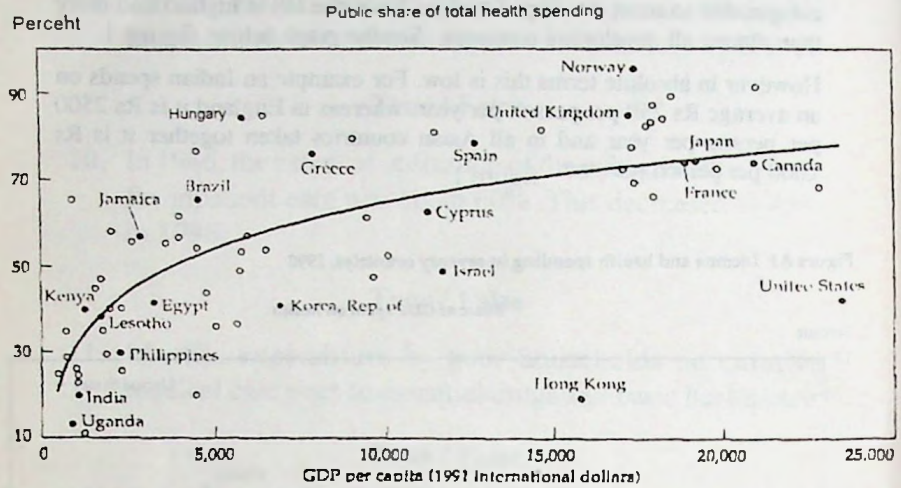


figure 1

2. **False:** The public sector share of total health expenditure is about 22%. This is about the lowest in the world. The figure for all the developed capitalist nations together is about 75%. The lowest figure for any developed nation is the US, but even there it is 44%. This is twice the Indian figure. see figure 2



Source: Murray, Govindaraj, and Chellaraj, background paper.

figure 2

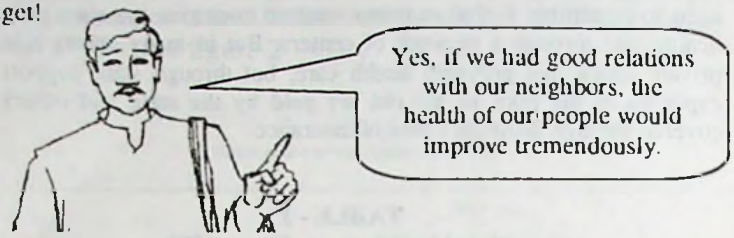
It is important to note this information because when governments and policymakers talk of privatizing in the Indian context one forgets this is the most privatized health system in the world. One other feature we need to remember is that in many western countries the state provides health care through a network of centers. But in many others it is the private sector that provided health care, but through state support the expenses of the poor or the old are paid by the state and others are covered through different forms of insurance.

TABLE - 1
Global health expenditure, 1990

Demographic region (DM=Demographic)	% of world popn.	Total health expense (billions of $)	Health expense as % of world total	Pub.health expense as % of regional total	% of GNP spent on health	Per capita Health expenditure ($)	Ratio of per capita spending (SSA=1)
Established market economies	15	1483	87	60	9.2	1860	78.9
Formerly socialist economies of Europe	7	49	3	71	3.6	142	6.0
Latin America	8	47	3	60	4.0	105	4.5
Middle East	10	39	2	58	4.1	77	3.3
Other Asia & Islands	13	42	2	39	4.5	61	2.6
India	16	18	1	22	6.0	21	0.9
China	22	13	1	59	3.5	11	0.5
Sub Saharan Africa	10	12	1	55	4.5	24	1.0
DM-ly Devp-ing countries	78	170	10	50	4.7	41	1.7
World	100	1702	100	60	8.0	329	13.7

Source: World Development Report, 1993 page 52

3. **False**: India has one of the highest ratios of defense to health and education, for a country not having a war. On defense we spend 15% of the budget while health and education account for about 3 to 5% of the budget!



4. **True**: In cash terms it has increased. However if we adjust for inflation the increase is not so remarkable. If we look at the expenditure as a percentage of the total expenditure on health there is actually a decrease in health expenditure though together with family planning it remains at about 3 %. However there was some increase in expenditure on drinking water in the eighties. This is shown in the table given below.

Table 2
Health Expenditure by Five Year Plan Periods

Plan period	Total plan investment outlay	Health	Family Welfare	Sub-total (col. 3+4)	Water supply and sanitation	Total (col 5+6)
I 51-56	19600 (100)	652 (3.3)	1 (0.0)	653 (3.3)	110 (0.6)	763 (3.9)
II 56-61	46720 (100)	1408 (3.0)	50 (0.1)	1458 (3.1)	740 (1.6)	2198 (4.7)
III 61-66	85765 (100)	2259 (2.6)	249 (0.3)	2508 (2.9)	1057 (1.2)	3565 (4.1)
IV 69-74	157788 (100)	3355 (2.1)	2708 (2.1)	6135 (3.9)	4589 (2.9)	10724 (6.8)
V 74-79	394262 (100)	7608 (1.9)	4918 (1.3)	12526 (3.2)	10916 (2.8)	23442 (6.0)
VI 80-85	109291 7(100)	20252 (1.8)	13870 (1.3)	34122 (3.1)	39776 (3.6)	73898 (6.7)
VII 85-90	220216 3(100)	36941 (1.7)	29581 (1.3)	66522 (3.0)	71227 (3.2)	137749 (6.2)
VIII 92-97	434100 (100)	75759 (1.7)	65000 (1.5)	140759 (3.2)	167110 (3.8)	307869 (7.0)
Note: Figures in brackets show percentages.						
Source: Social impact of economic reforms in India; EPW vol.35.No.10 March 4-10.pg 841,based on GOI reports						

During the reforms period of the nineties the percentage spent on health remains constant, but due to the drop in all developmental expenditures there is a sharp drop in the actual amount spent as adjusted for inflation. This is shown below:

Table 3
Real expenditure/allocation in the health sector in annual plans in the nineties
(At constant1990-91 prices in Crores of Rupees)

	Total developmental expenditure			Health expenditure		
	Center + States	Center	States	Center + States	Center	States
90-91	40062	23511	16551	659 (1.65)	189 (0.8)	471 (2.84)
91-92	39075	22839	16236	629 (1.61)	183 (0.8)	447 (2.75)
92-93	39946	23958	15988	665 (1.67)	210 (0.88)	455 (2.85)
93-94	44573	27942	16631	658 (1.48)	203 (0.73)	454 (2.73)
94-95	48482	31186	17296	780 (1.61)	273 (0.88)	507 (2.93)
95-96	54662	33518	21144	924 (1.69)	285 (0.85)	639 (3.02)

5. **False:** The government health expenditure in rural areas is 46.5% while in urban areas it is 53.5%! This 53.5% serves 23% of the population. (Source: *State of the Nation's Health* – Report of the Independent Commission, published by VHAI). Other estimates would put the rural spending as even less. Except for the primary health centers and the minimum expenditure on these, there is little that is expended in rural areas. All the medical colleges and all the hospitals and research centers are urban based. Of course, many of the urban hospitals do cater to rural areas since there are no rural alternatives.

6. **False**: On the contrary, the states with poorer health status are spending less on health per capita and as a percentage of their budget. These are also the economically weaker states and they find it much more difficult to raise the resources needed for investment in health. Thus the highest under five mortality are in the six states of MP, Orissa, UP, Rajasthan, Assam, Bihar - in that order. The poorest performance in DPT immunization for example is Bihar, Assam, MP and then UP,

Assam, Orissa. The six worst states in terms of births attended by untrained personnel are Assam, Bihar, MP, Orissa, Rajasthan & UP. The highest poverty levels were also in Bihar, Assam, Rajasthan & MP.

7. **True:** Family planning programme expenditure accounts for almost half of all health expenditure. (See table given for answer 4)

8. **False**: The major expenses are in the provision of family planning services, including payments to beneficiaries. Maternal and child care services account for only about 13.1% of this entire expenditure. Family planning expenditure accounted for 73.3 % of the expenditure. (Source: 1985 figures based on same source as question 5.)

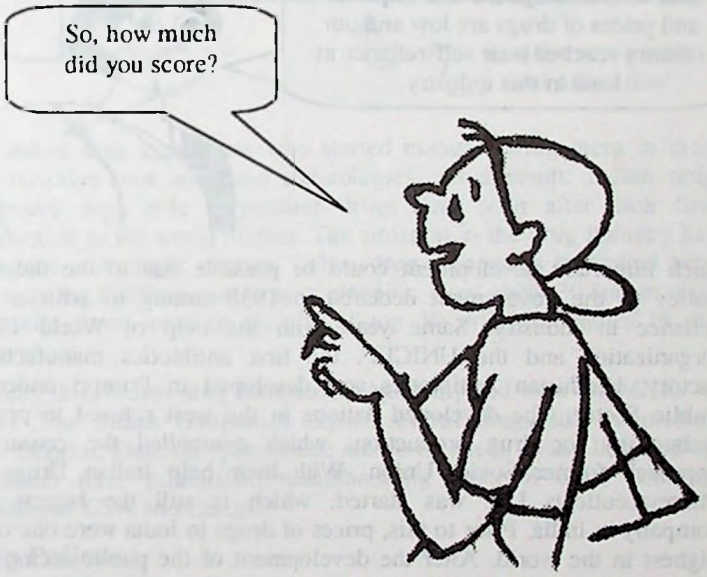
9. **False:** In reality, the out of pocket expense for in-patient care went up almost four times. At constant 1986 prices, the out of pocket in-patient care expense in 1995-96 went up to Rs. 1404 (from Rs. 886 in 1986-87). Since for low income groups, income has not kept up with inflation, the effective increase in health care cost is even more. Most conservative estimate put the health costs at more than 20% of the total family expenditure. This is one of the immediate and most evident impact of globalization.

10. **True:** The dependence on private health system has gone up from 40% to 55% for in-patient care and from 75% to 80% for out-patient care.

11. **False:** On an average 71% of the family's health expenditures go to drugs and fees and diagnostics. Transport accounts for 8% of the costs and hospitalization and surgery about 13%. Expenditure on pujas and such like account for less than 1% of the expenses. The major part of the family's expenses on drugs and diagnostics goes to inessential or hazardous medicines. This amount has been estimated from 60% (the most conservative estimate) to over 90%. Also include expenses due to choosing drugs instead of non-drug remedies or homemade preparations for symptomatic relief instead of drugs (like cough remedies). This is as true if not truer for poor families. For example, the most common expense is on diarrhea treatment, which may cost from Rs 20 to Rs 50 for treatment without hospitalization for a mild to moderate treatment. Yet rational therapy could achieve the same therapy with no expense except the consultation of the local health worker. (Source same as for answer 5 and also Rational Drug Usage by Anant Phadke.)

12. **True:** According to a world bank estimate, the entire foreign aid and loan contribution to health in India is less than 9% of the total health budget.

13. **False:** For one, what we receive as loan and aid is only a small part of what flows out of our country to these countries as profits and products. Secondly even of the amount received as aid and loans, a fair percentage flows back to these countries as consultancy charges and as commodities and equipment bought from these countries. Thirdly, the aid or loans given are not disinterested. They extract a price in terms of forcing us to change our policies and surrender a part of our sovereignty. Finally, it is not clear why they were needed in the first place. Such resources could have been raised in the nation. And we are burdened with loan repayments and this in turn forces us to bend further. Had we chosen different strategies of development that were based on empowering local communities we would have been more effective for less expense. It is only because we are reluctant to empower local communities, despite our rhetoric to the contrary, that we subjugate ourselves to these loans and their conditionalities.



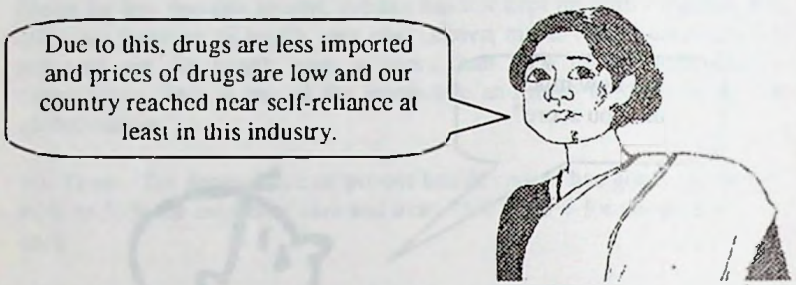
Chapter IV

The Pharmaceutical Industry

And how Globalization will take away its self reliance!

Development of Pharmaceutical Industry

Drugs and pharmaceutical industry in India has reached an annual sales of Rs.2000 Crore now. Most of the drugs are now manufactured by majority of the companies in the national sector in the country. The country has large number of technical persons and skilled workers required for production and research spread in the largest infrastructure available in the developing countries besides China.



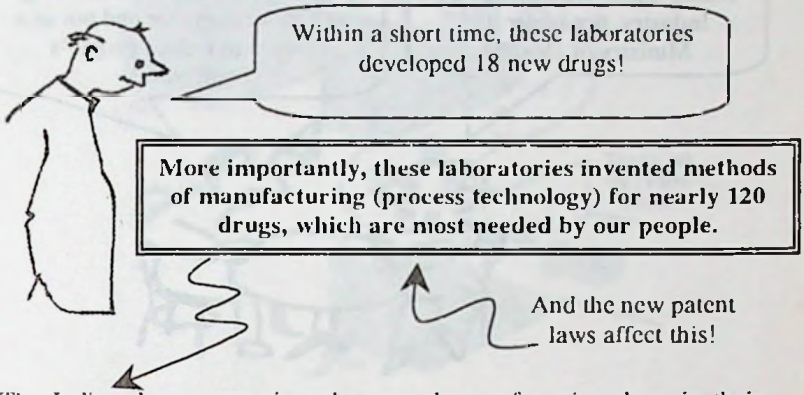
Such important development could be possible due to the industrial policy of the government declared in 1958 aiming to achieve self-reliance in industry. Same year, with the help of World Health Organization and the UNICEF, the first antibiotics manufacturing factory, Hindustan Antibiotics was developed in Primpri under the Public Sector. The developed nations in the west refused to provide technology for drug production, which compelled the country to approach former Soviet Union. With their help Indian Drugs and Pharmaceuticals Ltd. was started, which is still the largest drug company in India. Prior to this, prices of drugs in India were one of the highest in the world. After the development of the public sector drug companies, the prices of drugs started coming down. The foreign (multi national) companies were also compelled to bring down prices of their drugs and started to develop their manufacturing units in our country.

Prior to this, the multinational drug companies had monopoly and controlled the drugs market. They used to decide what drugs are to be marketed when and at what price. It was found that the multinational

companies marketed no new drugs in India until at least ten years after their introduction in the world market.

Drug Research

Before independence only one drug was invented in the country. Both IDPL and HAL had research facilities to develop drugs. Later the government established the Central Drug Research Laboratory (CDRL) at Lucknow, National Chemical Laboratories at Pune and Indian Institute of Chemical Technology (IICT) at Hyderabad.



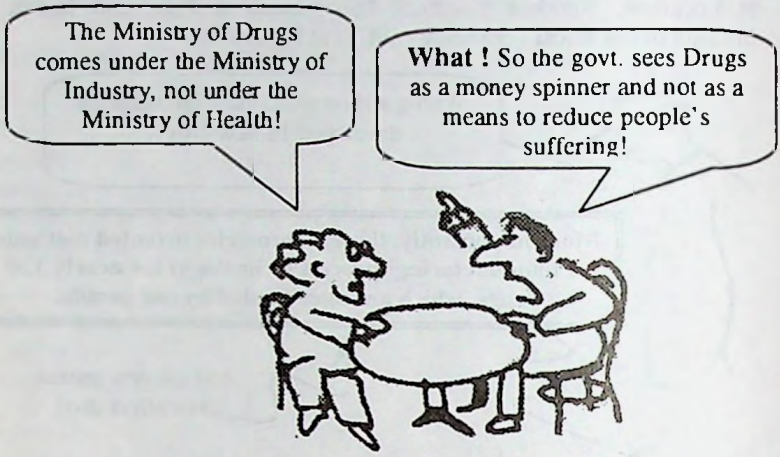
The Indian drug companies who started manufacturing them in their own factories took up these technologies. As a result, Indian drug companies were able to produce drugs very soon after their first introduction in the world market. The situation in the drug industry has undergone a dramatic change. Indian drug companies competed very well with the multinational drug companies. Now about 30 Indian drug companies have come in the list of top 50 drug companies in the country.

Not only this, Indian drug companies also competed with the MNCs in export. The Indian companies export several drugs like Ibuprofen, Trimethoprim, Dextropropoxyphene etc. to the west! Many Indian drug companies have established manufacturing units in other counties including in USA and Europe.

Drug Policy

It was declared in World Health Assembly of WHO in Nairobi in the year 1985 that no country can meet the health needs of its people without an appropriate drug policy. Even earlier, the Indian government constituted a Committee on Drugs and Pharmaceuticals known as Hathi Committee. Its report and recommendations were published in 1975.

Some of the recommendations of this committee part of the Declaration of WHO. The Committee had prepared a list of 119 drugs, which were most needed and used in the country and directed that production of these drugs should be ensured. This committee also recommended that all foreign companies should be nationalized after some time and before that foreign share holding of these companies should be gradually reduced.

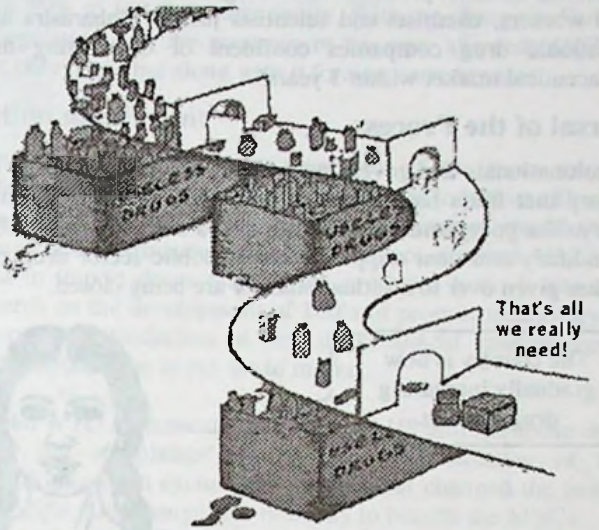


The government first declared drug policy in 1986. The policy did not follow much of the recommendations of Hathi Committee but tried to help development of national drug companies. They also provided certain safeguards for public sector drug companies. The First Drug Prices Control Order (DPCO) was declared in 1970 when **ALL** drugs were kept under price control. The next order was issued in 1987 when **nearly 387** drugs were kept under control. Now **only 63** drugs are under DPCO!

Essential drugs.

Really how many of the large number of drugs available in our country are Rational? Even the government is not aware of the number of drugs marketed in different brand names. According to government estimates made a decade ago, nearly 60,000 brands are marketed here. Many irrational and hazardous drugs proliferated the market. Most of these drugs should have been banned. It was urged that the government should prepared a list of essential drugs which are needed by most of the people to treat nearly all their diseases. The government should ensured production and availability of these drugs at affordable cost. Since drugs are not purchased directly by the patients on their choice, it

is more important that government should see that people are not dumped with irrational and hazardous drugs at high price. The government cannot depend on the industry alone to produce essential drugs but should make it an essential part of medical practice.



Though it was demanded from the government to prepare a list of essential drugs for our country, it took a decade for the government to come out with this list only in 1996. Even though the list was prepared, there is no attempt from the government to use it for rational use of drugs. In fact, no one knows where from such list would be available! Based on such a list at least the hospitals should prepare their formulary and the doctors can be asked to limit their use around the list. Similarly, the industry can also be asked to produce essential drugs without wasting limited resources on useless drugs for the sake of high profits.

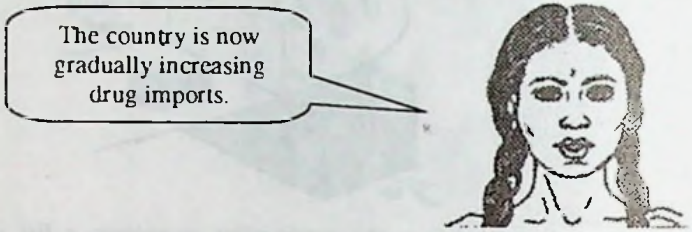
Multi-National Drug Industry

The multinational drug companies came in India with a meager investment but developed 100's of crores of assets without investing further. They did not provide much high technology, but rather drained away large sums of foreign currency by way of Profit, Royalty, Technical know-how, etc. The MNCs had first tried to disrupt the public sector and now are using them to earn profit. The strong international MNC lobby has influenced WTO to include patents (particularly Drug patents) in the GATT issues. They have also influenced our government to give up policies favoring people. It is the MNC lobby which has

threatened the US trade sanctions against Indian drug companies. The lobby has also threatened to file complaints against India at the WTO for violating patent agreements. Nearly all multinational drug companies have now closed their manufacturing units and are using small scale units to produce their drugs. This has meant laying off 15,000 workers, chemists and scientists just in Maharastra alone. The multinational drug companies confident of dominating the Indian pharmaceutical market within 3 years!

Reversal of the Process

The multinationals and government policy has systematically debunked the glory that India had earned in achieving self-reliance in the drug industry. The government first marginalized the role of the public sector drug industry and then crippled it. Now public sector drug companies are either given over to multinationals or are being closed.



Many bulk drug-manufacturing units, large and small, have been closed due to free import and dumping. On one side, the customs duty has been reduced and on the other, excise duty has been increased. This will make imported drugs cheaper but indigenous more costly. Remember that the excise duty for luxury items has been reduced!

Control of prices is now at a symbolic minimum and there are plans to totally withdraw it. The government has yielded to the pressure of the industry stating that there will be self-regulated prices. due to market competition. Already prices of many essential drugs including anti TB drugs have nearly doubled within a year. On top of it, prices of all new drugs and vaccines are exorbitantly high, since they are all imported.

Of nearly 10,000 drug producers, only 500 belong to organized sector rest are belong to the small–scale sector. They had survived by producing generic drugs and supplying drugs to various government institutions. With excise duty on generic drugs and the imposition of the condition that allows only drug companies with an annual turnover of at least Rs. 12 crores, many small companies are being forced to

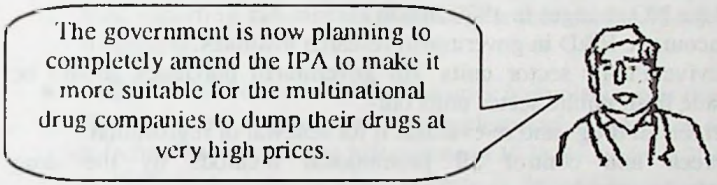
close down. This government policy will allow multinational drug companies to monopolize the Indian market again.

The government has now allowed multinational drug companies to function with 75% to 100 % foreign equity. With the change in Foreign Exchange Regulation Act, the government has now allowed MNCs to drain out not only profit but along with it foreign currency also!

Globalization and Patent

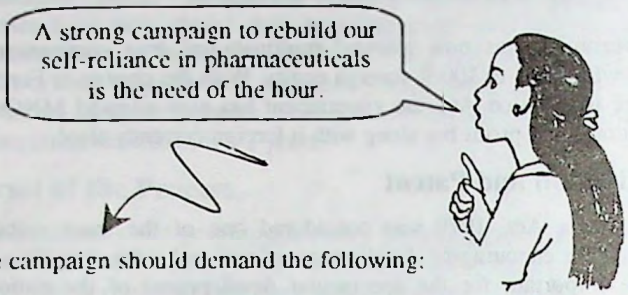
Indian Patents Act, 1970 was considered one of the most suitable regulations for encouraging development of national industries. This act has been important for the spectacular development of the national sector in drugs and pharmaceuticals. This has not allowed MNCs to compel India to import drugs that can be produced here. It has also allowed research on the development of 100's of process technology. It provided scope for introduction of new drugs almost simultaneously with their first introduction in the world market.

India signed the WTO agreement – this allowed US and European drug companies to file complaints against India for violation of the agreement. With this as an excuse, the government changed the Indian Patents Act in 1988. The change was basically to benefit the MNCs.



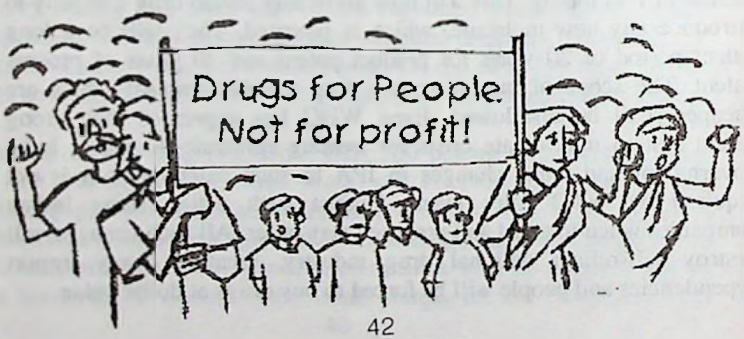
A new amendment bill has been proposed which a sub-committee is now viewing. Purpose of present amendment is to change all important section of IPA totally. This will now allow any Indian drug company to introduce any new molecule, which is patented. They will be a long patent period of 20 years for product patent and 20 years of process patent. The scope of importing any drug (parallel import) which are cheaper shall be disallowed. Even WHO has expressed that strong patent system may create crisis for treating epidemic diseases. India government had made changes in IPA to such extend that it is not required by WTO rules even. Against such action some Indian companies when to court and procured stay order. All such changes will destroy self-reliant national drug industry, creating heavy import dependencies and people will be forced to buy drugs at dollar value

What is to be done?



The campaign should demand the following:

1. Develop a comprehensive drug policy aiming to rationalize drug use.
2. Ensure production of essential drugs.
3. Develop the methodology of implementation of essential drugs list.
4. Reduce the price of all essential drugs and keep it under control.
5. Ensure that all essential drugs are available free of cost at all government run health care institutions.
6. Demand international bodies to suitably change the IPR regime for production of essential drugs. Particularly to revise the clauses on compulsory licensing.
7. Make NO changes in 1970 Indian Patents Act !
8. Encourage R&D in government research institutes.
9. Revive Public sector units. All government purchases should be made from public sector units only.
10. Screen all drugs and re-evaluate it for renewal of registration.
11. Screen and control all promotional methods by the drug manufacturers.
12. Develop and enforce a Patient's Charter!



Chapter - 5

Globalisation and Food Security

Introduction:

Food security of a nation means the ability of a nation to produce and distribute all the food grains it needs in a self -reliant manner. This would imply that one is not dependent on food imports for feeding ones population. All national economic planning since independence and upto the last 15 years or so have always had food security as one of the most important and central objectives of economic planning. For a family or community food security would mean a reasonable assurance of being able to obtain the food it needs for survival throughout the year.

Why is Food Security so Important ?

- Food security is the cornerstone of our economic and political independence. If we are dependent on food imports for survival then we are open to adverse political pressures, even political blackmail by food exporting nations. Food security is therefore a question of our sovereignty.

- Another basic reason why food security is crucial to us is the fact that chronic hunger and malnutrition is widespread in India. The total poor in India is estimated to be 320 million in 1993-94, up from 304 million in 1997-98.And this is when poverty is defined by the inability to afford even the basic minimum calories needed for an average person. For almost 90percent of the population the share of income that goes to purchase of food is above 50 percent. For the poorest 50 percent of the population it is over 70percent.In such a situation any food scarcity, however transitory and consequent rise of prices will have grave consequences for food consumption. Similarly any fall in wages, either in money terms or consequent on inflation will have an immediate adverse impact on food consumption.

- Since food consumption is the single most important determinant of good health, the impact on health would be terrible. The great Bengal famine of 1943 is a grim reminder of what "terrible" means. Over 40 lakh dead, and numerous villages ruined and all social life thrown into chaos. And that famine was a direct consequence of war related policies of the colonial state. It must be remembered that all through

the first half of the century famines and epidemics racked India. It was only after independence when the state intervened to control exports, and to import food in times of scarcity and manage distribution that such famines have lessened. Over 30 years of planning the Indian state built up carefully its ability to produce all the food that the nation needs. (But even now due to poverty and faulty distribution policies starvation deaths are still a continuing phenomenon).

- Such scarcity affects women more. The allocation of food within the family is such that women and that too the girl child bears a disproportionate reduction whenever there is a reduction of food availability. In 35 percent of rural households that are women headed the impact is even greater. The impact on women health of adverse developments in food security is immediate and grave.

How has WTO undermined Food Security?

The major economic changes consequent to the structural adjustment programme and India's accession to the World Trade Organisation have major implications for our food security. International trade in agriculture and food products is now regulated through the Agreement on Agriculture(AOA) agreed during the Uruguay Rounds. When finally agreed the AOA was based on a bilateral negotiation between the US and the European Union. Many developing countries were opposed to the AOA, but since it was presented as part of the comprehensive package, to be accepted on an 'all or nothing basis,' they were forced to concede.

The AOA is divided into market access, which deals with tariff barriers and import quotas and domestic support programmes such as price support to farmers and export subsidies.

Let us look at each of these areas:

1. Market access: As per the WTO obligations India has to reduce all import barriers on over 2700 items, of which over 800 are agricultural items. This includes milk and milk products wheat, rice, pulses, livestock, agricultural chemicals, tea rubber and so many other commodities. Succumbing to this pressure, over 700 items went off all quantitative restrictons this year. Now this has already created a crisis in tea and rubber industry where lakhs of workers are unemployed as result of their plantations being unable to face the competition from cheaper imports.

This danger of loss of livelihoods will now spread to milk and milk products where millions of women earn their livelihood and even to growing cereals like wheat and rice.

2. Support to farmers and export subsidies: The AOA lists a number of subsidies to be reduced over time.

These include direct subsidies, sales from stocks by government at lower price than the domestic market, subsidized exports —to name a few. In India this means that there is pressure to lower government procurement and support price policies. Indian farm exporters do not get direct export subsidy. The subsidy on fertilizers is sought to be lowered greatly . But the countries to which the Indian farmers are allowed to export or with whom they compete get extensive subsides for agriculture. Almost all-western nations subsidise exports. The US subsidy on wheat export was around 30$ a tonne. To China it exported at 60$ subsidy for every tonne. In the industrialized countries put together more than 182 billion dollars are spent on export subsides and the treaties have been signed in such a way that they are permitted to keep these subsides at least till 2003 while we have to remove ours. Do you know that there are farmers in England who are paid about one lakh pounds(about 70 lakh rupees) every year for not growing anything!! Just to keep their land fallow. How on earth can our farmer compete with them in the world market!

The WTO's justifications:

1. The proponents of the WTO agreements argue that it is cheaper for countries like India to buy their wheat and milk and meat from the west, where these products are cheaper. Instead they should concentrate on growing high value crops that the west needs and which could fetch them (the farmers of India) a better price. Since the west has a food surplus there is no danger of our running short of food supplies. Thus we could produce say flowers or vegetables and fruits or oilseeds that do not grow in the colder climate of the north and instead buy the wheat and soya from them.

2. The proponents of WTO also deny that there is any danger of the industrialised nations dumping products on the south. Dumping refers to selling off at throw away prices surplus stocks. In the west the producers are subsidized by the state. Dumping not only helps them to get rid of stocks that would otherwise have to rot in their godowns, it also helps

destroy the third world producers, so that in subsequent years the market can be captured by them. The West claims that there are rules against dumping and the third world country or producer can go to court.

Both these arguments hold no water! Food is not like any other commodity. If we have a shortage of any other commodity and prices go up we can afford to wait, or go without it. If coffee is in short supply, or radios are too costly one can manage. But if food grains are in short supply or costly people and livestock will starve.

Moreover for us to give up self reliance in food grains in favor of reliance upon the international market for our food supplies we need to consider the following:

a) how sure are we that there will always be an exportable surplus in the international market for us to buy.

What happens if there is a shortfall in production in one or more areas of the globe in a particular year.

What happens if there is a sharp rise in prices. After all we know that international grain trade is largely controlled by just a few (about five transnational). Of which just one Cargill controls 60 percent. What if they decide to hike prices!

b) How sure are we that channels of international trade will flow freely, based on the market and not be disrupted by war or other political factors. What about Iraq or Cuba? Do they not face embargoes? The American Medical Association has specifically pointed out that in Cuba the embargoes have had a very adverse impact on child health. Are we immune from this?

c) What are the chances of finding alternate employment for all the lakhs of workers that will be displaced from agriculture because of so called more efficient markets(we saw earlier that this was not efficiency but subsidy).Historically when labour is displaced from agriculture; growing industries absorb them. But the industries are growing in the industrialized nations. Will they be willing to lift all visa restrictions and allow free flow of human labour! Then perhaps a 100 million of our poor can settle in Europe and the USA.

Will they allow that? Even with a few hundred thousands of legal and illegal immigrants they are getting upset. No, the answer is clearly that there are no new livelihoods for most of these displaced populations.

d) What are the chances that even if food imports are permitted we will have the money, especially the foreign exchange needed to pay for these food imports. Given the degree of indebtedness of the nation, given the fact that our imports are far higher than our exports, there is a likelihood that when we need it most the foreign exchange needed will just not be available.

e) Finally what are the chances that the international market would be really a free market operating on the basis of fair competition. We know that a small handful of transnational corporations control it. And governments of the west support them. To give an example, there was an international decision called the Marrakesh Ministerial decision that promised food importing countries financial assistance to ensure adequate food imports in crisis and to improve food productivity. In 1996 cereal prices soared by 40%and food importing countries sought the financial assistance. But the WTO committee on Agriculture, advices by the IMF refused to implement it, saying that the price hike was not due to AOA policies and therefore no assistance was called for. The developing nations could do nothing about it. To think therefore that we can stop dumping is overly optimistic. Indeed it is a falsehood. What is likely that in the near future commodities like dairy products, wheat, meat etc ,where the west has a major surplus will be dumped on us.

The changes consequent to WTO :

- As agri-exports become the main strategy, cultivation of staple foods is replaced by cash crops. Even amongst cash crops export oriented crops get the priority. Thus we have shrimp farms replacing rice farms, we have tomatoes replacing wheat, we have paddy field becoming coconut plantations, we have ragi and millet growing areas becoming paddy growing. And all this happens on more fertile lands.

Diversion of agricultural land to non-agricultural uses also affects fertile lands predominantly.. We thus see that as a result of all this one of the main consequences is the decline in food production, that too in the essentials -cereals and pulses — in the country.

- The second major consequence is the worsening situation in equity. To promote commercial agriculture land ceiling laws are being relaxed. Since commercial cash crop farming is more capital intensive and more risk prone small farmers do badly, whereas corporate farmers and large landowners can do well. Large farmers with access to foreign

markets can make a quick profit and their profits are not taxable! The small farmers tend to get pauperized more and their land holdings get more fragmented . This lowers agricultural productivity for commercial crops even further.

- The third major consequence is a decline in food security in farming families and in rural communities.

Production for consumption is one of the most important forms of food security in a predominantly agrarian country. Earlier farmers would grow a number of coarse grains and other crops that suited the local climate and which needed little external inputs. Much of this would go for their own consumption. When this is replaced by commercial cash crops the food security of the family and the local communities evaporates. They now have to buy their food in the market and due to the way the market works, what they buy is always far costlier then the price they get for their produce. When in addition the public distribution system is non existent or being wound down the poor are left with no food security at all!

Biodiversity, biotechnologies and patents:

Even more worrying development is the increasing controls over agriculture that the developed world will have following changes in patenting regimes. Traditionally the natural plant varieties from which all food crops have been evolved are mostly in the tropics. These natural plant varieties are needed even today to bring new genetic vigour to food crops as crop varieties tend to lose resistance over repeated cultivation.

Moreover it is now recognized that the innumerable plant and animal varieties of the tropics are essential for the creation of many new drugs and food products and materials. Now as the natural habitats of these life forms get destroyed the industrialized nations try to preserve these forms in what are called gene banks.

Side by side with this these companies are developing new seed varieties that are more productive but which cannot be replicated by the farmer himself as they have been used to doing. Farmers will have to come to the companies to buy seeds for the next crop. Since the gene banks are in the hands of the corporate and rich countries we automatically have to depend on them for seeds! This is yet another route to undermining our food security.

And just in case we get smart and start developing our gene banks and our own seed lines and our own new organic products, the patent laws are altered. Now the right to produce the seed of his choice is not to be left open to all, or even to a free market. No. Only those who hold a patent can produce it. There have been attempts to patent neem. To patent turmeric, to patent basmati so that they can monopolise it. Of course these are so obviously unfair that we have been able to fight the patents even if we had to go to the US and other foreign courts to do so. But the real danger is what lies ahead. As genes surreptitiously taken from here or otherwise are the basis of new seeds, then we will not be able to replicate them or anything based on them even if their natural parents were ours in the first place!

The other danger of this patent regime, is that a few companies can develop a monopoly of knowledge and a monopoly in the generation of knowledge. The entire area of agricultural research and development comes under corporate control. Research will no longer be decided by what farmers need but what can bring maximum profits to agri buisness. This means research on crops like millets or pulses will be less in priority as compared to high value commercial crops. Second, is its impact on the choice of technologies.

Seed varieties that can farmers can easily replicate will lose to terminator gene technologies. Seed varieties that need less chemicals do not become a priority as the pesticide companies and seed manufacturers are the same. The latest danger is from genetically modified crops which are being carelessly introduced without adequate studies on their safety.

Such corporate control of agricultural technology and research is one of the most serious threats to our food security.

Why does the WTO demand such obligations:

If the case against such regulations is so obvious we need to know why they are being imposed on us and why the Indian government has agreed. The reasons are simple.

- There is a tremendous surplus in the western industrialized nations in their main agricultural products wheat, milk products and meat. The huge corporates that control trade need to find fresh markets for this produce.
- Secondly the pattern of consumption in the industrialized countries is such that it needs a large number of products from tropical countries

to maintain their standard of living. Sugar, coffee, tea, cocoa, fruit juices, vegetables and fresh fruits, vegetables, nuts, tobacco, flowers - to name just a few. Moreover as awareness of health and environment increases so does the recognition that synthetic alternatives are no substitute, and are dangerous as compared to their tropical natural equivalents. Thus cotton fabrics or vegetable dyes, fruit juices and natural colours are all back in demand. It suits them to have the Tropical countries produce their requirements while their surplus is exported to us. Now the Tropics can produce almost all the food stuffs and organic material it needs, but the Temperate Zone cannot.

Yet the industrialised nations must work out a system by which our markets are opened to their surplus and our production shifted to their needs. In an equitable world perhaps one could have agreed. But in this world our food security is possible only if we are self reliant in our food production. Also the terms of trade are such that the value of commodities exported by the developing nations continue to be very low while what we import is progressively higher. So to meet our imports payments we have to export more and more goods for less and less. This will not lead to development. It will only deplete the soil and natural resources of the nation. One has only to study the situation in Sub Saharan Africa to understand the truth of this statement. These structural adjustment policies were started in Africa as far back as 1985.After 15 years we can see the state they are in. It should lead us to realise the fate that awaits us down this lane.

Also let us remember it was this need for Indian spices and Indian cotton and other Indian goods that brought the west to our shores. It started as trade but ended in our colonisation and enslavement. Under colonialism our markets were kept open to their manufactured goods but our exports of such goods were kept in check. The colonisers were able to extract raw materials at the cheapest terms and change our agricultural cropping patterns to suit their needs. The indigo plantations are one of the best known examples of this. Such a situation did not lead to our growth. It led to such misery and famines and such huge epidemics that millions of Indians died. Today , though it is covered up by a lot of pretty phrases, the present policies represent a return to market relationships similar to that we faced under colonial rule. That is why we call this neo-colonialism. The danger to our sovereignty and to the lives and health of the people are the same as it was under colonial rule.

A second freedom movement:

In such a context what do we do. By we, one means the peoples movements and organizations that represent the poor and weaker sections of society as well as all groups who hold the interests of the poor as their agenda. We also mean the local communities and local organizations who try to organize for resistance or to cope with the increasing hardships they are facing.

- One immediate agenda is of course to let people understand the causes that lie behind the increasing hardships they are facing. About why agriculture is so non-remunerative and why the farmers are getting pauperized and why hunger and malnutrition is so widespread. And of the threat to food security.
- Another immediate agenda is to build up public opinion for strengthening the public distribution system and increasing its outreach. The PDS should include at least 14 essential commodities with at least 30 kgs of food grain allocation per card per month. Targetting does not help the poor. It is more useful to have comprehensive coverage with decentralization of administration and community participation to ensure that the services are effective. Equally important is to strengthen the ICDS programme and base it on locally produced and processed food.(the current move to introduce corn soya mix -possibly of a genetically modified variety needs to be reversed).
- Another peoples initiative that is possible and has been tried successfully is to set up systems of grain banks from the micro to the national level as a basis of local food security and a community based distribution system.
- Yet another area for people's initiatives is the creation of agricultural cooperatives and group farming and collective wasteland reclamation programmes, that strengthen the organizations of poor farmers, help them cope with the present crisis in agriculture and provides for their food security.
- Build up public opinion for policy changes. This includes a) ban on food exports and use of existing burgeoning stocks for food for work programmes that create public infrastructure. b) Reimposition of quantitative restrictions in all areas where the livelihoods of millions of workers are threatened. c) Contesting the unfair patent laws and

policies on biodiversity and biotechnologies that dominate the international research and development scene.

- But most important is bringir g back food security as the central concern of the planning process.

Annexure

1. The Alma Ata declaration

The International Conference on Primary Health Care meeting in Alma-Ata this twelfth day of September in the year nineteen hundred and seventy eight, expressing the need for urgent action by all governments all health and development workers and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration.

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

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

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

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

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

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

VI. Primary health care is essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms as integral part, both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII. Primary health care:

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

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

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

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

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

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

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

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

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

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

The International Conference of Primary Health Care calls for urgent and international action to develop and implement primary health

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

Book Titles in this Series:

1. What Globalization Means for Peoples Health!

-Understanding what globalization is all about and how it affects the health of the poor.

2. Whatever happened to Health for All by 2000 A.D?

-an understanding of the making and unmaking of the Alma Ata declaration.

3. Making Life Worth Living!

-Meeting the basic needs of all-Inter-sectoral issues in health care

4. A World Where WE Matter!

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-A brief introduction to the ethical and professional dimensions and quality of care implications of the growing thrust to privatize all health care services.

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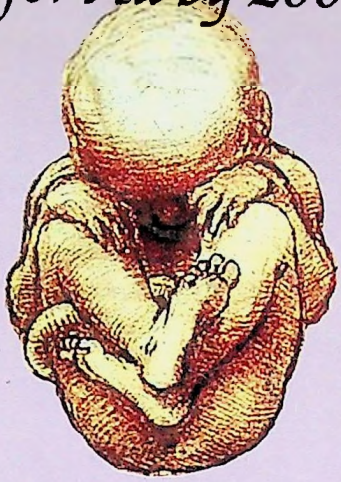
Whatever Happened to Health for All by 2000 AD?



Towards the People's Health Assembly Book 2

126. 15 figures

Whatever Happened to Health for All by 2000?

Prepared and Published by

The National Coordination Committee

for the

Jan Swasthya Sabha

Towards the People's Health Assembly Book–2

Whatever Happened to Health for All by 2000 AD ?
First Edition: 1st May 2000

Authored and Published by:
National Coordination Committee, Jan Swasthya Sabha

National Coordination Committee Members:

- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- Bharat Gyan Vigyan Samithi (BGVS)
- Catholic Health Association of India (CHAI)
- Christian Medical Association of India (CMAI)
- Forum for Creche & Child Care Services (FORCES)
- Federation of Medical Representatives Association of India (FMRAI)
- Medico Friends Circle (MFC)
- National Alliance of People's Movements (NAPM)
- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Society for Community Health Awareness, Research and Action (SOCHARA)

Participating Organizations:
Over 1000 organizations concerned with health care and health policy from both within and outside the above networks have joined the Jan Swasthya Sabha campaign as participating organizations.

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Contents

About the Jan Swasthya Sabha

Governments & international agencies have forgotten the goal of **Health for All by 2000 A.D.** But we, the people, cannot forget it. It is time to strengthen & expand people centered initiatives - to find innovative solutions & to put pressure on decision makers, governments and the private sector.

There is a need to reiterate that attaining **Health for All** means ensuring everyone has access to affordable quality medicare, safe drinking water and sanitation, adequate nutrition, clothing, shelter and employment and no one is discriminated against on the basis of class, caste, race or gender. People need to be made aware of the links between globalization and the worsening health of the people. When structural adjustment policies work to undermine the vision of Alma Ata, renewing the Health for All call is an imperative.

With this understanding a large number of people's movements across the country have jointly initiated a national campaign called the Jan Swasthya Sabha. This has three broad objectives:

- To re-establish health and equitable development as top priorities in policy making with primary health care as the strategy.
- To forge a local, national and global unity of all democratic forces to work towards building long term sustainable solutions to health.
- Reinforce the principle of health as a broad inter-sectoral issue

The campaign has a four-tier structure. 2000-3000 blocks in 200-300 districts mobilize people on **Health For ALL – Now!** and conduct block level enquiries into the state of health services. These enquiries culminate in block seminars highlighting the findings & helping formulate people's initiatives for primary health care. Then, each district has a district level mobilization culminating in a District Seminar. All this builds up to the Jan Swasthya Sabha to be held in Calcutta from Nov 30th – Dec 1st 2000. Four trains with representatives from various parts of the country will arrive at the National Assembly. The Jan Swathya Sabha – with over 2000 representatives – will call for a reversal of structural adjustment policies and a renewal of the *Health for All* pledge. The assembly will also send its representatives to the international People's Health Assembly being held at Dhaka from Dec 4th-8th, 2000 where similar representatives from other countries will gather. Following the Jan Swasthya Sabha, each interested block or district follows up with health intervention and advocacy.

The Jan Swasthya Sabha is being coordinated by a National Coordination Committee consisting of 15 major all India networks of peoples movements and NGOs. This book is the second book in a 5 book series brought out by the NCC for guiding the block, district and state seminars.

Chapter I

nderstanding Primary Health Care

ealth is a state of complete physical
ıental and social well being and not
ıerely the absence of disease.
- Alma Ata Declaration, 1978

at causes ill-health?

1. Malnutrition is the most important cause of ill-health!

The major cause of malnutrition is Hunger.

Hunger is the result of poverty.
(Lack of food is not the problem – the ability to buy it is !)

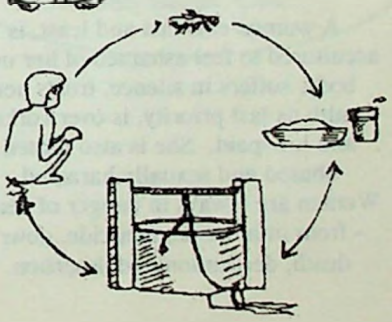
Malnutrition leads to
frequent infections

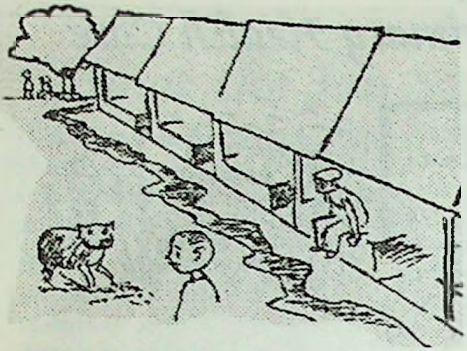
Frequent infections
leads to Malnutrition

2. Unsafe drinking water & ınitation is another important cause

Most infectious diseases spread through water.

Water gets infected due to poor sanitation.





3. Poor living conditions and ecological changes affect health

Overcrowded homes, damp leaky poorly built houses, smoky environs increase TB and respiratory infection.

Migration & Squatter settlements are major sites of disease.

Poorly designed development projects with water logging spreads malaria.

4. Poor Working Conditions!

Hey! I work 12 hrs a day and at the end, am more dead than alive!

Exhaustion due to long hours of work, continuous exposure to dust and dangerous chemicals, unprotected machinery and crowded & ill-ventilated workplace is a major cause of ill-health.

5. Patriarchy is a cause for ill health!

And don't forget me – I am half of humanity. I do two thirds of its work and earn one tenth of its income.

A woman eats last and least, is accultured to feel ashamed of her own body, suffers in silence, treats her health as last priority, is overworked and low-paid. She is also beaten, abused and sexually harassed. Women are always in danger of death – from infanticide, foeticide, dowry death, destitution and desertion.

Stress is also a cause of ill health

ess results from an individual's inability cope physically and mentally with social personal adverse conditions. The eakdown of collective institutions, mployment; lack of leisure, lack of urity, consumerist culture and high mpetitiveness is leading to an increase in ss related diseases and suicides.

Lack of access to good health services is a problem.

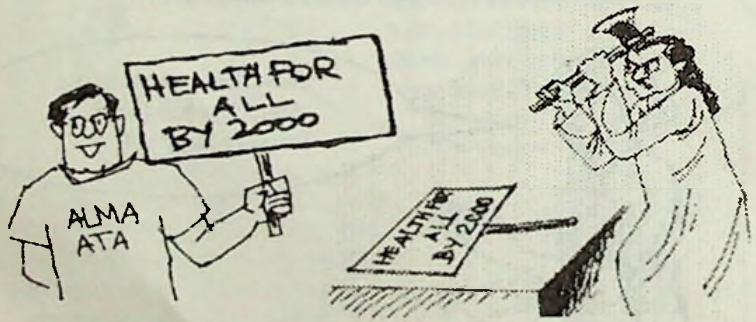
True. Doctors and Health Services are important. But ill health has many causes and cannot be just ascribed to a lack of doctors and medicines.

was this broad understanding of health that guided the Alma Ata Declaration in 1978 on Primary Health Care.

Now, let's see what the Alma Ata has to say on Primary Health. Care...

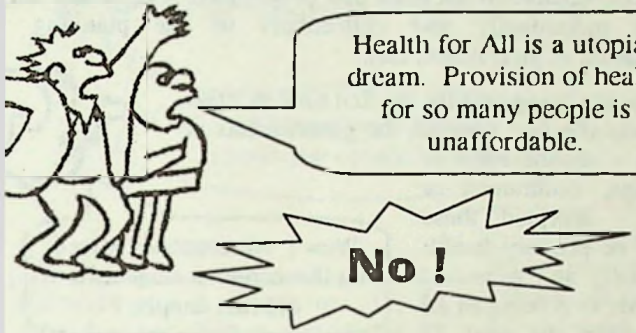
The Alma Ata Declaration...

Primary health care is essential health care... based on methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part, both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

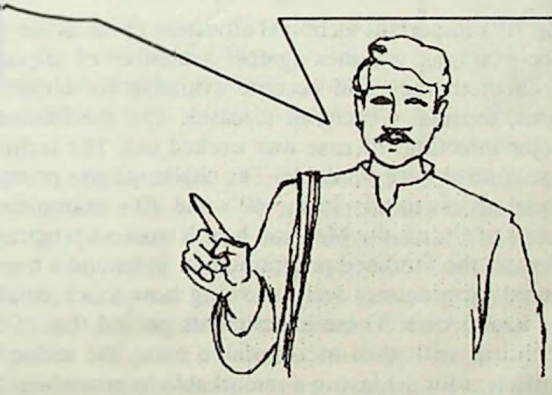


1978 **2000**

ealth for All was meant the provision of primary health care for one, irrespective of the ability to pay for it. The declaration er clarified... **Primary health care included in the least health ation, promotion of food supply and proper nutrition, an uate supply of safe water and basic sanitation, maternal and health care, including family planning, immunization st the major infectious diseases, prevention and control of y endemic diseases, appropriate treatment of common ses and provision of essential drugs.**



95% of all the useful remedies that science and human experience has discovered, whether in curing or prevention, can be provided at a cost that even the poorest countries can afford for their entire population. **Health for All was not a pipe-dream in 1978 and is not so now in 2000.** Primary health care for all was clearly achievable aim if only governments and people could have generated the political will for it.

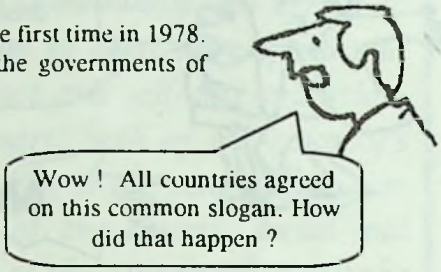


Chapter II

The evolution of the Alma Ata Declaration

The Alma Ata declaration did not just accept that Health for All is something that can be achieved. It also accepted that Health is a fundamental human right. It accepted that the gross inequality in health status is unacceptable. It declared that people have a right and duty to participate individually and collectively in the planning and implementation of their health care.

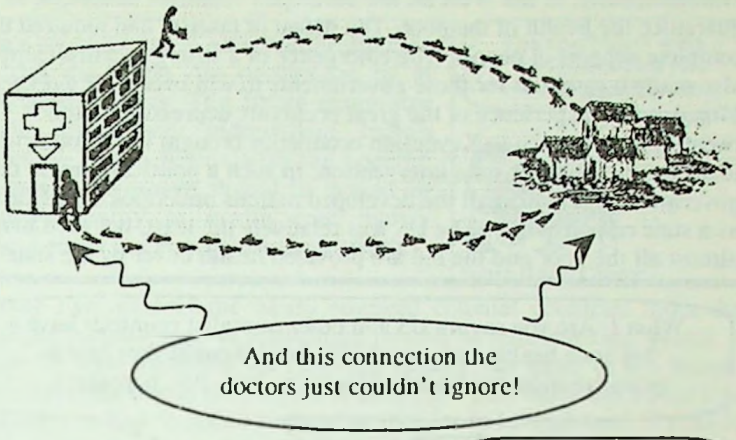
All this was not being said for the first time in 1978. But this was the first time all the governments of the world – democracies or dictatorships, communist or capitalist - accepted these principles of primary health care officially and promised to bring this into being in all nations within the next 22 years.



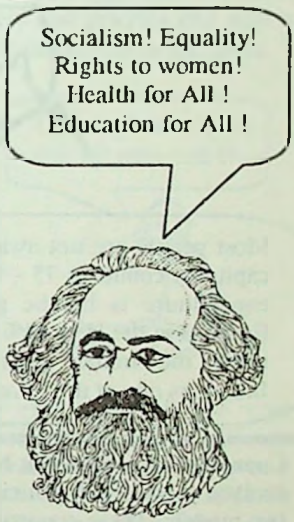
There are four major reasons why Alma Ata happened. One reason is in medical science the other three are in politics.

Medical science realized that poverty & related social conditions like poor sanitation was the major cause of ill-health. Studies showed that irrespective of medical interventions health status improved remarkably when the basic requisites of good health became available.

In the 50's to the 70's important technical advances in medicine were being made - for example, vaccines against a number of important diseases. Good chemotherapy had become available for almost all infectious diseases, especially bacterial diseases. The mechanism of spread of all major infectious disease was worked out. The technical means for disease control were available. The challenge was primarily a question of equal access to all. In the 60's and 70's examples like the barefoot doctors of China, the Mexican health workers programme under David Werner, the Jamkhed programme in India and a number of mission inspired programmes were showing how much could be done in primary health care. These experiments proved that if there was adequate political will, then at affordable costs, the technology available was sufficient for achieving a remarkable improvement!



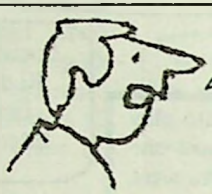
One political factor that came into play was the rise of socialism in almost one third of the world. These countries were committed to state funded healthcare for all. This was an old demand of left parties dating back to the French revolution when the more radical section - the Jacobeans - raised this demand. So deep was this commitment that the first intervention after a socialist change was in most countries providing state supported health care. Also by giving rights to women, education to all, by actively addressing poverty, dramatic improvements were shown in the health status.

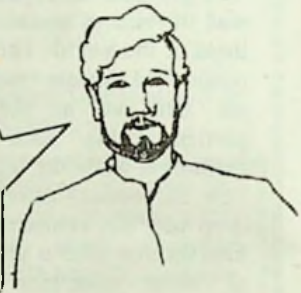


There are many differing views about the achievements of socialist countries. But even the worst detractors had to accept that in health status they marked tremendous improvements. After what a poor country like Cuba, completely isolated from trade or Vietnam, totally racked by war or, China with almost no health infrastructure at the time of liberation could show, it was obvious to the world, that indeed health for all was an achievable goal.

Simultaneously, in the West all the developed countries undertook to guarantee the health of the poor. The defeat of fascism had required the complete support of people. The emergence of a strong socialist camp also made it essential for these governments to win over their workers. Moreover the experience of the great economic depression in the twenties and the turn to Keynesian economics brought these countries to accept the need for state intervention. In such a political context the governments of almost all the developed nations undertook healthcare as a state responsibility. The US was relatively the least, but even here almost all the poor and the old are provided health cover by the state.

What ! Are you saying US and other capitalist countries have a big state health care system ??? But I thought they love to privatize industry, health, education, love, life, happiness...





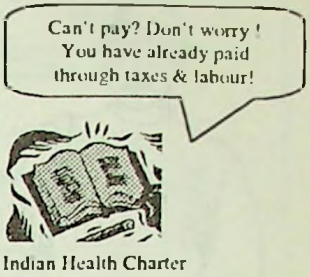
Most people are not aware - but in these capitalist countries 75 - 90% of all health expenditure is by the govt. The lowest figure is in the US - 44%. But even this is twice the Indian figure - only 22%. India's is one of the lowest in the world.

Countries like India that had recently thrown off the colonial yoke evolved their health policies in the 50's and 60's inspired by these two models. These countries, most of which came into being due to anti-colonial movements where millions participated, also promised their people complete health coverage.

It was this coming together of various factors which gave the context for the Alma Ata Declaration. Whether it was welfarist, socialist or a post colonial nation, there was a commitment to state supported universal health car. **It was only under such a situation that the WHO could propose the Health for all by 2000AD declaration and all governments of the world could accept it.**

Alma Ata and the National Health Policy of 1983!

India's commitment to universal health care precedes the Alma Ata declaration by at least three decades. The Bhore committee report, which was independent India's charter on health begins with the opening statement - no citizen should be denied an adequate quality of health care merely because of his or her inability to pay for it.

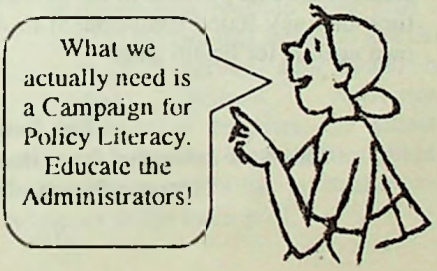


Indian Health Charter

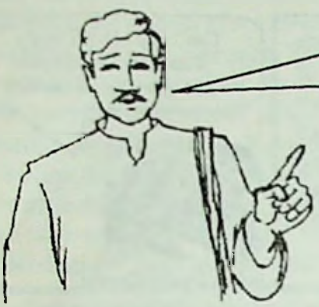
However like most of the newly emerged colonial countries India did not follow the socialist path in eradicating poverty or redistributing wealth. In the absence of such measures the resulting system was more in the nature of a welfare measure like in the West. But unlike the west India was a poor country, and further it had to spend to develop its own industrial base. So the health delivery system that developed had a relatively low priority and was totally inadequate for the needs. Also it remained concentrated in urban areas.

The Alma Ata commitment did lead to some renewed attempts at achieving these goals. Soon after this, the Indian government passed in Parliament a national health policy in 1983. In this policy all the process elements of primary health care as understood at Alma Ata was highlighted. The National Health Policy went further to talk of large scale of transfer of knowledge and skills to health volunteers. It talked of a nationwide chain of sanitary cum epidemiological stations. It also talked of decentralization in health care and a referral system. It talked of inter- sectoral cooperation and even a better utilization of traditional Indian medicine. It even explicitly promised to phase out private practice by medicos in government.

Unfortunately, even the senior health administrators did not read the health policy. World over the Alma Ata declaration was gradually marginalized and forgotten.



Why was the Alma Ata declaration scuttled?



The main reason was the change in the economic and political climate all over the world in the 80's – for the worse.

Under the leadership of Reagan in the US and Thatcher in the UK the welfare state came under attack. The reason for this attack on welfarism was the economic problem in these countries. This forced the ruling sections of these countries to reduce expense on welfare in their countries. Of the welfare expenses the burgeoning costs of health care provision was the largest and therefore there was pressure to cutback on this. The transnational companies were also keen to enter the third world markets and health care was a major area in which they could enter and make super-profits.

Meanwhile, the Soviet Union and the socialist bloc had fallen. The example of state supported health care was no longer in focus. Also with that the third world's ability to bargain and resist pressures of the west was severely curtailed.

The World Bank & the IMF now became the main institutions through which the US and the West operated to secure their interests. Unlike the WHO and the UN, these are not political forums of world nations. They are US dominated bureaucracies. The World Bank's pressures were to cut back public funding for health & shift as much curative care as possible to the private sector. The World Bank at no time had any stated commitment to Alma Ata declaration. It had its own agenda for health care.

The Result
The state retreated from its commitment to provide comprehensive health care!

The Story in India

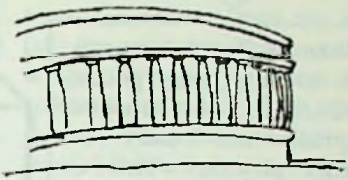
1946-1983

Wision of the Bhore Committee report. Maintaining, reiterating this through other committees.

Sshhh... Committee at work!!

1984

The National Health Policy



1990

What 'Health for All' ? Don't waste our time talking about all this nonsense!

The guiding vision since independence is no longer even a statement of intent.

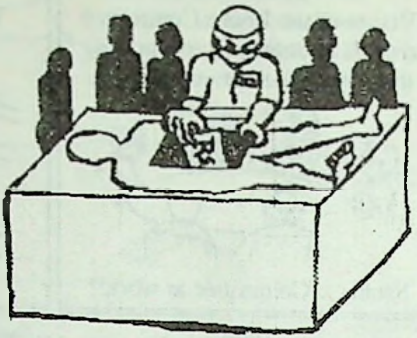
The WB document of 1993 - "Investing in Health" set the new agenda and this becomes the new Indian Health Policy. This new policy calls for focussing on a small set of public interventions that technocrats feel can show the maximum improvement in indices for the minimum expense. For the rest, the private sector should provide the answer.

Not enough ! We need more profits. **Set up the WTO !**

The discussions leading to the WTO tries to abandon even this already compromised position. The goal is now to declare that health is just like any other service and should be traded without restriction. Privatization becomes the answer and government documents actually start talking of increasing the profitability of health and related industries as the main goal.

Other
Changes

Delicensed Pharmaceuticals and soaring drug prices. Proliferation of Corporate hospitals and entry of foreign players. This is encouraged to attract foreign exchange!

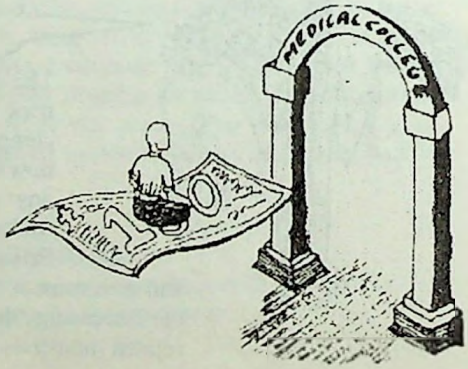


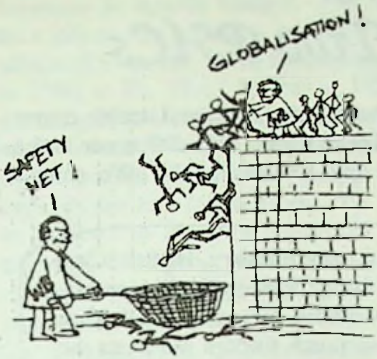
Don't forget why the Alma Ata declaration was scuttled!

Primarily it is a retreat from the goals of health & drug policies as part of an overall social policy - a direct consequence of Globalization and the Structural Adjustment Programme

One way in which this retreat manifests, is the decline in budgetary allocations. But another even more dangerous consequence is the shift in values away from seeing health as a fundamental right guaranteed by the state.

Whereas earlier the fundamental purpose of government intervention was to reduce inequality in health status and provide access to all especially the poorest, now a new set of values is emerging where profitability of the health industry and the medical professional is the central concern. Illustrative of this is the sudden increase in





private medical colleges where fees of about 30 lakh rupees per seat is being charged!

The World Bank is pushing the idea of health care as a safety net. By this they mean that the economic reforms they are forcing on the country will cause an increase in poverty and therefore in sickness and death. Such setbacks can jeopardize the economic reform itself. Their solution is to invest in health such that by careful planning they can with the least possible expenditure keep the poor from dying and spoiling the reforms. This safety net approach to health care means that a state supported intervention is essential but this must be limited to a very select role. This revolting idea is now fast replacing the earlier notion that Health is

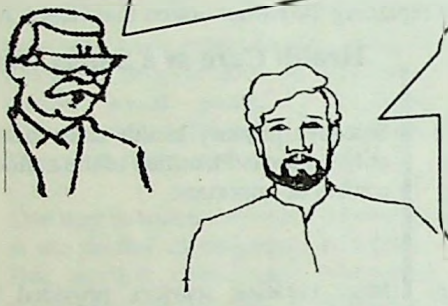
Health Care is a Fundamental Right	Health Care as a Safety Net
Comprehensive health care 'addresses the main problems in the community, providing promotive, preventive, curative and rehabilitative services.'	Selective primary health care: tackles only six areas identified at the national centers as important.
National Health System bringing health care close to the people.	Most curative services provided by private sector. (And they prefer towns!)
Emphasis on process: Intersectoral linkages, equality, basic needs & participation.	Emphasis on elimination of disease by targeted technological means. Efficiency measured in terms of number of deaths averted at unit cost.
People have a right & duty to take part in planning & implementing health care.	State will decide which diseases can be tackled at least cost and focus only on these (to keep expenses limited)
The aim of health care is to find the best way to ensure a good quality of life.	Aim of state's health care is to find the least cost approach to ensure survival. Quality of life does not matter.
Motivation – a genuine concern for people's health.	Motivation – fear that too many deaths will question the basis of profit-driven structural adjustment programmes.

Chapter III

The Tale of Two PHCs

There is a vast difference between the existing primary health center network and the concept of Primary Health Care. This difference is the reason for the Jan Swasthya Sabha and for this book. We should understand this difference clearly.

What is all this about forgetting our Primary Health Care commitment? We have opened so many primary health centers. We have deployed so many health workers, increased health care budgets year after year. There is so much foreign aid from the World Bank. There is a large decline in infant mortality, in maternal mortality and gains in fertility control. And you say we have scuttled the Alma Ata promises! Are you mad?



No doubt the Alma Ata call was useful and some gains have been made. But the question is – is it adequate and does it conform to the promise? Let's see each claim closely.

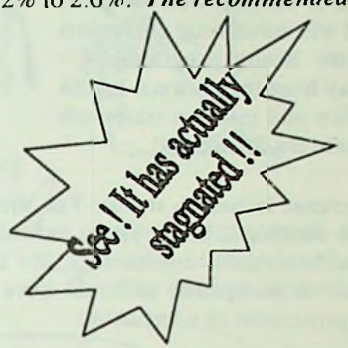
Yes, there has indeed been a tremendous expansion of the PHC network - thanks to Alma Ata.

	Sub Center	PHC
1980	47,112	5484
1998	1,36,818	22,991
	It's Trebled.	1985-90 PHCs Doubled. Little further increase.

So the claim about the PHC network was correct. What about the Health Budget? Has it also increased as claimed?

Increase in health budget: OK. Health budgets have increased, but let's adjust for inflation and see what percent of the total budget is allocated to health. Total health expense **went up** from Rs. 11.89 billion in 1980 to Rs. 78.67 billion in 1994-95. But as a percent of the total govt. expenditure it **went down** from 3.2% to 2.6%. ***The recommended minimum is 5%***. The annual per capita growth rate of state health expenditure has fallen from 15% in 1980-81 to 7% with the fall in disease control programmes and in capital expenditure being much sharper than in other components.

Ref: Duggal, et al 'CEHAT database special statistics: Health expenditure across states-Part I', EPW.



Let's look at some data now!

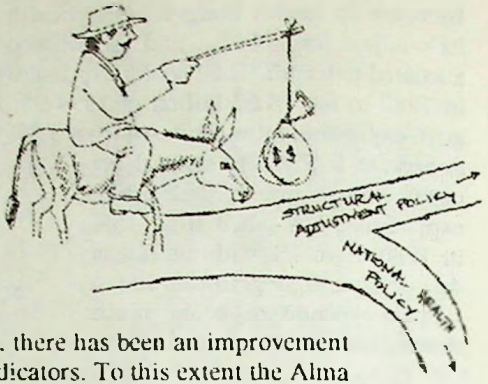
Health Infrastructure and Manpower - Coverage and Gaps

	Popn. covered	No. existing & in position	No. needed for 100% coverage (for 2002 popn)	% vacant or uncovered
Sub center	5000	136818	23190	14.91%
PHC	30,000	22991	4212	16.25%
CHC	100000	2712	3776	58.28%
ANM	5000	133567	27501	5.12%
MPWM	5000	72869	64860	16.39%
LHV	30000	19364	4224	13.76%
Doctor	30000	24648	1531	-15.11%

No. of ANMs, MPWM, LHV needed figures include both vacancies in current requirements & posts to be created. The uncovered areas for Sub center, PHC and CHC relate to infrastructure that needs to be created for meeting 2002 requirement. For all three institutions the shortfall is not even within states. HP, JK, Kar., Kerala, Orissa, Raj., Sikkim, TN & all union territories except Delhi have adequate or excess to requirement. At the other end Bihar & UP together account for 1649 PHCs shortfall, which is 39% of the entire shortfall. AP, MP & WB account for 12% each and Assam & Mah. for another 6% each. Tripura's 75 PHCs shortfall is 56.39% of its requirement - the poorest performance for any state. Bihar' s shortfall is about 30% and the other states have shortfalls of 25% or much less. Thus UP needs 774 PHCs which is only 17% of its requirement.

Source: Bulletin of Rural Health Statistics in India: June 1998, Rural health division. DGHS, MOHFW, GOI

Foreign aid: It has come in but is only 9% of the total govt. expenditure on health. Despite that, this aid has been used to bargain with the govt. and win substantial alterations in the health programmes – away from the national health policy and more in tune with World Bank dictates!

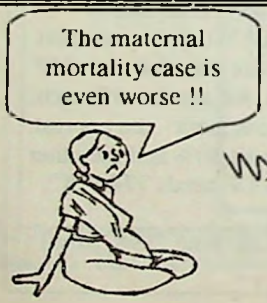


Increase in health status: Yes, there has been an improvement in a number of health status indicators. To this extent the Alma Ata declaration was useful. But these achievements are far, less than what is acceptable or could have been achieved. Let's examine this improvement in some detail.

There has been a definite decline in infant mortality & under 5 mortality. But our infant mortality is still very high - higher than many comparable countries. We have not reached even the modest target we set ourselves in mid-80's.

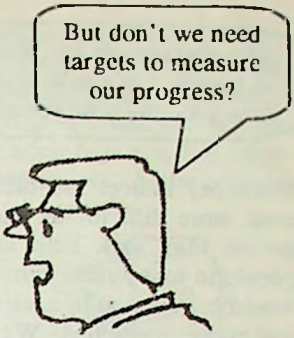
Under 5 mortality fell from 236 in 1960 to 105 in 1998. But this only takes India to the 49th rank (from the bottom) amongst 189 countries. Only some of the poorest African and Asian countries are below this level. Compare India's 105 figure with Sri Lanka's 18, Malaysia's 10, China's 47, Vietnam's 42 or Mexico's 34! Even poorer African & Asian countries like Namibia or Guyana, have figures of 74 & 79 respectively.

The Indian government had set itself a target of 70 as part of the national health policy and even this was not achieved. The current figure implies a total of 25,90,000 child deaths per year, most of which are preventable.
Source: State of the World's Children-UNICEF, 2000. Figures for 1998



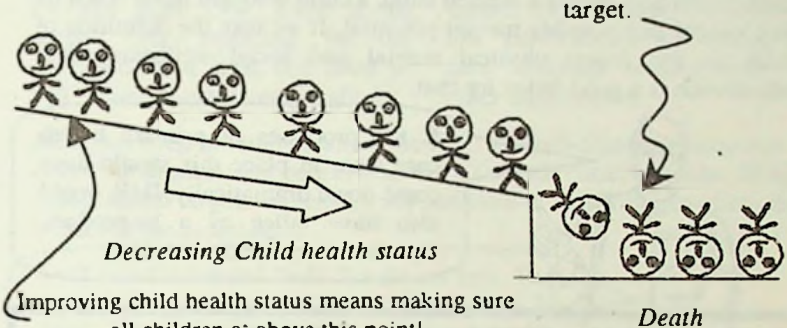
The government maternal mortality target of 200 per 100,000 is itself impermissibly high. At 1976 the maternal mortality stood at 450 per 100000. At present it is 410 - only a marginal decline. In contrast almost all developed countries have a maternal mortality of less than 25 per 100,000. *(Source: same as above)*

Why are we limiting ourselves to the government's targets? Primary health care is not about achieving targets – it is about establishing a set of processes.



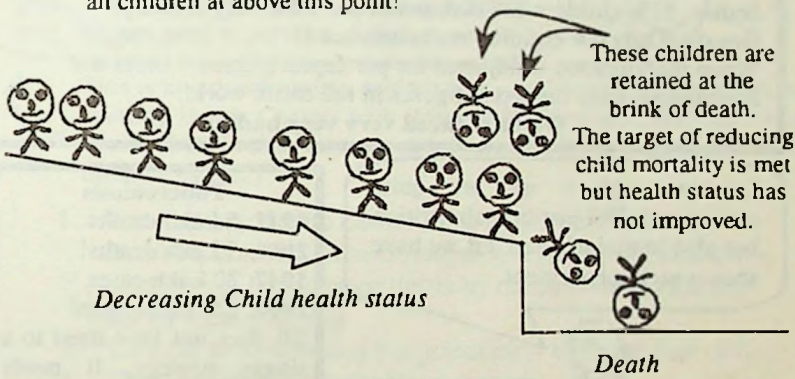
No! We need indices to measure outcomes, not targets to direct our work. And there is a difference – if these indices become 'targets' then there is a false feeling of improvement.

Child mortality as an index of child health is fine until you make it a target.



Improving child health status means making sure all children ai above this point!

These children are retained at the brink of death. The target of reducing child mortality is met but health status has not improved.



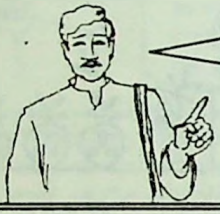
Moral

An index is an index only when it is not a target.
Using the index as target gives a false picture.

The government has used IMR and MMR as targets. Let's look at other indices to see how good the achievements really are.

Morbidity indices are difficult to collect and even more difficult to interpret. An educated person may seek help for measles whereas people in many rural cultures may not. In one culture white discharge would be reported in a survey as a sickness, but in another culture may just not be mentioned. We need some other index of health.

Malnutrition levels in children are a good index of health. It is easily measured. One just needs to take the weight of the child. Malnutrition occurs due to lack of food. But it also occurs due repeated sickness. Malnutrition also means a stunted child, a child who will never reach its full physical and possibly mental potential. If we take the definition of health as the fullest physical mental and social wellbeing, then malnutrition is a good index for that.



If the processes of primary health care were in place this should have come down dramatically. IMR would also have fallen as a by-product. How have we actually fared?

India: 53% children are malnourished. 22% very severely.
Brazil: Only 6% children malnourished !!
When malnutrition is adjusted for per capita income – India and Bangladesh have the worst figures in the entire world!
We have fared very very badly!!

Let me add – we are quite consistent! Not just in malnutrition but also in malaria and TB we have shown no improvement.

Tuberculosis
1947: 5 Lakh deaths
2000: 5 Lakh deaths!
1947: 20 Lakh cases.
2000: 120 Lakh cases!
TB does not lend itself to a single strategy. It needs comprehensive health care. But that was just not available.

In malaria we had 700 lakh cases annually and a single intervention - DDT spraying was to bring about a dramatic decrease to less than a lakh cases per year by the mid sixties. But this gain was fragile and soon it shot up to 70 lakh cases from which by early nineties it had stabilized at 20 lakh cases per year. However during the nineties it is rising again and the current malaria strain is resistant to treatment. Malaria again needs comprehensive primary health care for its control.

With all this infrastructure, why is the health status so poor? Are PHCs are not supplied with enough drugs? Don't the nurses and doctors do their jobs?

This only true to some extent!

In most states the vacancy accounts for less than 15%. Even if we accept over reporting by the government, at least one third of PHCs must be adequately staffed.

Drugs supply is inadequate & erratic. This explains TB but not low performance in antenatal care, diarrhea management & other dimensions.

Moreover even in villages where the PHC and sub-center is functional only a small percent of people resort to it for their curative needs. Many public health targets are usually not met even in such villages where the infrastructure is adequate

I tell you it's not our fault. We do our best. The people are ignorant and don't know what is good. There already is enough primary health care. We just need to persuade people to use it.

This is a very convenient explanation – and equates the network of Primary Health Centers with Primary Health Care. But there is a world of difference between these two PHCs! Let's see what the differences are...

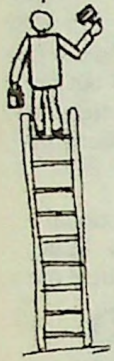
1. The Primary Health Center aims to deliver *Selective Health Care*, NOT *Comprehensive Primary Health Care.*
2. Selection of health priorities is by distant bureaucracies not by local planning.
3. There is no community participation – in fact a fear of it.
4. There are no effective referral systems.
5. The focus is on fragmented health sector inputs – not an integrated inter-sectoral approach. The focus is on *targets* as different from *processes.*

The above differences are very important. The difference between the two PHCs is the difference between health and sickness. So let's understand each of the 5 differences in more detail...

The First Difference

Selective ~~Comprehensive~~ Health Care

- ~~Alma Ata~~
- World Bank

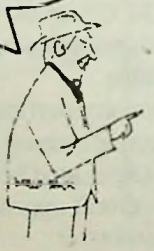


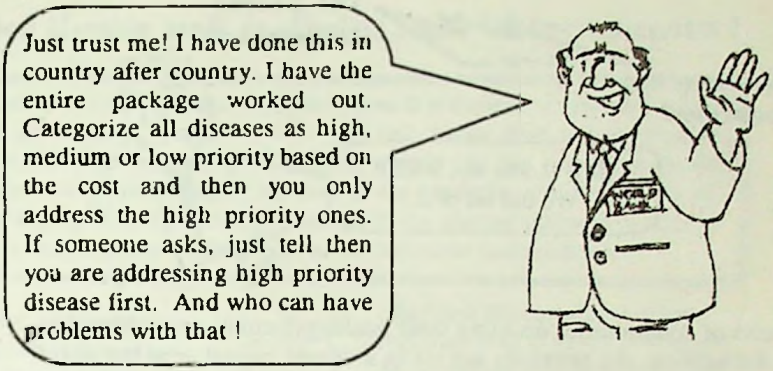
Yes! Yes! That's right! Change that and that. Those Alma Ata fellows were fools. There is just no money to provide everything to everyone.

Even before the ink dried on the signatures to the Alma Ata Declaration the World Bank helped by institutions of the rich like the Rockefeller institute, got into action. By 1985 they managed to push selective primary health care instead of comprehensive primary health care.

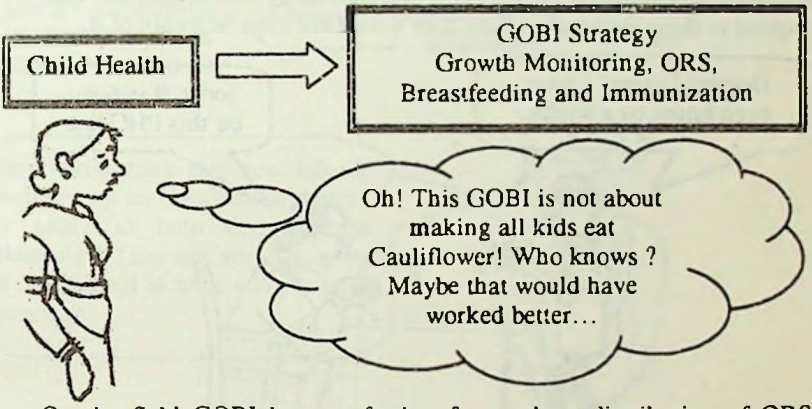
We can't do everything. So we focus only on cost-effective interventions. The important thing is that you keep your expense low.

Hey! But we also need to show progress in health indicators!

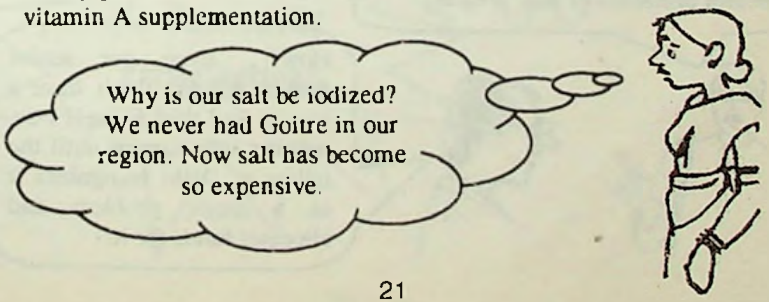


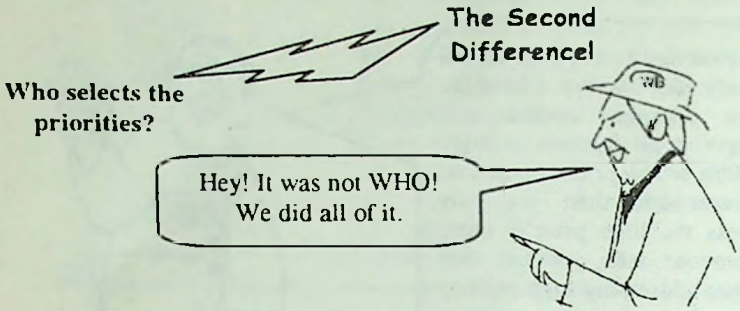


And then they decided that India's priority in health was Family Planning, Women and Child Care, Nutrition, TB and sexually transmitted diseases. Next within this they decided to focus further:

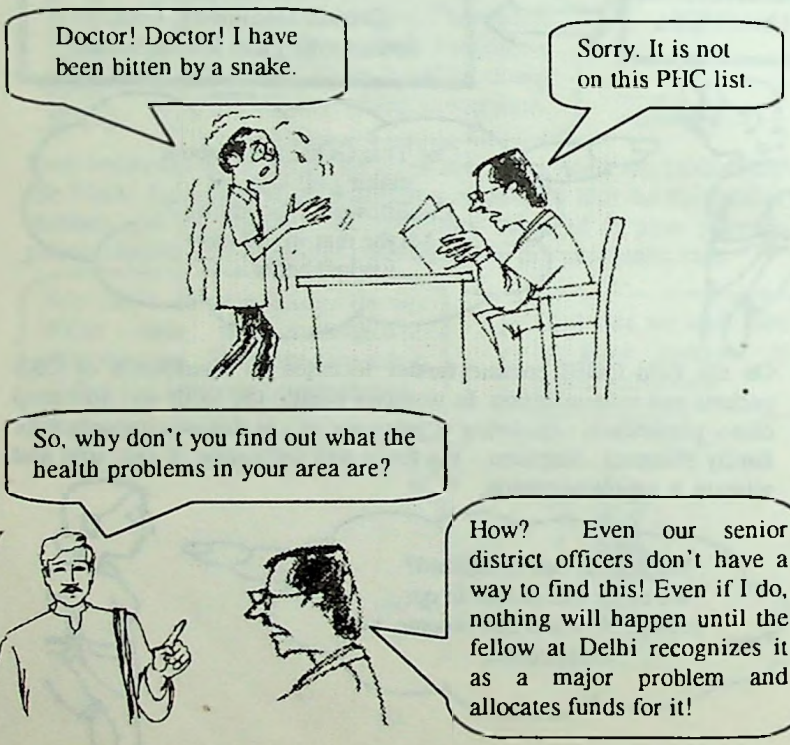


On the field GOBI became further focussed on distribution of ORS packets and immunization. In women's health, the focus was antenatal care – particularly registering of pregnancies - as this was important for family planning. Nutrition - the focus was iodination of salt, iron and vitamin A supplementation.





Instead of communities deciding their health priorities, as envisaged in the declaration, the priorities are set in a distant capital or at the world bank and just thrust on the entire population. So it is not just selective health care. It is selection of health priorities by a distant medical bureaucracy – not even by local health officials. let alone the people. If a particular area has a major snakebite problem or a disease like anthrax or hepatitis is spreading there is no mechanism by which the PHC can respond to these problems. Often they would not even be aware of it.



Local planning needs an effective health information system !

Most districts claim that immunization is complete. Only 14% of the ill go to govt. centers. How does one know that the very same diseases like measles or whooping cough are not prevalent in the district in some villages? No district for example, will be able to tell the extent of jaundice in their area. Till the distant authority wakes up to it, major health problems in an area remain unattended to.

Why is a functional health information system to guide health planning non-existent?

Because decentralized district level planning is never envisaged! So no pressure to build a system that can assess the local health needs on a continuous basis.

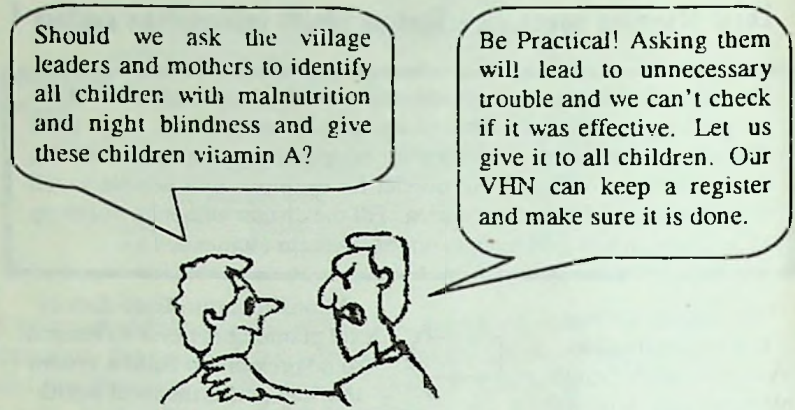
What do they do instead?

Conduct sample surveys periodically or sporadically and pray it is enough for central planning.

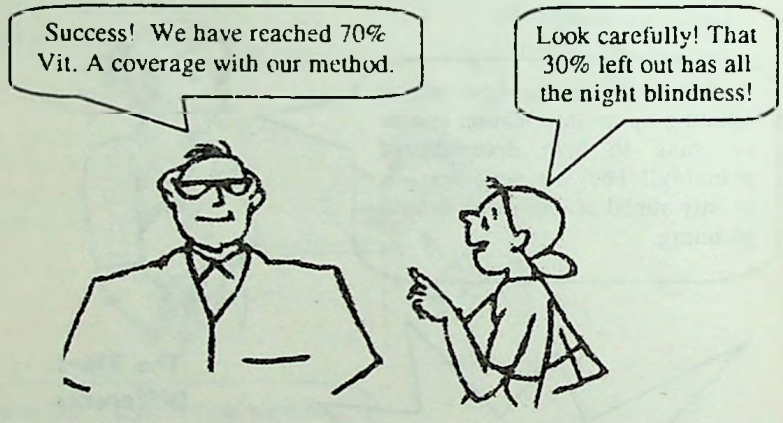
And don't think this new talk of building up an information system is going to help decentralized planning!! They are very clear - it is only aimed at improving central planning.

The Third Difference

No Community Participation!



All programmes are designed so that the health bureaucracy can use its junior staff to apply the remedy with no participation what so ever from the community. But such an administration driven approach is neither easy to implement nor even effective.

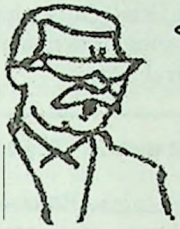


DOTS: Directly Observed Treatment Short Course!

Take the current DOTS approach to tuberculosis control as an example. Ensuring that the patients take drugs regularly by calling for direct observation by health staff is not just impractical, it also means limiting the programme's coverage. The option of involving the community in case detection and monitoring compliance is just not considered though there is much better demonstration of the success of such an approach.

What you say is not true. We strongly believe in community participation. In fact it is our ideal.

All these critics! They just can't understand that the community is unreliable...



This poor experience with community participation is because of three reasons...

First ⇨ Community help is sought only to implement pre-decided programmes without bothering about their needs. This is community manipulation not participation.

Second ⇨ There is neither resource nor a planned process for capability building. Without it, community participation becomes an excuse for transferring the blame to the community. This is particularly true where panchayat involvement is proposed.

Third ⇨ Community participation needs to be catalyzed by elected panchayats, people's movements and NGOs. It is not something that can be n*or should be* secured by the bureaucracy acting alone. Mechanically naming some committee or group as representative of the community is paying lip service to community participation.

Real community participation needs community organization. Such an organization will not be limited to the mandate set by the bureaucracy. It will evolve demands and actions on many of its local concerns. This is the true test for the genuineness of community participation.

But the local bureaucracy-politician-contractor axis finds this threatening and prefers to keep the initiative at Delhi.

And don't forget...
There is no effective Referral System!

The Fourth Difference

It is true that PHCs can refer cases to the district hospital even now. But does not mean a referral system exists! Only when the PHC, the secondary hospital and the district hospital function as a single team, we can say we have an effective referral system.

This is what effective referral means: Team Work

High risk pregnancy → First seen at local level → Referred to and seen at secondary level → Referred back to the PHC → Followed up at local level till child birth → Admitted and managed at the secondary hospital

Similarly, a person with diabetes seen in a PHC can be referred to a secondary hospital for blood tests and expert advice and is then referred back to the PHC for follow up daily at the PHC as if the entire structure was a single unit.

Such a referral system extends the capacity of the PHC to manage a wide number of felt needs largely of a curative nature, which otherwise it cannot cater to.

The community health centers, planned at one per 100000 population, was to fill this gap. The FRU - First Referral Unit – was a referral specifically meant to reduce maternal mortality. Not even 50% of the required number has been established. And even those that have been, don't have the minimum staff and provisions needed.

Why did this happen ?

Because of the conflicting desire and mandate to privatize at this secondary level !

Thus though we have a reasonably extensive antenatal care, in most of the country through the ANMs, we can offer very little to the high-risk cases. In the absence of such a referral back up the main purpose of antenatal care is lost. Except to an extent, treating anemia & preventing tetanus, antenatal care mainly serves to identify family planning beneficiaries!

Wherever awareness of risks at childbirth has risen, it is private institution based delivery that has benefited. The almost complete neglect of secondary level health care and the understanding that one should encourage private provision for it is a complete misunderstanding of the primary health care concept.

This misunderstanding is there even in the national health policy document.

We still rely on Fragmented Interventions !

The Fifth Difference!

Without addressing malnutrition, diarrhea cannot be prevented. Without preventing diarrhea, malnutrition cannot be addressed. Claiming one intervention is more cost-effective, focusing on it and ignoring the other is absurd!

Another example: Separate malaria and filaria control programmes make no sense. In both mosquito control is the key! And mosquito control requires the coordination of several sectors, not just the health sector. Unfortunately, almost all national disease control programmes are examples of such completely fragmented vertical interventions.

There are 16 vertical disease control programmes. Each disease is assumed to have one most effective technical solution. Apply this solution (often a marketable commodity) widely and the problem will be solved.

This top-down, technology-oriented view of health is a serious limitation to our disease control efforts.

The Alma Ata declaration and the National Health Policy emphasize the necessity for inter-sectoral coordination of over 10 sectors. But in practice and even in programme design reliance on a single technology bullet precludes such a coordinated effort.

Medical professionals who contribute to health planning understand technical interventions but have no experience of multi-sectoral developmental processes.

The marketable commodity has its lobby but there would be no lobby for a multi-sector process. (The promotion of the Hepatitis B vaccine amongst children is an example of this. This has not yet built up enough support to become a government programme. Once it does, like iodination of salt or impregnated mosquito nets or universal vitamin A administration, there is no stopping it.)

Almost all vertical disease control programmes are seen as being implemented by the PHC. In the PHC it is only the Multipurpose Health Worker who is involved in public health concerns. Their priorities are already fixed as family planning, a bit of care at pregnancy and immunization. This is what is monitored, and this is what happens. Therefore the vertical disease control programmes remain largely on paper.

The family planning programme swallowed up the entire primary health center !

The Net Result

The primary health center (as it exists today) is unable to enthuse the public. It seems irrelevant to their needs. Because of the resulting apathy even the demand for a better primary health care goes.

This becomes a convenient excuse for:

1. Expanding private health care and further curtailing public health care.
2. Talk of handing over PHCs to the industry, to NGOs etc.
3. A new world bank move to limit primary health centers to first contact care and use the private sector for other dimensions of primary health care.

There is no protest over these moves not because people like these new plans, but because people have no confidence in the ability of the PHC system to deliver what they want in health care.

A perception is growing that 'state supported primary health care was built up but has failed and therefore we have to rely only on the private health sector.' But this is just another way of justifying the abolition of the Public Health Sector. Primary health care as a set of desirable processes was never really given the chance. It lost out to the growth needs of the health industry right from the beginning. This 'failure' argument is therefore wrong and totally misleading.

A selective, administration driven, fragmented approach fails to address not just people's problems - it even fails to deliver these very selective targets on which it is focused !!

Unable to win people's confidence, the PHC is forced to thrust all the packages - be it vitamin A or immunization or family planning - on them. And there are limits to thrusting such health care on passive beneficiaries...

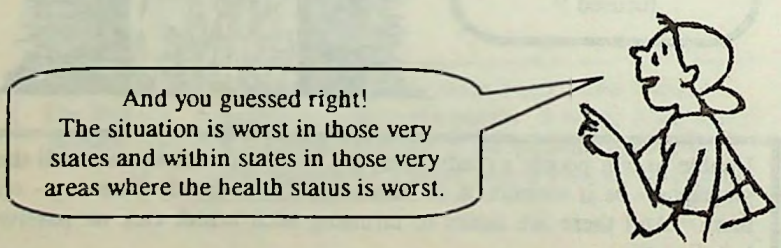
The Gap Between Health for All Targets and the Performance

Indicator	Status 1983	Target set	Status 1998
Infant Mortality Rate	104	<60	69
Under 5 Mortality Rate	140	<70	105
Crude Death Rate	12.5	9.0	9.0
Life expectancy	54	64	63
Maternal Mortality Rate	450	200	410
Crude Birth Rate	33.8	21.0	25
Total Fertility Rate	3.8		3.1
Immunization (BCG)		100%	79%
Immunization (DPT)		100%	73%
Immunization (Measles)		100%	66%
Pregnancy-TT		100%	80%
Trained Dai or Inst. deliveries		100%	34%

Note: The figures for the status in 1983 and the target set are taken from Park's textbook of Preventive and Social Medicine. The status achieved in 1998 is taken from the UNICEF publication "Status of the World's Children 2000" - which is the latest update on these figures available. The figures in this source are based on UNICEF surveys and may differ from the governments' figures.

Lack of resources

One cannot forget that in large areas across the country one of the main reasons the PHC fails to enthuse is simply the lack of adequate personnel or facilities or funds. The question of the correct processes can arise only after this minimum is made available.



The Minimum Requirements !!

1. **PHC:** 2 Doctors, at least one resident. In most states it is still the one doctor system.

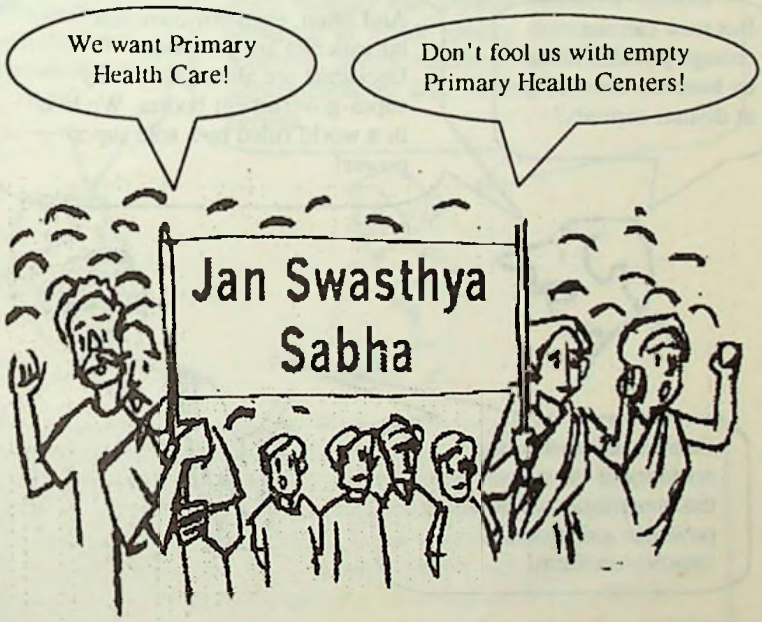
2. **Sub center:** 2 Multipurpose workers 12 MPWs/PHC. In most places the male worker is not sanctioned, or not functional.

3. **Facilities:** To conduct delivery at any time of the day & manage the entire range of diseases that a general practitioner manages routinely.

4. **Drugs:** 50 essential drugs at the PHC and 25 at the sub center available without a break.

5. Adequate transport and communication facilities to enable the PHC and sub centers to function as part of the district team.

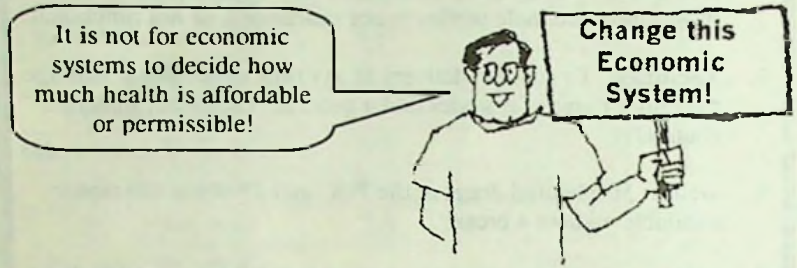
Dismissing the primary health center as a failure without ensuring these basic provisions for it's functioning cannot be accepted!



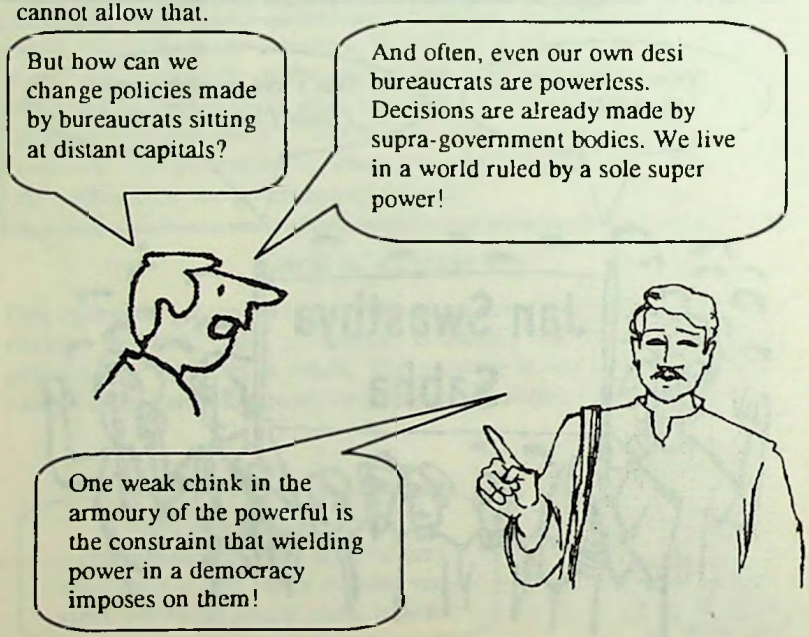
Chapter IV

What is to be done?

Health is a fundamental right. Good health is as essential as life itself. The nature of economic and social systems must flow from this premise.

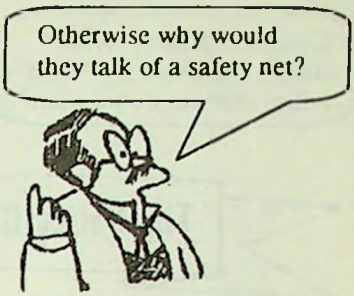


If today economics decides how much health is affordable, it is only because this is an unequal world where a few have the power to control the lives of the majority. It is now time for the people to assert themselves, to force decision making to reflect the will of the majority. **Health for All by 2000 AD** is not a programme that can be quietly forgotten once its period is over. Governments may do so. But people cannot allow that.



And What's this Constraint?

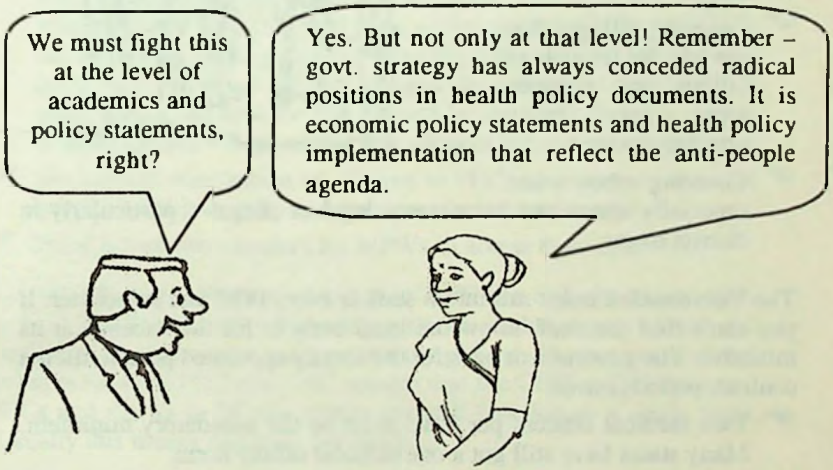
In a democracy, the rulers are forced to win the consent of the people for their policies. When most nations are democracies, even international bodies recognize certain limits beyond which they cannot push governments.



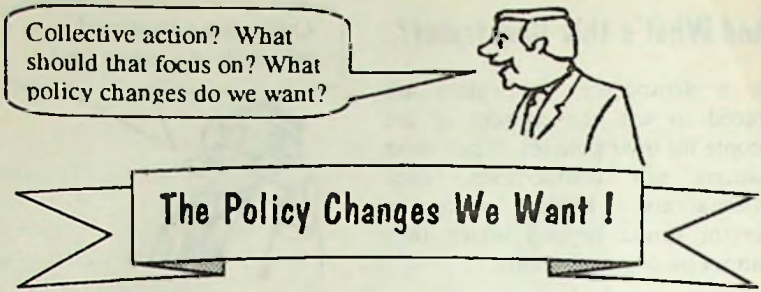
What are they doing ⇨ Defeating the Alma Ata and removing it from public consciousness.

What should we do ⇨ Build a public consciousness of this erasure – make people remember how they were conned into forgetting.

We must also challenge the false reasons that are created to explain the failure of the public health sector and manufacture consent for the health policies that flow out of structural adjustment and globalization.

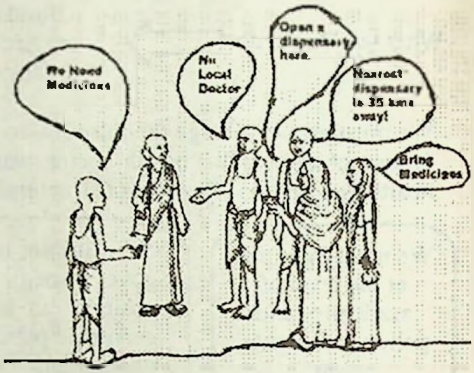


Building up public consciousness also means that collective action must win immediate relief in health care, for health is an urgent and pressing need for the poor. It is in the course of such action that most of the poor will be able to enter and intervene in the decision making process. It is largely through such action that a genuine public consciousness can be shaped and the manufactured consensus for privatization questioned.



Ensuring Minimum Infrastructure

The Hardware: Cover every habitation, rural or urban, with a PHC. Gaps that need mending include:



- Opening PHCs in areas where they don't exist.
- Covering villages that get left out because of falling in between areas or being remotely located.
- Covering urban areas, especially slums and hutments – legal or illegal – particularly in district towns.

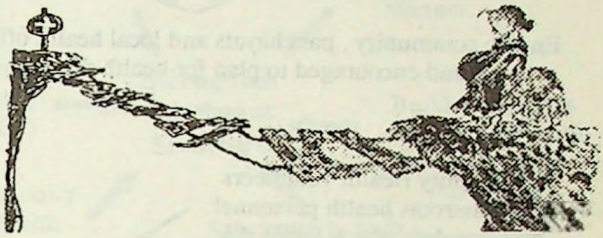
The Personnel: Ensure minimum staff in every PHC and sub-center. If you can't find the staff, allow the local body to fill the vacancy at its initiative. The government pays for the locally appointed person, till the contract period is over.

- Two medical officers per PHC must be the mandatory minimum. Many states have still got a one medical officer norm.
- Ensure the norm of 2 MPWs for every sub-center. Check absenteeism of the male MPW by closely monitoring his work. If community is organized, articulate, and actively facilitating their work, the problem of MPW functioning can be resolved. Appointing 2 women workers can be a way out. Or arranging for both to be paid out of state-funds.

- Ensure minimum service conditions for adequate functioning of cadres. A special rural allowance for doctors to offset loss of city allowances is desirable.

The drugs: Ensure that every PHC has a minimum supply of 60 essential drugs and the sub-center 25. Final choice of the 25 or 60 drugs is made from a state essential drug list based on the area health plan.

The question of Access: Access to Primary health centers is another major issue. Concerns include:



- Good all weather road leading to the PHC and out of all habitations to the main road.
- Proper location or relocation of PHCs so that they are situated at a place where conveyance is easily available. The condition that the village should offer free land for a government to set up a PHC has usually meant a village bigwig donating low priority land, like land next to the cremation grounds, or land that is far from the main road and market. The land for PHC should be chosen at the local weekly or daily market village so that bus services are readily available.
- Mechanical distribution of villages to PHCs has led to sacrifice of geographical proximity and transport facility considerations.
- Provision of two wheelers for MPWs to access their field area.

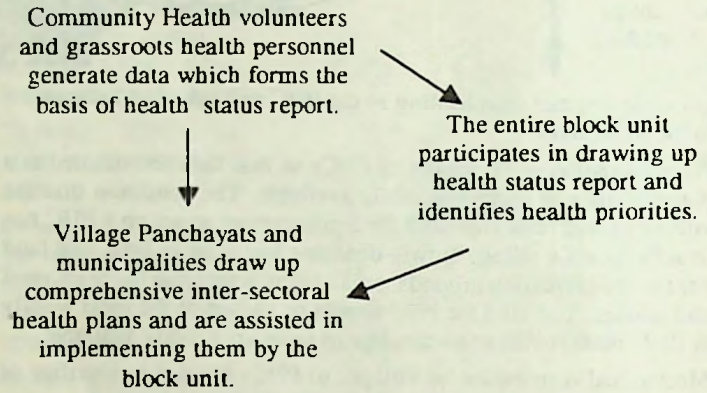
Stronger Referral System: Link every PHC to a fully functional CHC by both ambulance and telecommunications so that expert advice and specialist care is brought much nearer the patient. The two-way referral linkages between PHC and CHC require that the CHC and all the 3 or 4 PHCs and the 18 to 24 sub-centers under it function as a single team. (Usually this means one team per block).

Broad-base secondary health care: A fully functional CHC implies the capacity to intervene in a high-risk childbirth, which includes the capability to carry out a Caesarean and manage a premature new born. Building such infrastructure takes care of all elements of secondary healthcare including the ability to carry out a wide number of investigations and surgeries. The provision of such a center for one lakh population is imperative.

Decentralized Health Planning

From top-down to bottom-up in planning

Ensure community , panchayats and local health officers are equipped and encouraged to plan for health needs in that area.



Provide **technical support** for the community planning efforts by linking each CHC to an epidemiologist (posted or available on consultancy from a medical college or from a qualified NGO).

For **resource support,** funds from all central and state schemes, especially the vertical disease control programmes, can be allocated to the block on different heads according to locally assessed priorities.

Monitoring programme effectiveness should be based on indices that are more reflective of the processes of health care rather than fragmented interventions. For example malnutrition in children, birth weight of babies, TB cases suspected on clinical grounds can be some indices. It should be based on health status assessment and involve private sector as well as community volunteers.

Building Panchayat Capabilities and Facilitating Community Participation

Provide resources in related areas like water and sanitation

Hand over responsibilities to Panchayat in a phased Manner

Joint planning with Panchayat, PHC, village and NGO

Strenghten Panchayat Structure

Build a women's committee to work in tandem with Panchayat

Train community-chosen health volunteers who report to Panchayats

Sub center to train health volunteers in first contact care

Sensitize people against marginalization of weaker sections.

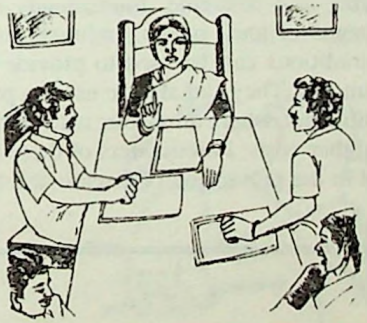
Train community volunteers from weaker sections – women, dalits, tribals, etc.

Role of state and NGOs in addressing weaker sections!

Special Focus on Weaker Sections

Link with other activities for empowerment – education & livelihoods

Create organizational structures for women and other weaker sectoion.



Other fronts in which we need policy changes!

1. Making Radical changes in medical education.
2. Ensuring Provision of Basic Needs to all.
3. Regulating the private sector and stopping its encroachment into public health. Ensuring no private practice for government doctors.
4. Strengthening ability of modern medicine to provide holistic care, resisting the trend to medicalize and mystify health and disease. Also resisting obscurantism and irrational understandings of medicine.
5. Systematic and urgent research on traditional health systems and efforts to integrate them into a holistic health care perspective. Efforts to document and preserve the knowledge base as well as conserve the natural biodiversity on which these systems are based.
6. Implementing a policy on pharmaceuticals that ensures adequate and self -reliant production of essential drugs at affordable prices and the banning of all inessential and hazardous drugs.

Local Health Traditions and Primary Health Care

India has a rich tradition in folk medicine as well as in organized non-allopathic systems of medicine like Ayurveda, Siddha and Unani. There is urgent need for systematic research & community-based evaluation of these traditions. Developing these systems, complementary to modern medicine and as part of a holistic healing perspective is possible and desirable. Immediately there is need to integrate some elements of local health traditions in primary health care. Local health traditions can be used to provide care for a large variety of simple ailments. They can also be used to provide relief in a number of chronic ailments, where allopathic care also only offers such relief but at much higher costs. Practitioners of these health traditions can also be involved in the prevention of disease and the promotion of health.

People's Initiatives

In vast areas of the country, the existing PHC network is dysfunctional. We also saw how in all areas there is a gap between the existing PHC network and the concept of Primary Health Care. The question is what we, as part of civil society, can do about it? What can People's Movements do and what can local communities do?

Below are some things that are possible:

1. Create awareness about health and prevention of disease.

2. Act as pressure groups to ensure that health priorities are attended to by the public health system and to ensure that the public health system functions optimally and the private sector functions ethically.

3. Ensure effective utilization of existing government schemes related to health, both by creating awareness and facilitating the functioning of these programmes.

4. Build capacities of panchayats to assess the health situation, to monitor and to facilitate the public health system and organize self-help measures by which considerable health gains can be achieved.

5. Organize massive training programmes and transfer of skills to representatives of the community. Such a transfer of skill will ensure that knowledge for most preventive, promotive and even curative care is available locally.

6. Build organizations of women and weaker sections to use health action as an entry point to contest their marginalized status.

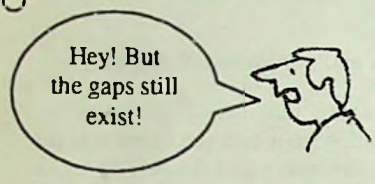
Chapter V

Two Worlds, One Planet!

Let's look at the basic understanding of the **Health for All** slogan...

Health for All

Disparities in health status are unacceptable – whatever the reason!
Reducing the gaps our major goal!



There is large gap between the rich nations of the west and the health of all other nations! The top 25 countries are all are European or North American (western) except for Japan.

	Top 25 countries	Developing countries	Last 43 countries
Life expectancy	76	62.2	51.2
Literacy rate	98.6%	70.4%	49.2%
Maternal Mortality (per lakh births)	30	488	1100
Under Five Mortality (per 1000)	16	65	171

Source: Human Development Report 1998, a UNDP document

And there is also a large gap within the rich nations - between the health of the rich and the health of the last one third.

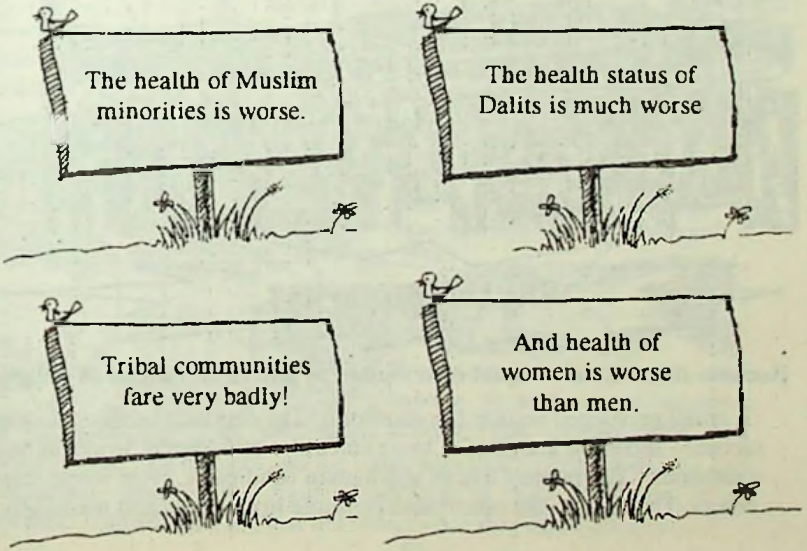
In a developing country like India there is a wide disparity in the health situation between states.

State	Under -5 mortality (NFHS)	Maternal mortality	Literacy rate	Access to safe water	Access to sanitation	TB Per lakh	Per capita income
Kerala	32	<200	89.6	79.2	63.1	504	5778
MP	130	>1500	43.9	65.9	11.0	686	4166
Bihar	127	>1500	43.8	68.8	7.3	496	3691
TN	87	400	64.1	71.6	11.1	583	5122
Punjab	68	500	60.2	96.1	19.8	230	6380
India	109	500	53.5	72.0	15.3	423	4485

Source: India, Human Development Report, Abusaleh Sharif, NCAER, OUP

The state with the best index is Kerala. It's under-five and maternal mortality rate are comparable to the industrial nations. In contrast, states like Bihar or Madhya Pradesh have very poor figures. Even states like Punjab or Maharastra, which have a relatively high per capita income, have a relatively poor health status.

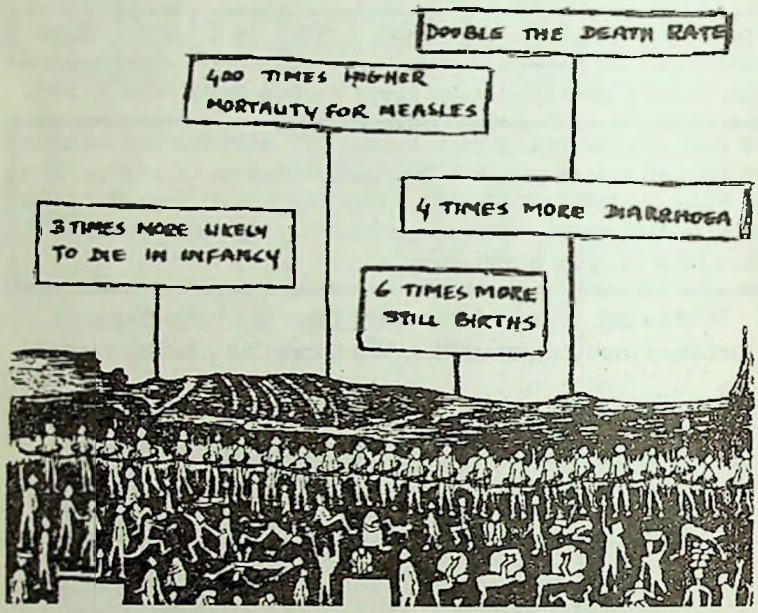
Within any state in the country there is a large disparity between many communities. What can that possibly mean?



The poorer the family
the higher the chance of ill -health and sickness!

Social group	Crude Death rate	Under 5 mortality
Tribals	9	129
Dalits	13	140
Landless wage earner	14	135
Above 86.000 per year Upper Income Group	7	71
All India Average	11	117

Source: India, Human Development Report, Abusaleh Sharif, NCAER, OUP



Why this disparity?

Because there is an unequal distribution of power and assets in society

A small privileged section has most of it. The deprived section has less income - therefore less food & basic amenities and lives & works in bad conditions. The poorest live in sub-human conditions, often worse than beasts. The rich on the other hand consume luxuriously and wastefully.

How much inequality are we talking about?

The money spent on perfumes in Europe and the US is enough ($ 12 billion) to provide reproductive healthcare to women all over the world!

The money spent on cosmetics in just one country – USA, can provide basic education for all or can meet almost all the water and sanitation provision needed for all peoples of the world.

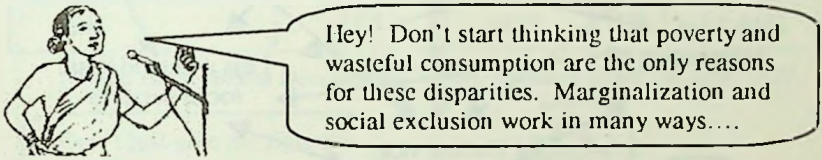
The cost of alcoholic drinks bought in Europe alone is $ 105 billion. This is two and half times the cost of providing basic social services (basic health, including reproductive health, nutrition, education, water and sanitation) for the entire world. (This will cost about $ 40 billion).

World's military spending at $ 780 billion is 20 times the money needed for providing health, nutrition, education, water and sanitation to all.

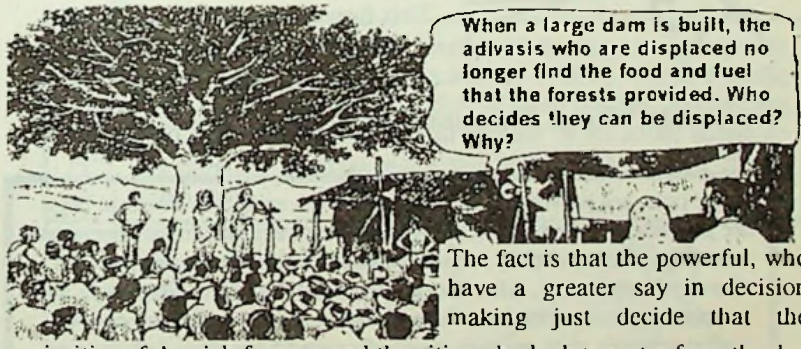
The 3 richest people have more assets than the GDP of the poorest 48 countries and the richest 32 persons more than the GDP of all Asia.

If the richest 225 people donate 4% of their wealth, the money to provide basic social services across the globe will be available.

Source: *Human Development Report 1998 - A UNDP document.*

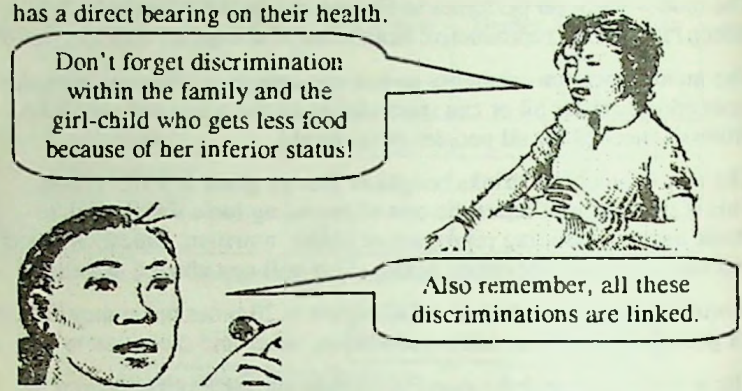


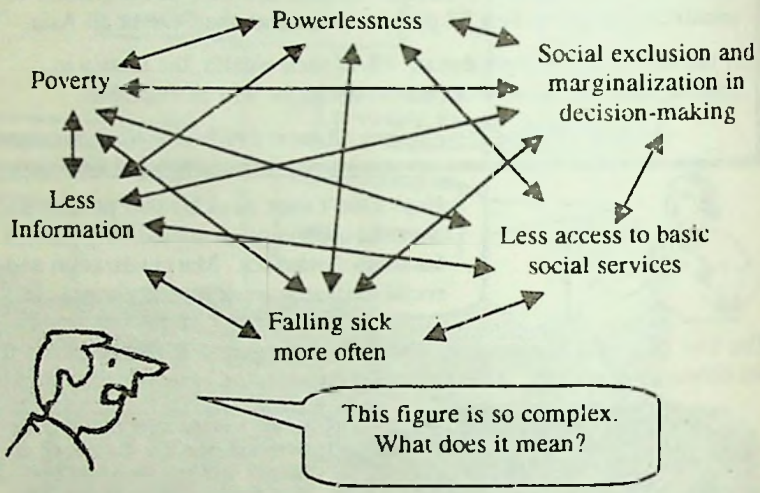
The less powerful are actively discriminated against & marginalized from the economy & society. This reduces their access to basic necessities of life.



The fact is that the powerful, who have a greater say in decision making just decide that the priorities of the rich farmers and the cities who look to water from the dam is important, whereas the right of adivasis to their livelihood is not important. The adivasis are just not asked what they think about it!

Dalits in many villages are not allowed to access a clean water source within the village and have to either walk long distances or make do with unsafe water. This is form of discrimination – social exclusion – has a direct bearing on their health.





It is complex because discrimination is complex. Let's understand this...

The poor are powerless and the powerless are poor. Because they are powerless, tribals, dalits and women are excluded from decision-making. Because they are so excluded they have less power and therefore are poorer. Also because they are excluded, they have less access to basic social services. Because they have less access to social services they are sick more often and have even less income. Because they have less information, they are even more powerless.

Precisely because they are disadvantaged, the state should provide more services to these sections. It is the duty of govt. to address these inequities in health so that everyone is guaranteed a basic minimum health. What else is a government for?

Making the same investment and providing them the same access as those who have better social status and wealth is unfair. **Treating unequals equally is wrong**. Unequals must be treated unequally. The reality however is that, these sections that are not able to access even the existing state provided services.

Social Group	Literacy	% Immunised DPT 3 doses	% births unattended	% access to PDS	Per capita income
Landless labourer	36.6	58.4%	54.7	44.3	2308
Tribal	38.7	46.6%	68.1	37.5	3504
SC	41.1	53. 6%	62.4	32.1	3237
High income	74.3	77.1	43.4	28.0	17865
India		57.5	60.0	33.2	4485

Source: India, Human Development Report, Abusaleh Sharif, NCAER, OUP

Don't just give me figures! Tell me what it means?

Deprived sections need 100% coverage by the state more urgently than the rest. At a per capita income above 17600 per year, a public distribution system is useful and 28% of these families have access to this. But at a per-capita annual income of Rs 2308, access to PDS is a must for survival and a full 56% of this section do not have access to it!

OK. So, have we looked at all the kinds of disparities possible in a country with a skewed development like ours?

Hey! How about the disparities between India and Bharat?

And between the urban rich & urban poor too.

Also, don't forget that disparities between social groups is more in the large Hindi speaking Northern states!

Are such disparities acceptable?

Certainly Not!

தனி ஒருவனுக்கு உணவில்லை எனில்
ஜகத்தினை அழித்துடுவோம் !

If a single individual does not have food to eat, we will destroy the world!

- Poet Subramania Bharati

We have a duty !

Every single individual should have the minimum material necessities for a human existence.

Neither governments nor communities can ever be excused any failure to ensure this!

Do you know why the rich countries are rich and why the poor countries are poor!

Because they work hard and are more enterprising?

How quickly we forget! And it is only 50 years since we became a republic – after such a glorious freedom struggle!

All western nations were colonizers and the entire poor underdeveloped world was colonized and looted by the colonizers.

Man's struggle against oppression is a struggle between memory and forgetfulness!

Some western countries like Switzerland or Sweden never actually held colonies but were part of the same economy, acting as its bankers & traders!

Japan is an Asian country but it is part of the industrial world. That's because it was the only Asian country that was never colonized and was the only Asian country that actively colonized other countries.

The rich are rich because they looted the poor!

Talking of disparities... Are they not inevitable ?
Can all five fingers be the same ?
Are not these differences natural ?

Certainly Not! I think you need some history lessons...

But, I don't like history!

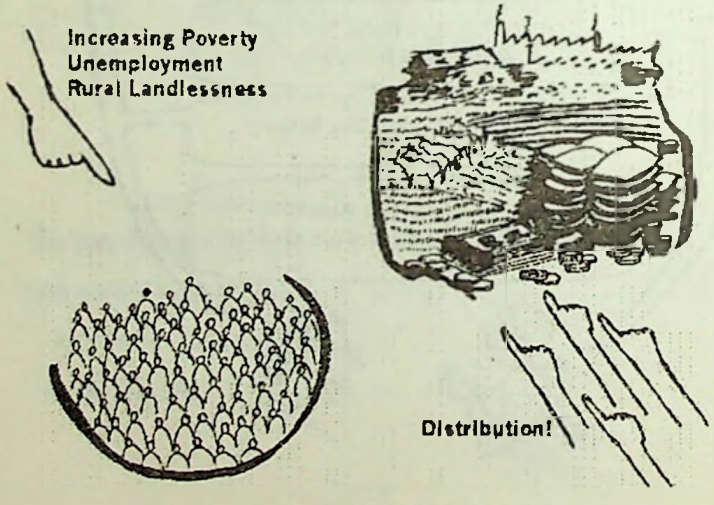
And that's why you believe in nonsense like 'disparities are natural!'

During a certain period in history natural resources held in common were wrested and made the private property of a few. Similarly, assets created by the labour of all came to be owned by some. Often this was achieved by brute force. By declaring that some people were not humans and therefore had no rights. This way the Native Americans were wiped out by white settlers of the Americas, and the invading settler-farmers in India conquered the tribes. This is also the way common village land became the zamindar's property with the permanent settlement act! And the way irrigation water became private property with the energized tube well. Since the few who now held property and power could also have a major role in shaping culture and beliefs, even the memory of the loss became blunted over time. But it never quite disappeared...

The urge to freedom, to basic human rights cannot be obliterated! It is an essential value of all societies.

The fight for adequate access to social services is the fight against discrimination and inequity. Better health and education empowers these sections to challenge discrimination in all aspects of life.

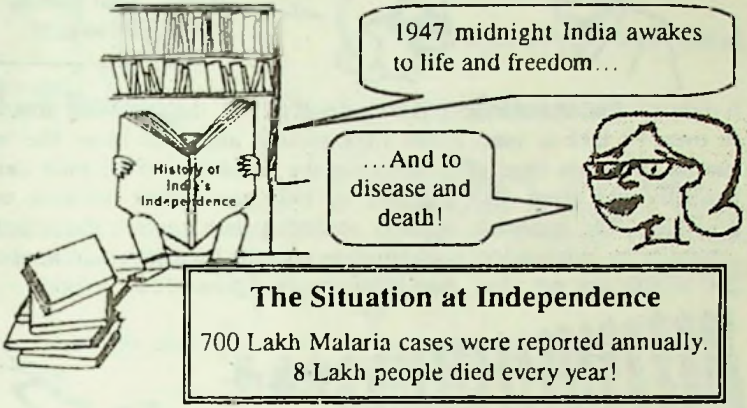
All right-thinking men and women - and not just the marginalized - should join this struggle !



Chapter VI

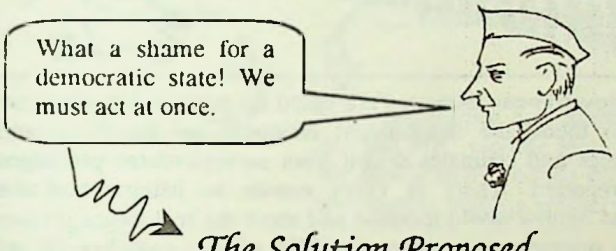
Case Study: The War Against Malaria!

Lessons from a war that was won and then lost!



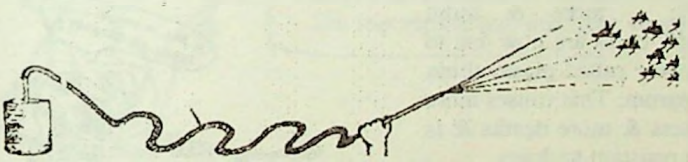
The Situation at Independence

700 Lakh Malaria cases were reported annually.
8 Lakh people died every year!



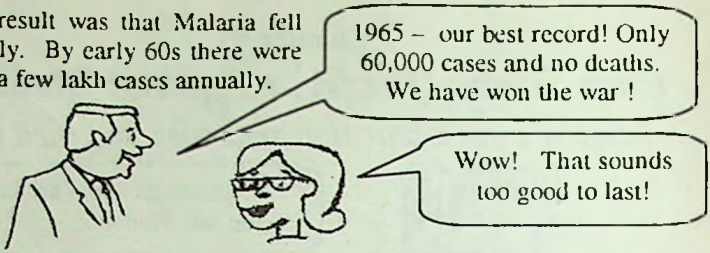
The Solution Proposed...

Spray DDT and eliminate all the Anopheles mosquitoes!

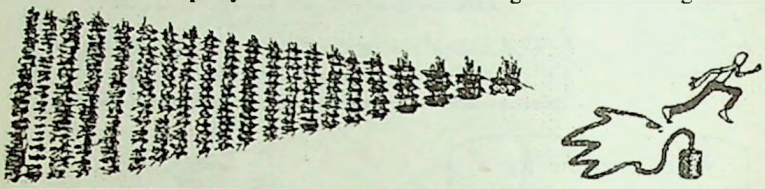


Even though other options were considered, DDT spraying along with giving chloroquine for those affected with malarial fever was the mass-scale solution. In every block, malaria workers were appointed for both spraying DDT and for taking regular blood smears to detect outbreaks early. Supervising them were a hierarchy of officials leading all the way to the National Malaria control office at Delhi.

The result was that Malaria fell rapidly. By early 60s there were only a few lakh cases annually.



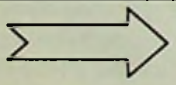
It didn't ! Malaria started to rise again. By 1972, the cases had gone up to over 70 lakh a year. Plans were revised and once more the war started. But this time after lowering the incidence to 20 lakh cases annually and about 30000 deaths by 1985, no further decrease was possible. The incidence actually started to rise again. Painstaking estimates by independent academicians puts the incidence now at about 200 to 300 lakh per year. And is 10 times the government's figure.



Whereas, government estimates are based on positive blood smears reported to them, the independent estimates are based on anti malarial sales and estimates drawn from surveys where prolonged fever is reported. There is every reason to believe that the government figures would increase and show the real figure if cases seen in the private sector (where over 70% of fever cases report) are included and if government does more blood smears.

Worse – more & more malaria cases are now due to a parasite called plasmodium falciparum. This causes more sickness & more deaths & is often resistant to drugs.

Result: The real estimate of deaths is likely to be in the range of 75,000 in 1987. The government only reported 188 deaths.



Malaria is also now occurring in many urban areas and newer areas where it has never existed before.

We have to accept that the Malaria programme failed!

Why? Why did it fail? We tried so hard this time...

Many answers have been offered.

The Causes of the Failure !

The insect vector developed resistance to DDT.

Doctor

Carelessness and apathy in vigorously maintaining spraying once the incidence came down. Sustained attack on vector absent.

Administrator

Economist

Not enough money for drugs. And not even for research.

Health Administrator

No! Integrating anti-malaria work into the PHC was the main mistake. We should have retained the cadre of uni-purpose malaria sprayers!

Full points, gentlemen. You are all right. But incomplete and therefore wrong!

The spread of malaria depends on a specific relationship of the parasite, the mosquito and the human, a relationship that depends on the environment – both natural and social environment. Because of this, the exact causes and mechanisms of spread vary widely between one place and another.

Look at the five situations below...

Rajasthan

Major outbreak of Malaria along the Indira Gandhi canal system. Migrant labour from endemic Bihar introduced the infection in this area. The vector bred in waterlogged areas adjacent to the canal especially in areas where seepage was high. Estimated deaths – over 4000. Fortunately there were few resistant strains. However the number of cases who died as compared to those who had fever was high.

Urban South Madras

It has about half the cases of malaria that occurs in Tamilnadu. The vector breeds exclusively in fresh water wells and overhead tanks, collections of rain water in tins or tyres lying around. Most of the parasites are plasmodium vivax sensitive to chloroquine but occasionally also the odd case of resistant vivax or falciparum. This is largely an affluent part of the city except for a few slums where the fever cases are more.

Northern Maharasthra

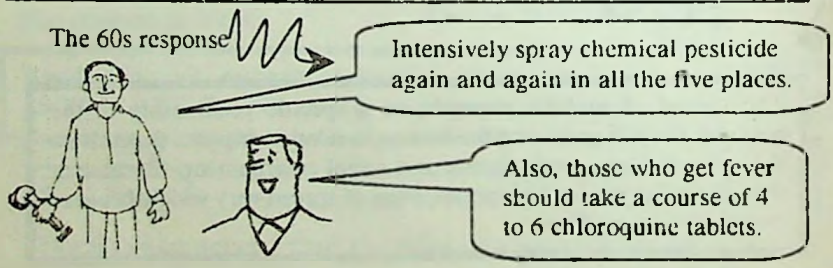
Here Malaria is low in incidence though showing a mild tendency to increase. The dangerous situation here is that the vector is resistant to all three -DDT, BHC and Malathion. There are however no Falciparum cases.

Assam

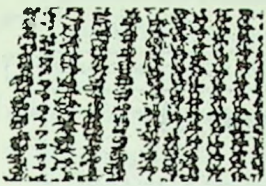
Every year after the rains there is an outbreak of malaria. The usual insecticide spraying does not seem to help. Each year the number of cases is on the increase and more resistant strains of the germ is being seen.

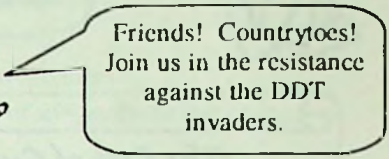
Tribal District in Orissa

Major malaria prevalence. More than 30% of the children have enlarged spleens. Malnutrition is predisposing people to infection and more deaths. Most parasites are of Falciparum variety and Chloroquine resistant. The mosquitoes breed in forest streams, collections of rainwater in the trees and in small depressions on the forest floor.



In the 1960s all the above five reports would have met with the same technical response. Needless to say in most of the above places it would not have worked. In some places where the mosquito is sensitive to insecticide it would have worked for some years and then the mosquito would have developed resistance.





The 90s response → Still the same! Except for more regular taking of blood smears for surveillance and more powerful insecticides and drugs against the vector and the parasite.

This is a technology centered, fragmented, administratively driven vertical intervention. Such interventions may or may not be successful in the short run, but invariably in the long run they always fail.

Technology centered → Sees the disease as being caused by a parasite and a vector and fails to see the social and ecological setting of the disease. Thus response is based on a technology attack against the parasite or vector.

Fragmented → Only one or two of all the factors that go into the disease setting (and that too in isolation) are sought to be addressed.

Administrative driven and vertical → The entire planning and packaging done in Delhi (or New York). Only local thing about it is the application (under a chain of command). No role for community participation. No local planning. Of course, no question of technology choice.

The Result → An inappropriate package for local needs. Local people are indifferent - sometimes even resist. Finally, even the administration cannot in perpetuity keep its attention on this programme alone.

What other disease control programmes in India have been like this - technology centered, fragmented, administratively driven and vertical?

The List of Culprit Programmes

The Malaria Control Programme, The Filaria and Kala Azar Control Programme, The Leprosy Control Programme, The Family Planning Programme, The Vitamin A Administration Programme, The Diarrhoeal Diseases Control Programme, The AIDS Control Programme...

My God! You mean all of them?

Yes! The vertical approach worked for Small Pox eradication. But for most other diseases, it did not work. Its biggest failure was MALARIA.

Then, how do we make these programmes work?

- Plan locally and holistically emphasizing socio-economic, cultural and environmental factors .
- Involve the community in planning and implementation. Make institutional arrangements to facilitate community participation.
- Make arrangements for adequate surveillance with inputs from the community, the private sector and the state health sector.
- Make the minimum resources needed for this approach (and this is usually cheaper than vertical approaches) available through the state health sector.

I almost forgot! What is the right thing to do in those five places?

There are a host of choices and we can choose the most appropriate for our place and situation. Let's look at the technical options available...

Personal Prophylaxis

- Impregnated nets or Ordinary mosquito nets.
- Commercially available insect repellants.
- Local herbal fumigants and herbal repellants.
- Chemo-prophylaxis – taking a dose of anti malarial drug daily.

Environmental Management

- Filling up ditches & pouring kerosene on small water-collections that can't be filled up. Regularly (especially after rains) checking for collections of water in upturned trash tins, hollows in the tree bark, rubber tyres and other such spaces and emptying the water out. If done once a week - if we ensure that stagnant water does not stay for more than a week – this is adequate to prevent malaria breeding.
- Ensuring water tanks have covers that prevent mosquito access.
- Clearing ponds of excessive vegetation and introducing larvicidal fish in ponds and irrigation tanks.
- Changes in irrigation practices like draining of standing water in rice fields at least once in 5-7 days to combat mosquitoes breeding.
- Planning all development & construction projects (roads, canals, buildings) so that there is adequate drainage & stagnant water collection is prevented.

Spraying Pesticide

- In house walls after identifying which are the most likely places for mosquitoes to rest. Some species rest on the high walls, and some prefer the bottom. Some do not rest on walls at all.
- As fog to knock down flying mosquitoes – generally useless though it is very impressive. Sometimes this may be needed in places where a huge crowd is likely to assemble or at travel points like airports & stations.

Drug Treatment

- Identifying fever cases early and prompt and full treatment.
- Giving a round of anti-malarial to the entire population!

To ponder over...

Which of the above measures the health department staff can just not implement? Which need the active cooperation of individuals? Which measures need collective action by local communities - they can neither be achieved by individuals, nor by the department? Which of the above needs departmental intervention?

Coming to what can be done in some of those five places...

In Bastar – The Elected Panchayats and specially created Women's Health Committees were motivated to take up this task. To cut transmission of malaria – which was due to high prevalence of disease and high mosquito population in their area – they used impregnated nets and administered chloroquine to all suspect fever cases. Some indoor spraying was done but was given up when the entomologist opined that this sub species of mosquito does not rest on walls.

In South Madras – Indoor spraying does not help. What is needed is a massive mobilization, so that all the potential breeding sites are identified & managed by volunteer brigades. A good way to manage breeding sites in open wells & in seawater along the coast, isn't clear.

In Rajasthan – Better drainage along the canal is the key issue. Improved surveillance, timely treatment, providing health care for migrant labour and the active involvement of a number of local voluntary organizations (Lok Jumbish was one such organisation) were able to control the epidemic. Vigorous spraying operations could help in the short run as insecticide resistance is low, but if drainage does not improve then such resistance is likely to develop soon.

Moral: *Beware of vertical programmes. The emphasis should be on local planning, adequate surveillance and on community participation.*

Policy Recommendations For Malaria Control

Estimating disease load and surveillance

Make reporting all malaria cases compulsory and operationalise a district level system where regular reporting from multiple sources is collated and a feedback provided. Ensure lab-technicians at the PHC level are present and functional, conducting minimum number of smears needed for effective surveillance.

Decentralize the Planning

Each district should draw up its plan according to local-specific conditions. These plans must be holistic drawn up after studying:

- The resting, feeding and breeding behaviour of the local vector.
- Reasons for increased availability of breeding sites.
- The exact parasite type and whether it is resistant.
- The mosquito's insecticide resistance, as well as social and cultural determinants of the disease in the area.
- Other vector borne diseases in the same area.

Community Participation
Both planning and implementation needs the active participation of the community. This means:

- Creating an institutional mechanism by which the community including the local elected body can participate.
- Initiating a process for capability building and empowerment of the community. Most important in this is public education.

Resources
The minimum resources and infrastructure should be made available through the local health department. This includes:

- Adequate anti-malarial drugs and anti-mosquito insecticide.
- Two multipurpose workers per sub-center with adequate mobility.
- Adequate equipment for both the laboratory and for spraying.
- The ability to procure other inputs like fish seedlings or fair priced impregnated nets etc.
- Resources needed for the provision of basic drainage and other public works to build a healthy environment should be available.

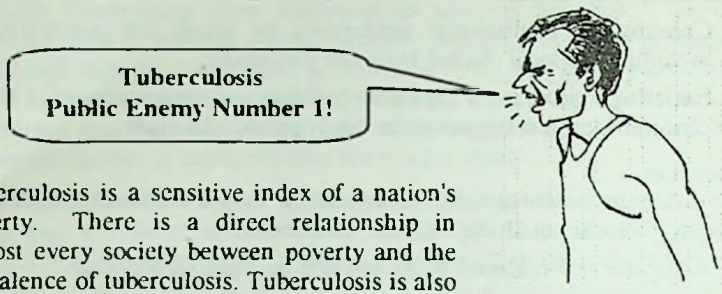
In principle, the government does not refuse the role of either local planning or organizing the community. These measures are accepted on paper. However in practice the government takes no initiatives for this.

People's Initiatives For Malaria Control

We can petition, lobby or pressure the government to take the policy changes suggested above. We can even organize agitations for this. In which case a few token gestures may result. Often the response is some thing dramatic and visible and rather ineffective. Like the fogging of pesticides or killing of pigs every time there is an outbreak of encephalitis. Instead, we can organize people and with the help of suitable resource persons, begin local planning and community initiatives. Note that much of the technical options outlined in the earlier page can and must be done by the community. While we take such initiatives we can bring pressure for appropriate supportive measures by the government health department and other concerned departments. Done in this manner the voluntary work becomes an instrument of advocacy for policy change; it acquires a political character – like a Satyagraha. And yes, the means would be meaningful in itself! At least some awareness and some amelioration of the problem may result as an immediate outcome!

Chapter VII

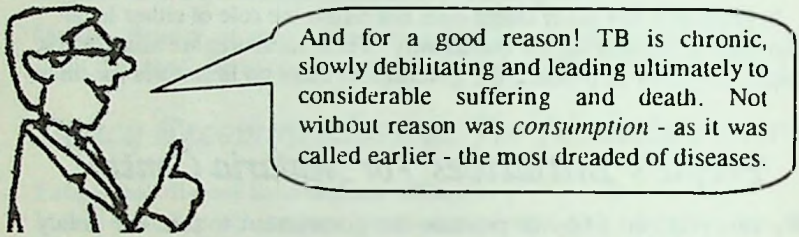
Case Study: Strategies for Tuberculosis Control



Tuberculosis is a sensitive index of a nation's poverty. There is a direct relationship in almost every society between poverty and the prevalence of tuberculosis. Tuberculosis is also a sensitive index for the state of public health services of a nation.

This is why even governments, which don't care much for equity, have addressed TB as a minimum social service provision.

Of course apart from legitimacy, there is also considerable concern at the infection spreading to other more affluent sections!



1947
Population: 300 Million
Suspected TB-Infected: 200 Million!!

1947
TB disease: 2 Million
Death by TB: 5 Lakh Annually

But most people who have TB germ do not develop the disease...

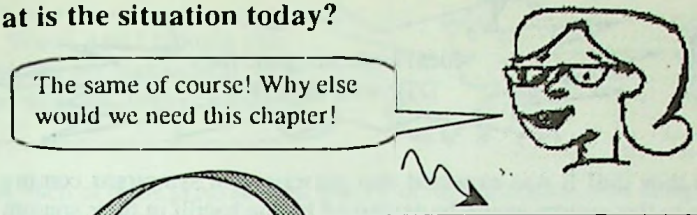
...only those whose body resistance is lowered develop the disease.

Resistance is lowered because of malnutrition, other diseases, overwork or poor working and living conditions...

Therefore the poor are most affected!

That's why TB is an index of poverty

What is the situation today?



Now – 50 years later...

Active disease: 13 Million
(6 times the earlier prevalence!)

Infectious Stage: 2.5 Million

TB Deaths: 5 Lakh Annually

The lower death rate is due perhaps to the much better drugs available now.

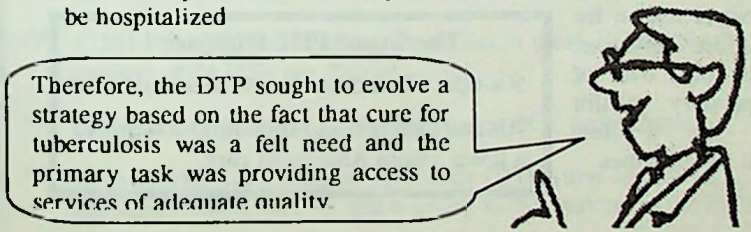
This makes us the Nation with the Maximum Number of Tuberculosis affected people in the world!

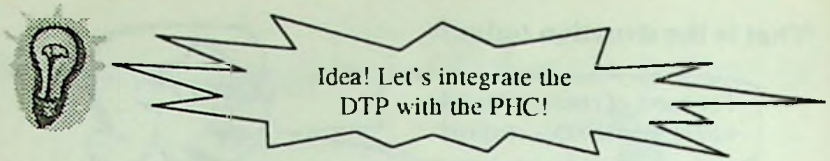
Now, let's see what measures were taken to control it and how it failed.

The District Tuberculosis Programme - DTP

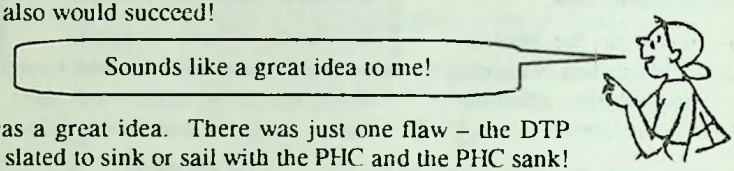
After independence the govt. started making plans to address the TB problem. Based on carefully done studies led by the National Tuberculosis Inst., a better understanding of the disease and the way people respond to it was gathered. The highlights of this understanding:

- 3 to 5 per thousand have active tuberculosis.
- The disease has a rather uniform spread across the country.
- < 10% of the cases have access to treatment or even diagnosis.
- At least 50% of people with symptoms had sought medical help but in over 90% of cases they had been sent back with a cough mixture. Even the rest were conscious of their symptoms & desired medical help.
- Diagnosis can be inexpensively and reliably made based on symptoms alone with confirmation by sputum examination
- Domiciliary treatment is adequate and seldom do patients need to be hospitalized



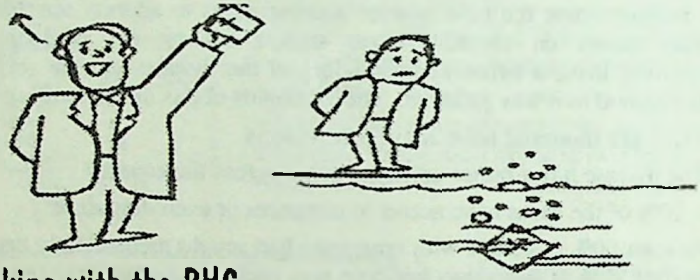


And so they did! It was expected that persons with symptoms coming for help to this system would be examined for the bacilli in their sputum and would be followed up. The PHC would have a lab technician and the sub centers would have a multipurpose worker who would attend to case diagnosis and follow up. The presence of a PHC with a lab technician and health workers would make it possible to improve other general health services with the same investment. If one worked the rest also would succeed!



It was a great idea. There was just one flaw – the DTP was slated to sink or sail with the PHC and the PHC sank!

The DTCP Shall Swim or Sink with the PHC



Sinking with the PHC...

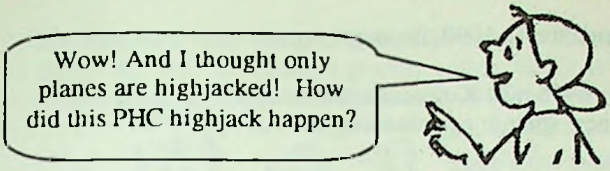
In over 50% of villages and in urban areas effective primary health coverage was not reached till the eighties. Even now, in terms of lab technicians and male multipurpose workers who are assigned TB control duties, the vacancy situation is alarming.

The central reason for the failure however, was the take over of the primary health center by a few vertical programmes.

The Grand PHC Highjack !

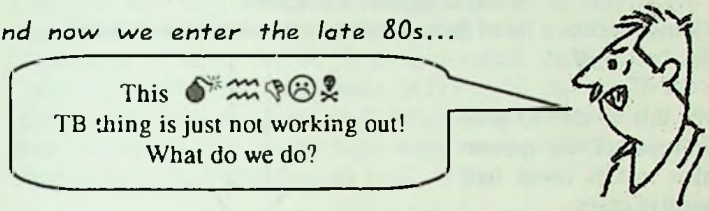
50s-60s: FP and to a lesser extent malaria.

70s and later: FP and Immunisation and to a lesser extent Ante-natal care.

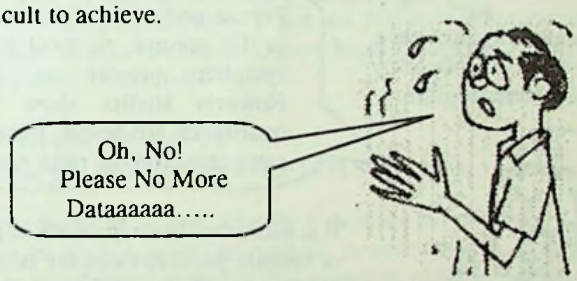


Well, each of these programmes, like FP or immunization, was designed for implementation in a top-down fashion and was rigorously monitored, pushing all other activities out. TB was one such activity that got marginalized. Also, at no time was the community involved.

And now we enter the late 80s...



In the eighties, short course chemotherapy with Rifampicin was introduced into the DTP and it did not make much difference. Of course no one was surprised! If anything, because of frequent shortages and supply constraints of this costly drug, case-holding (follow up) became even more difficult to achieve.



1994

- 391 DTPs operating out of a total of 496 districts.
- 17381 Public Health Institutions (PHIs) in these 391 districts – average of 44 PHIs per district.
- Of these 391 districts, 252 have ongoing SCC programmes.
- Each district has a District TB Center (DTC) that supervises, provides referral back up and training to the workers in the PHIs.

With this infrastructure, in 1994, on an average...

6465 new X-ray examinations and
11094 new sputum examinations are done per DTP.

Of these, 3788 were diagnosed as TB though
only 770 (20.3%) were sputum positive.

X-ray diagnosis was 73.9%
which means a lot of false positive cases were on treatment.

Part of this is due to poor performance of the sputum test that misses about half the positive cases.

Assuming all the cases diagnosed were put on treatment,
only 35% completed treatment!!

Completion rates were worse for the biweekly intermittent regime.

Private sector is playing a major role in TB control, as most people with symptoms prefer to go there. However studies show very poor quality of treatment there. Relapse rates and drop out rates are unknown.

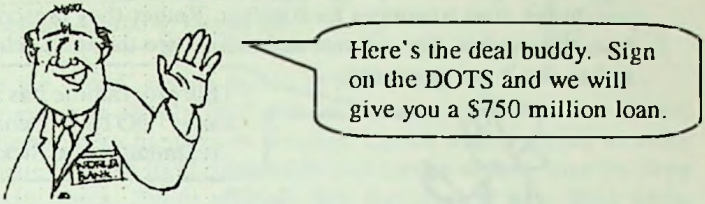
It is estimated that only 30% of potential open or sputum positive cases are being diagnosed as of now. That would mean that the cycle of transmission continues undiminished.

Eureka! I have found a new disease!

The Rediscovery of Tuberculosis

In the late nineties tuberculosis became a central issue again. One reason was a number of articles that started appearing abroad on the theme of tuberculosis - the global epidemic or as

the forgotten epidemic etc. The AIDS related TB increase was also a threat. In 1991, it regained priority within WHO as well. In 1997 the World Bank offered to give a loan of Rs 440 million dollars.



The WB was very insistent that they would fund only if the DOTS approach was followed. DOTS stands for - Directly Observed Treatment – Short course. It is also called the Revised National Tuberculosis Control Programme (RTCP). In contrast to the earlier programme there was little study or consultation before the new plan was drawn up. No studies were done on the effectiveness of these approaches. The major changes were:

a) The programme was limited to 105 districts - 41 in the first phase, 40 in the second phase, 24 in the third phase.
b) In these districts the treatment profile was standardized & there was a shift to a regime with higher dose, intermittent, with higher costs.
c) The heart of the strategy is to watch the patient consume the tablets. Apparently the presumption is that an Indian patient cannot be relied upon to take the drugs to save himself and only the DOTS approach can ensure this.

The implications of DOTS

There are a number of objections to the DOTS approach.

☞ The programme is limited to only a third of the districts. A high coverage in such a selective manner is not likely to slow down spread in other areas, and after this intensive phase in completed it will not prevent spread in this area either. Moreover, the rationale of choice of districts is the highest likelihood of showing a reduction. Therefore of the 105, 14 are from Kerala as compared to 16 from the 4 states of Rajasthan, UP, Bihar and MP put together! From Rajasthan there are only 3 districts and from Madhya Pradesh only 4 districts.

☞ The insistence of direct observation is leading to a number of cases – about 40% to 70 % - being thrown out of treatment. If the health staff find a patient unlikely to come regularly thrice a week they just do not start treatment for him/her. Rather they prescribe drugs from the market. The poorest and sickest are the least able to come and so don't get treatment.

This programme has an apt name: DOTS - Denial Of Treatment to the Sickest!

☞ The intermittent regime being followed for DOTS may be associated with a higher relapse. The evidence is not clear. What is clear however is that the chances of transmission are not less under this approach. Even if case detection and treatment is over 80% - and it is not – the spread would be the same as in the earlier approach.

Also remember: The DOTS drug course is a lot costlier!

Despite such reasons many people think it wrong to oppose the DOTS approach!

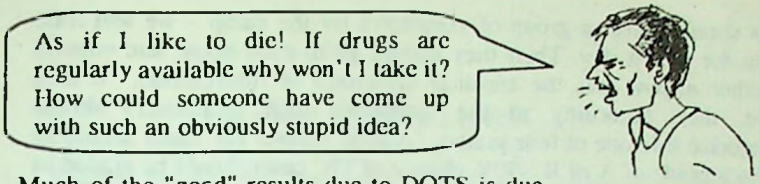
Why?

They argue that the DTP has failed and there are no funds. If the WB is giving funds for drugs, this will lessen some suffering, even if only for a limited number of districts. So why not?

But isn't the WB money a loan to be repaid? Why take a loan to do something so useless?

Exactly! Especially when there were alternative approaches possible! Approaches that can get more out of the basic DTP strategy if tried in a complementary manner.

Also, these alternative programmes are based on Indian experiences and Indian expertise – and so the results are likely to be much better. These approaches were open to discussion. They did not have to be pushed through a small section of the bureaucracy as DOTS has been done.

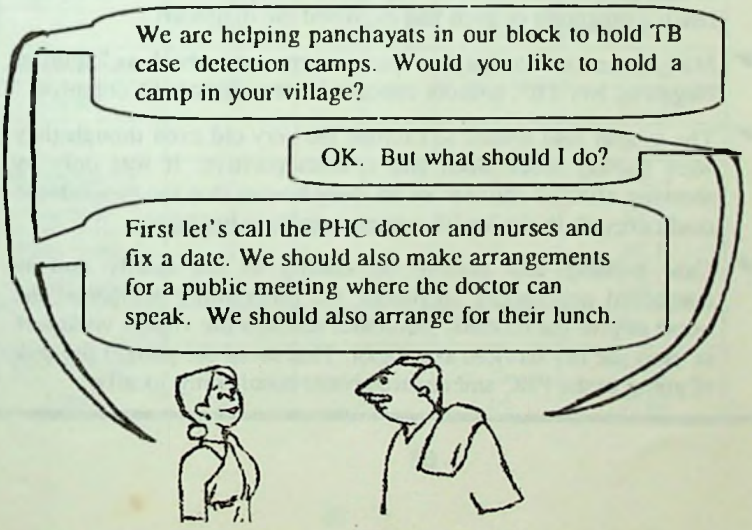


Much of the "good" results due to DOTS is due to the good drug supply (and the careful selection of cases). Direct observation seldom happens in practice. Health workers learn to make adjustments with the local community and leave a week or months' drug supply with them. Junior officials flex the rules at field level while maintaining the correct stance with officers. But policy makers attribute the success to their policy whereas in reality, the limited achievements are due to how people cope with policy! Had policy makers read the correct lesson the alternative approaches would have been obvious.

Alternative Approaches In Tuberculosis Control

Many NGOs have shown that it is possible to involve the community in case detection and case holding. Most of these approaches involve a public education programme, and the formation of organizational structures at the village to help in case detection and case retention. A referral linkage to a hospital equipped with a simple laboratory for sputum examination and where drugs are available free has been an essential component of most of these programmes.

Recently in Tamilnadu, in about 40 villages the TNSF tried an approach that was community centered and community led.



You should select a group of volunteers for the camp – we will train them for half a day. Then they should go to each house and enquire whether anyone has the cardinal symptoms of tuberculosis. If they have, then according to the symptoms these volunteers should categorize into one of four grades. 'Almost certain TB' cases should be given a grade of A or B, '50% chance of TB' cases should be graded as C and 'very unlikely but still needs to be confirmed' cases should be given a D grade.

On the camp day, they should ensure that all four groups come and test their sputum.

After the camp, the volunteers should ensure that the suspect cases receive further diagnostic follow up and that those diagnosed are initiated on treatment.

The Actual Experiences

- Follow up was a problem as some doctors were reluctant to diagnose cases in the public sector. They wanted patients attend their evening clinic. Some doctors were more conscientious. Some doctors refused to come to the camp and the suspect cases had to be taken to the PHC.
- The quality of sputum testing was poor. The District Tuberculosis Center only took a limited number of X-rays every day. A number of sick people died on follow up while the system still refused to reach a diagnosis or even had excluded the diagnosis.
- Many patients with blood in sputum were turned back as "Sputum Negative, Not TB", without concern for the alternative diagnosis.
- The system also tended to exclude the very old even though they were frankly tuberculous and sputum positive. It was only by showing affected children in all these houses that the programme could prevail on the health system to initiate treatment.
- Case holding was assured by talking to the family and to concerned neighbours. In places, the programme persuaded the nurse to give the monthly medicines through the village volunteer or even use her services as a depot. This saved the patient the task of going to the PHC and ensured better monitoring locally.

The Main Lessons Learnt...

1. Almost always the community, and quite often the elected panchayat are willing and active partners in controlling TB in their area.
2. The system built to tackle this disease, on the other hand, needs a lot of persistence before it responds. Left to itself it cannot deliver.
3. With persistent pressure from the people however, in most cases, the government system does respond.
4. Since there is no absolute lack of drugs or staff (in the TN situation) considerable changes can be made with such pressure alone!

Area Covered Under The DOTS Programme

State	Districts in year I	Districts in year II	Districts in year III	Population Covered (in Lakh)
AP	1	-	-	35.5
Assam	1	-	-	11.6
Bihar	2	5	-	211.6
Delhi	1	-	-	100.o
Gujarat	5	8	6	451.4
HP	3	3	6	68.5
Karnataka	2	4	1	198.2
Kerala	7	5	2	311.7
MP	1	1	2	26.0
Maharashtra	3	-	-	176.4
Manipur	1	-	-	10.0
Rajasthan	1	-	1	67.1
Tamilnadu	2	3	1	168.6
UP	2	2	-	96.4
West Bengal	6	7	5	642.0
Total	38	38	24	2710

Policy Recommendations and People's Initiatives For Tuberculosis Control

Blind adherence to foreign prescriptions, especially those that come with a loan attached are to be guarded against. Such programmes are donor driven. We have to create a situation where the government's health programme is people driven. The best way to do this is to mobilize people against tuberculosis. Detect thousands of symptomatic cases, and demand that the public health institutions treat them. Refuse to be thrown out by DOTS or similar strategies. Make our own collective arrangements to treat them if they don't. As a form of Satyagraha, one could do the camp inside the PHC premises!

Remember: The mobilization against tuberculosis has the potential to transform into a mobilization against the conditions that make tuberculosis so prevalent.

In the immediate efforts to relieve the suffering of tuberculosis there are only two mantras:

- Minimum resources - infrastructure, human-power and drugs - in the public sector with adequate access to these facilities.
- Community leadership at all levels of the programme. A people driven programme, where the public sector is kept under constant pressure to respond at utilize its resources optimally.

About the Jan Swasthya Sabha

Governments & international agencies have forgotten the goal of **Health for All by 2000 A.D.** But we, the people, cannot forget it. It is time to strengthen & expand people centered initiatives - to find innovative solutions & to put pressure on decision makers, governments and the private sector.

There is a need to reiterate that attaining **Health for All** means ensuring everyone has access to affordable quality medicare, safe drinking water and sanitation, adequate nutrition, clothing, shelter and employment and no one is discriminated against on the basis of class, caste, race or gender. People need to be made aware of the links between globalization and the worsening health of the people. When structural adjustment policies work to undermine the vision of Alma Ata, renewing the Health for All call is an imperative.

With this understanding a large number of people's movements across the country have jointly initiated a national campaign called the Jan Swasthya Sabha. This has three broad objectives:

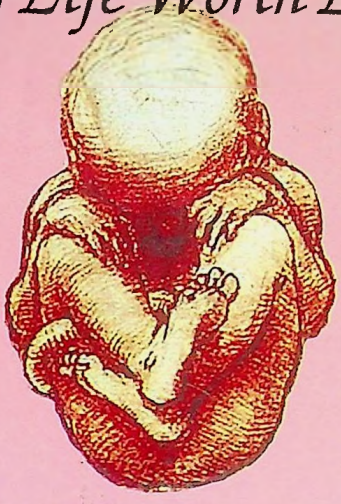
- To re-establish health and equitable development as top priorities in policy making with primary health care as the strategy.
- To forge a local, national and global unity of all democratic forces to work towards building long term sustainable solutions to health.
- Reinforce the principle of health as a broad inter-sectoral issue

The campaign has a four-tier structure. 2000-3000 blocks in 200-300 districts mobilize people on **Health For ALL – Now!** and conduct block level enquiries into the state of health services. These enquiries culminate in block seminars highlighting the findings & helping formulate people's initiatives for primary health care. Then, each district has a district level mobilization culminating in a District Seminar. All this builds up to the Jan Swasthya Sabha to be held in Calcutta from Nov 30th – Dec 1st 2000. Four trains with representatives from various parts of the country will arrive at the National Assembly. The Jan Swathya Sabha – with over 2000 representatives – will call for a reversal of structural adjustment policies and a renewal of the *Health for All* pledge. The assembly will also send its representatives to the international People's Health Assembly being held at Dhaka from Dec 4th-8th, 2000 where similar representatives from other countries will gather. Following the Jan Swasthya Sabha, each interested block or district follows up with health intervention and advocacy.

The Jan Swasthya Sabha is being coordinated by a National Coordination Committee consisting of 15 major all India networks of peoples movements and NGOs. This book is the second book in a 5 book series brought out by the NCC for guiding the block, district and state seminars.

Rs. 20.00

Making Life Worth Living!



Towards the People's Health Assembly Book—3

Making Life Worth Living !

Meeting the basic needs of all-Inter-sectoral issues in health care

Prepared and Published by
The National Coordination Committee
for the

Jan Swasthya Sabha

Towards the People's Health Assembly Book-3

Making Life Worth Living?

First Edition : May 2000

Authored and Published by :

National Coordination Committee, Jan Swasthya Sabha

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National Coordination Committee Members

- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- All India Women's Conference (AIWC)
- Bharat Gyan Vigyan Samithi (BGVS)
- Catholic Health Association of India (CHAI)
- Christian Medical Association of India (CMAI)
- Forum for Creche & Child Care Services (FORCES)
- Federation of Medical Representatives Associations of India (FMRAI)
- Joint Women's Programme (JWP)
- Medico Friends Circle (MFC)
- National Alliance of People's Movements (NAPM)
- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Ramakrishna Mission (RK)
- Society for Community Health Awareness, Research and Action (SOCHARA)
- Voluntary Health Association of India (VHAI)

Participating Organizations

Over 1000 organizations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Sabha campaign as participating organizations.

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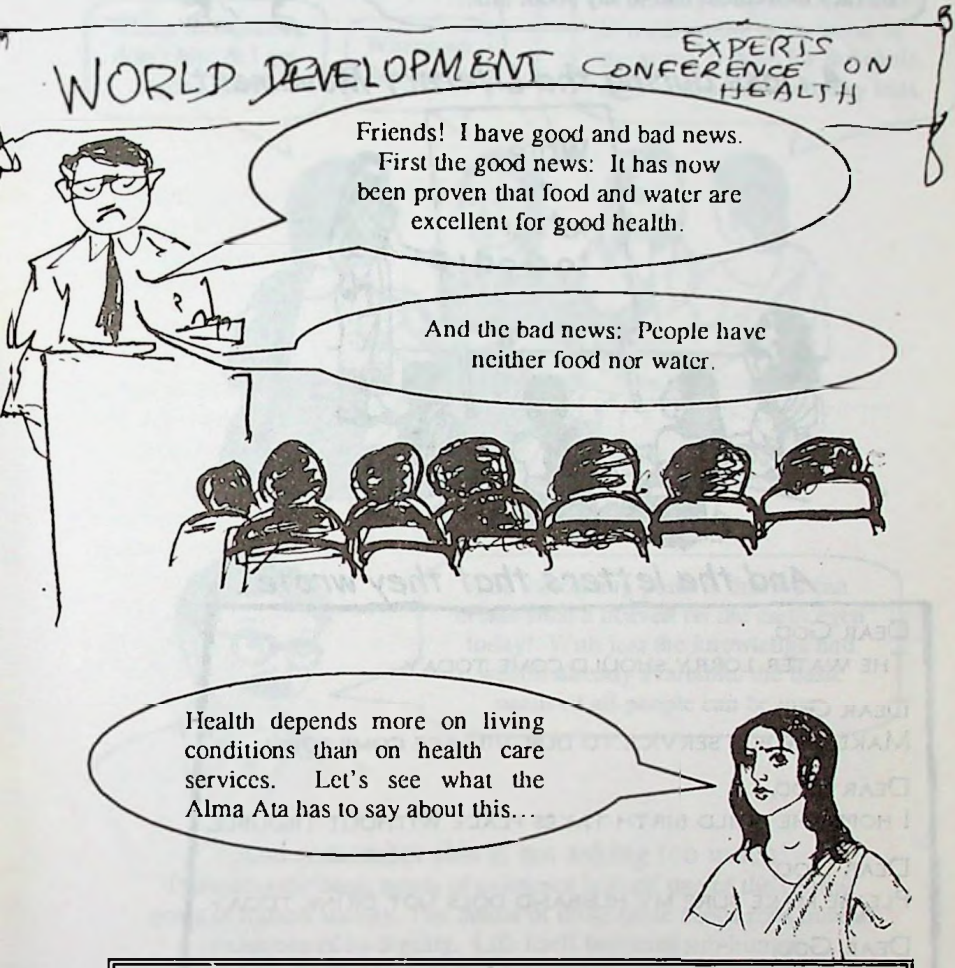
Health for All – Basic Needs for All



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

- Alma Ata Declaration, 1978

What do we need for a life with dignity? To ensure a life without drudgery? To lead a happy life? Let's see what poor women in the literacy movement had to say about this...

A class during the Literacy Movement

And the letters that they wrote...

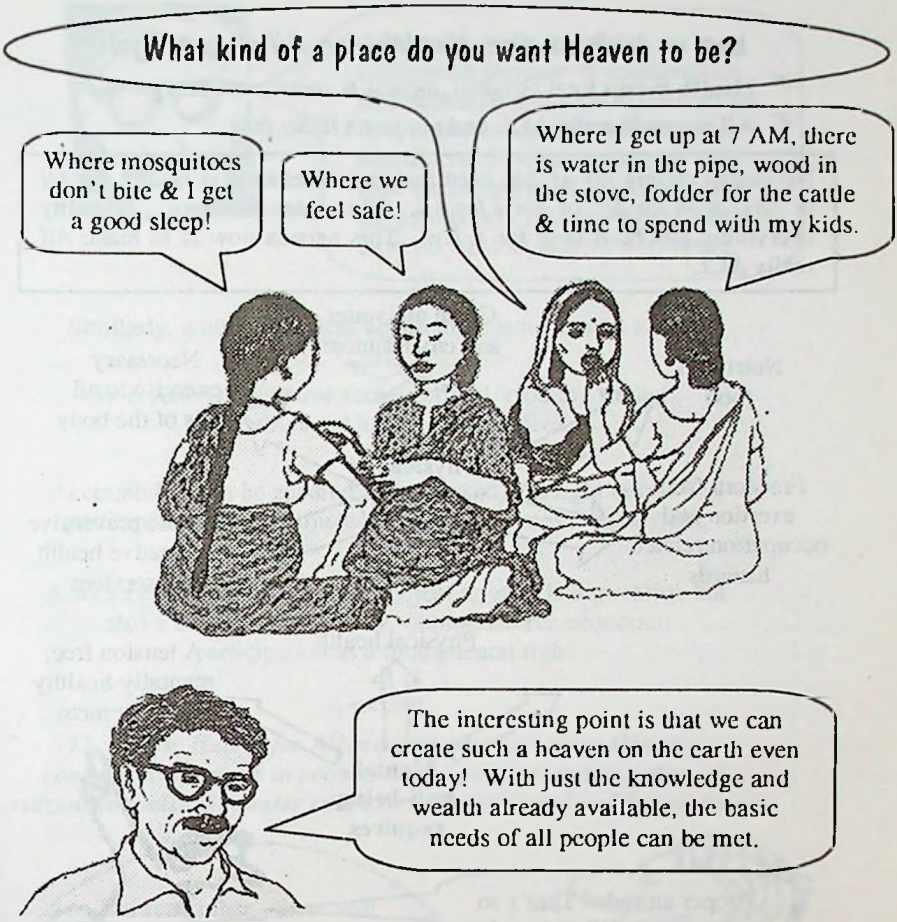
Dear God,
The water lorry should come today.

Dear God,
Make the bus service to our village come soon.

Dear God,
I hope the child birth takes place without trouble.

Dear God,
Please make sure my husband does not drink today.

Dear God,
I wish we get a fair price for the cocoons today in the market or else we cannot pay off the moneylender.



And remember this is not asking too much!

Providing the basic needs of existence is itself one of the central goals of human society. The denial of these basic needs robs human existence of its dignity. Life itself becomes sub-human.

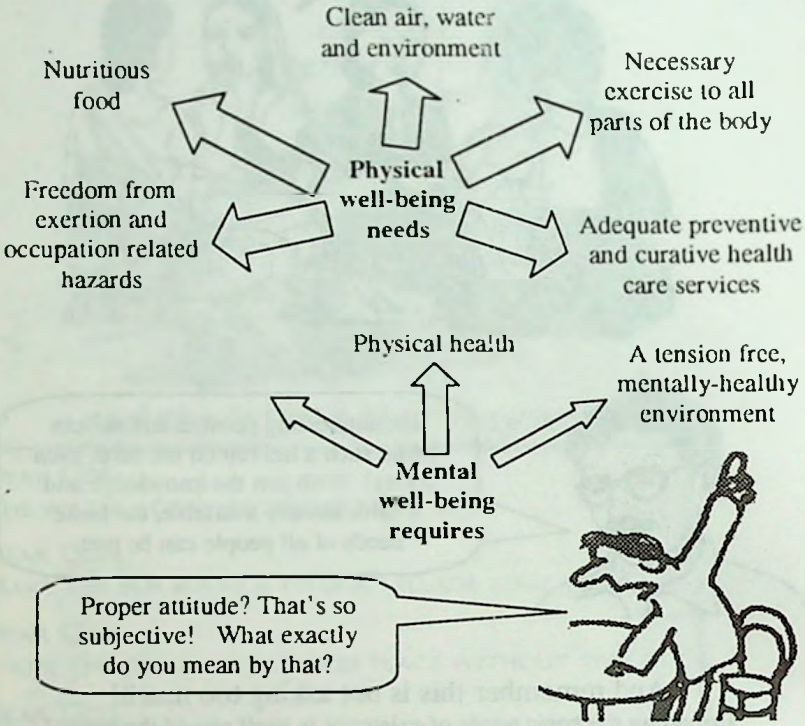
The Quality of Life

Health status is a measure of the quality of life of people. Where these basic necessities are available the quality of life can be said to be good and people are healthy. Where these are not available, the health situation is bad and life is a struggle.

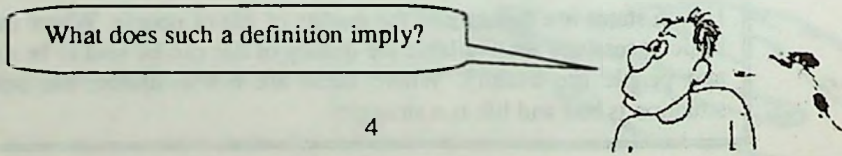
Let us look at the *Health for All* slogan again!

- **Health** means total physical, mental & social well-being.
- **All** means literally **ALL** and not just a lucky few.

No slogan ending *for All* has been realized, whether it is *Health for All* or *Education for All*, or *Food for All*. *All* remains a rhetoric. In reality everything has been only for a *few*. This agenda now is to make *All* really **ALL**!



By *Proper Attitude Towards Life* we mean "A proper understanding of human needs and their relationships, of basic needs like food, clothing & shelter; of emotional needs like affection & security; of social needs such as recognition." Without this mental well-being is not possible.



A society which demands a continuous increase of consumption and exchange of goods & services for its existence, a society which manufactures needs at a higher rate than the means to satisfy them, can have no proper understanding, can have no wisdom and no well being.

Similarly, without physical health there is no mental health.

⇩

Everyone should have access to food, clothing shelter, education and health care services.

⇩

Accessibility can be ensured and enforced as a right only when participation in economic activity too becomes a basic right.

⇩

A society with unemployment not just as an existing reality, but also a theoretical necessity, cannot enforce economic participation as a fundamental right.

⇩

Therefore, Health for All requires amongst other things a continuous increase in economic and political participation of citizens and also a counter education against greed and for wisdom.

But remember - these will not be provided by rulers and leaders of the present society! Their entire philosophy of existence is based on greed and competition.

And this is why we need to search for alternatives and the Jan Swasthya Sabha Campaign is an important attempt to further this search!

The Jan Swasthya Sabha Campaign Focus

The one year long national campaign preceding the People's Health Assembly at Dhaka, should be used as an opportunity to:

1. Raise the issue of genuine development
2. Question the wisdom of globalization, liberalization, privatization and consumerism

   To expose the complicity (both conscious and unconscious) of the minority (of less than 20%) in betraying the interests of ***All***.

The country has to re-charter its course in the interests of the majority. The Jan Swasthya Sabha Campaign should search and develop alternative paths of development and campaign for it. A campaign like this can be effective only when criticism is backed up by suggestions and actions – through which can flow people's creative energies.

The campaign should catalyze into action panchayats, voluntary organizations, people's movements, mass movements of workers, peasants, women, youth, students, professionals, artists etc.

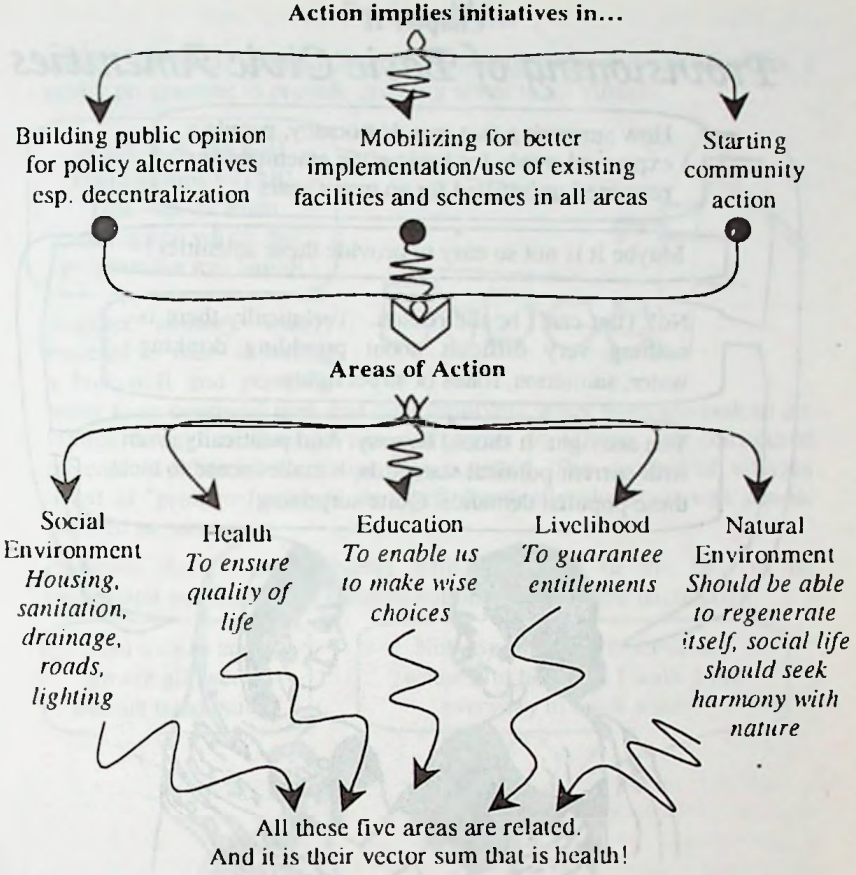
While criticism of state policy can be done at international, national and state levels, creative action has to be planned locally – in blocks, villages and panchayats. Seminars and workshops preceded by systematic enquiry and dialogue with the people can be held at these levels to generate possibilities for creative action.

Implementation campaigns for sanitation, safe drinking water, nutrition, basic amenities like housing and roads, education and livelihoods as well as interventions for preventive and curative health care can be effective only if planned and done at local levels.

The slogan '***Health For All Now!***' indicates that...

- We have been waiting with expectation that somebody will bring Health for All sometime in the future – say 2000 AD!
- We are disillusioned
- We are going to start acting *Now* for our health

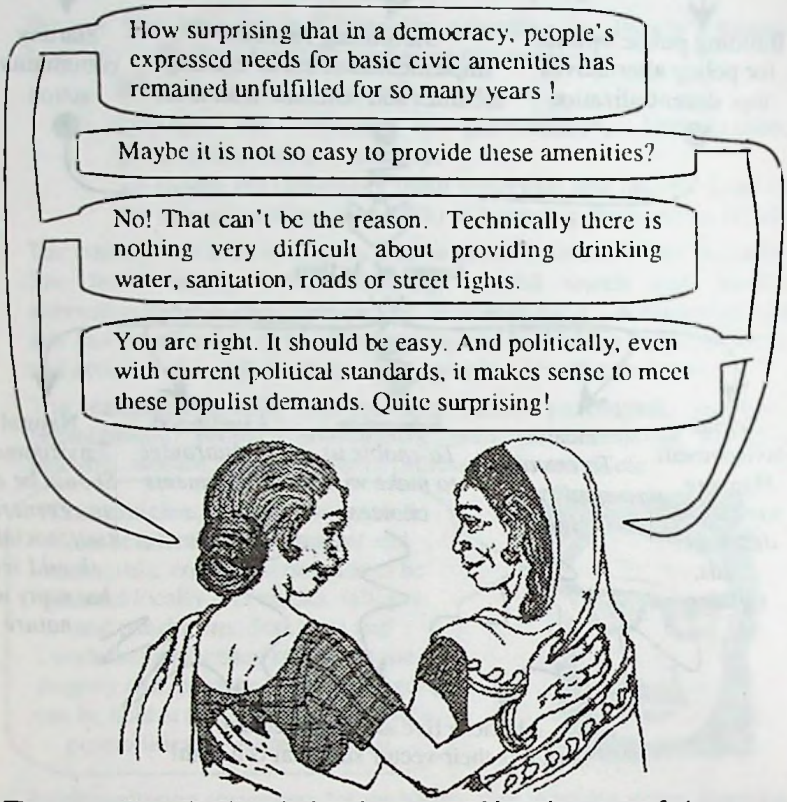
What does health action mean?



This book examines the crisis in providing these basic needs for a dignified life. It examines why despite needs like drinking water being a political demand, the government has been unable to deliver even these. It examines the impact of structural adjustment policies on the provisioning of these basic needs. This book presents some case studies of alternatives and discusses the nature of people's initiatives and policy changes that are needed to make the provision of basic needs for all a reality. Only then does health for all become a reality! Since the area to be covered is vast, we have not focused on a detailed critique of the existing situation. Rather, the focus is on a minimum understanding needed for us to initiate a dialogue with people and plan for alternatives.

Chapter II

Provisioning of Basic Civic Amenities

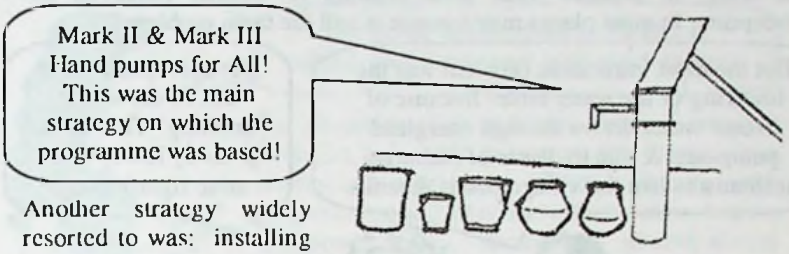


That providing livelihoods has been a problem because of the very unequal distribution of assets and skills as well as economic factors beyond the 'community's control seems plausible. Education and health care has had some effort at provisioning. Its quality is questionable – but at least something that can be called an education or a health care facility has been set up.

But what really makes no sense at all is how even simple civic amenities like drinking water or street lights – these simple basic amenities that every villager asks for and knows to ask for – are not yet provided for. Within a democracy, populist demands should have forced the state to fulfill these basic needs. But it has not yet happened.

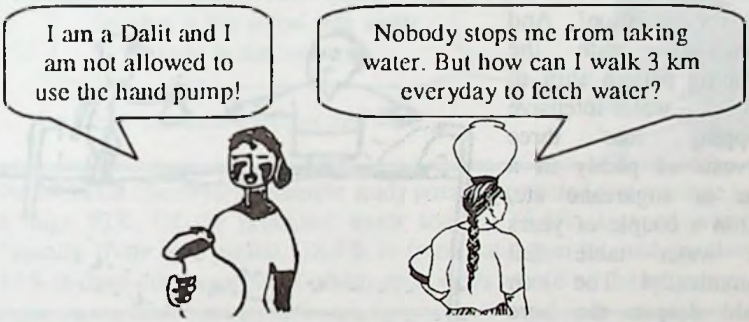
The why of this is what this chapter will look at through 3 examples – drinking water, sanitation and housing.

1980s: The Rajiv Gandhi National drinking water mission launches a major programme to provide drinking water to all villages.



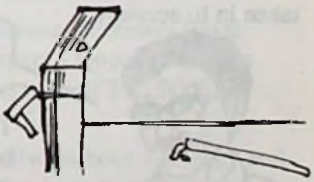
Another strategy widely resorted to was: installing a bore-well and pumping water to an overhead tank and then supplying water from the tank to the village through a stand post in each street. A village was considered covered if either of the above was installed. The number of villages listed as "problem villages" declined drastically and soon was almost reduced to zero.

However there were problems with this. One of the first to be recognized was that many hamlets within villages were uncovered.



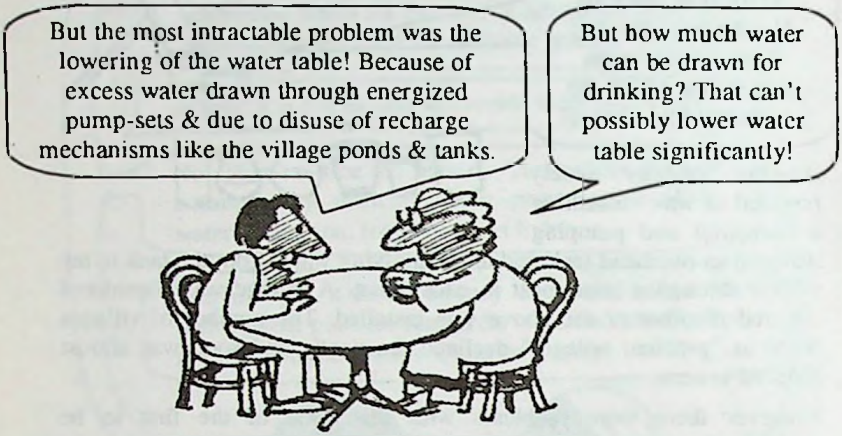
Disaggregated to hamlets, it was realized that a third of the hamlets were "not covered". The programme has since been addressing this and at present the number of habitations reported covered is in the range of 81%, with the corresponding figure for rural areas being 79% and for urban areas being 84%.

The second problem with the borewell strategy was the very common breakdown of the hand pump or mechanized pumping mechanism and the need to constantly repair it. To a large extent the Mark-III design was meant to overcome this. The

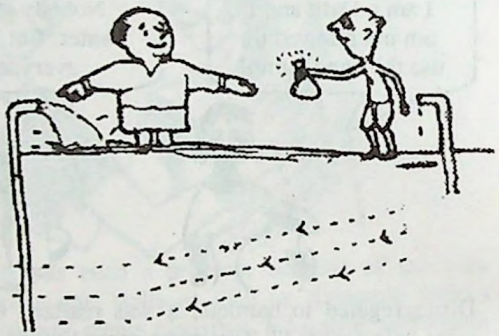


Who will repair the pump?

installation came along with training to the local community to repair it and with a tool kit as well. In many places like in Banda in UP women were trained to repair it. Though this was a good example of what could be done, in practice such local training of women remained an exception. In most places maintenance is still the main problem.



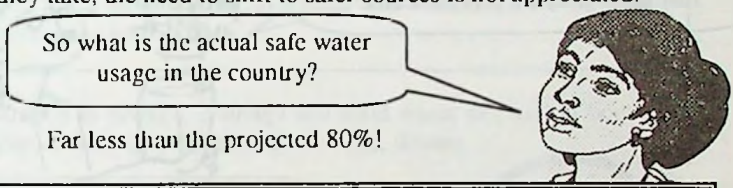
True – drinking water can't do much harm. But the excess water drawn was for irrigation! And particularly with the cropping pattern shift to more water-intensive cropping like three harvests of paddy in a year or sugarcane etc, within a couple of years the water table fell dramatically! The rich could deepen the bore wells, continued to draw long after the poor were deprived even of water for drinking! Obviously one needed an integrated planning and an equitable one, but such factors were never taken in to account.



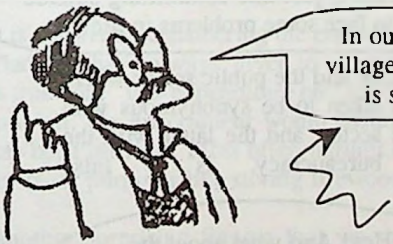
This is often because of iron which gives it a bad taste & colour. Sometimes it is fluorosis or arsenic – both dangerous. Both are also problems whose dimensions continue to

expand. As deeper & deeper groundwater sources are tapped, chemicals leaching out of rock formations contaminate the water. This was not a problem with surface water, but with groundwater it is and as water levels fall it will become more of a problem.

The advantage of groundwater sources extracted through a bore well is that mostly (though not always) it is safer water. Open wells are easily contaminated and all other surface water sources like ponds, tanks, streams are almost always contaminated. Of course, in many areas where ponds are the source of drinking water some ponds are earmarked for drinking & kept free from contamination due to washing, bathing & animals. Still, runoff contamination can't be prevented. However, in many villages where a tube well is installed & ground water is tolerable, surface water sources may still be preferred because of cultural factors. In the absence of adequate information on waterborne diseases & the toll they take, the need to shift to safer sources is not appreciated.



An NCAER countrywide sample study puts unprotected water usage at a huge 52%. Of the protected water sources 16.6% is piped water (usually from bore wells), 18.4% is from hand pumps, and another 13% is from other sources of which open wells would be the majority.



N. C. Saxena, Secretary Rural Development - Quoted in Indian Express, April 26th, 2000.

That this is the situation in a problem that has always been a priority and a problem for which sufficient political will has been there is indeed a sad commentary on the governance of the nation.

SAP and Drinking Water

Structural adjustment of course does not concern itself with issues like drinking water. Indeed drinking water has never been a major concern of such economists. However, as government expenditure is curtailed under SAP, the provision of such services is also curtailed. There is also considerable speculation amongst pro-SAP policy makers on the possibilities of privatizing drinking water supply.

The government has failed to provide drinking water. What's wrong with privatizing it?

This is a ridiculous argument! Why? Because...

1. Even in countries where water supply was privatized, there are considerable complaints of high prices, poor service & poor quality.
2. In a poor country like ours the idea that majority of people will have to pay for drinking water is just not acceptable.

I'm providing safe drinking water. Just leave it to the private sector!

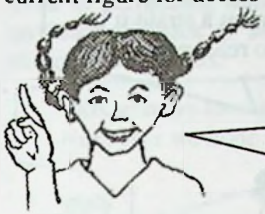
What we need to examine is how government schemes should function, not whether they should function at all! This is just like committing suicide because one has to face some problems in life!

This dichotomy - between the private sector and the public sector where the former is taken to be synonymous with the corporate sector, and the latter with the centralized bureaucracy, is a false dichotomy.

Hey! And what about the People's sector – control by local communities?

Sanitation

The track record in sanitation is dismal and has always been so. The current figure for access to latrines is estimated at 29%.



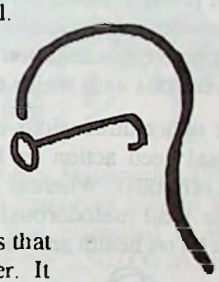
And this generous estimate counts everyone who lives in a habitation with a community latrine as having access – though in practice none of the latrines may be functional!

This also explains why according to these figures 70% of urban India is stated to have an access to sanitation. It counts every latrine built as being used, though this is far from true. Even with such fantastic over-estimation techniques, rural India sanitation coverage is a dismal 14% !

Even with such an over-estimation we are one of the poorest achievers on the sanitation front in the world. Thus even an impoverished Sub Saharan African country like Kenya has 81% coverage, Tanzania has 86%, Nigeria has 41% and Uganda has 57%. Even neighboring Sri Lanka and Pakistan have 63% and 56% coverage respectively.

The situation in sewage, drainage and solid waste disposal in both rural and urban areas is also equally, if not more, dismal.

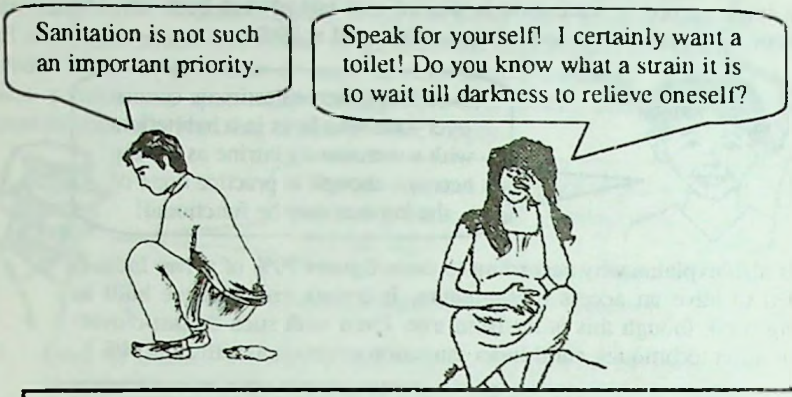
Imagine! And in a country where I once fought for sanitation as an important component of the freedom struggle!



It is surprising considering the consistent emphasis that Planners have always given to sanitation on paper. It is true that the expenditure on sanitation has been low but, the government would assure you, even this much utilization has been difficult. Most often latrines built are just not used or are used for other purposes like storing firewood.

Another surprising finding that we should read along with these very same figures is the consistent way surveys especially in the last decades have shown a fairly high awareness and demand for sanitary facilities. This is much more so amongst women for whom sanitation is closely

linked to the whole question of personal dignity. With declining scrub cover, privacy becomes such a problem.



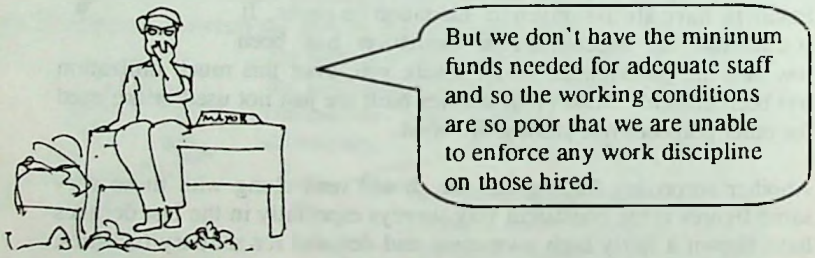
Tick the correct answer!

Which of the following is most closely related to sanitation demand?

(a) Per Capita Income
(b) Poverty
(c) Health Status
(d) Education

If you guessed Education – you are right! Education and the consequent changes in perception amongst women have also made sanitation an urgent priority, more so in semi-urban areas and large villages and areas where women's education is higher. As we compare across states the performance in sanitation is most related to education and the nature of interventions with which the problem has been addressed.

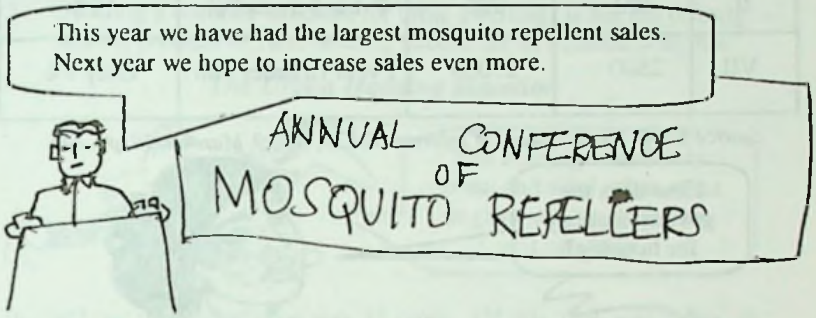
Other major dimensions like wastewater and solid waste collection and disposal need action by local bodies (both elected representatives and local officials). Whereas in urban areas this presents an enormous and visible (and malodorous) problem, even in rural areas it is a problem that tells on health and the quality of life.



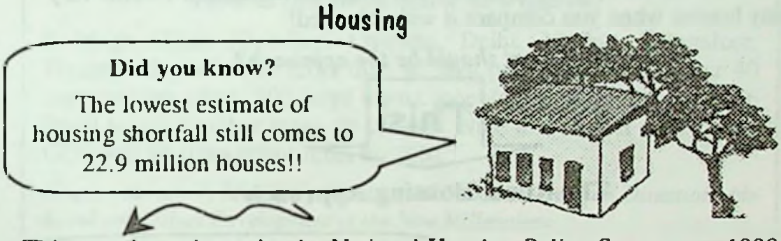
At least in urban areas, it's someone's job.
In most rural areas it is no one's agenda !

SAP and Sanitation

Sanitation is one of the least discussed sectors in the economic reforms literature. Obviously it is just not their concern. There is little interest even in privatizing sanitation, except in larger urban municipalities. If anything the lack of sanitation provides a multi-crore industry - like mosquito repellents!



Not surprising therefore, that sanitation is that one sector which all state & central governments allocate to local elected bodies - with almost no funds for the purpose! And as government funds are further curtailed, local bodies are told to raise their own resources!



This was the estimate by the National Housing Policy Statement - 1998 and is based on the 1991 census. The minimum resources needed for completing this task in the Ninth plan period was estimated at Rs. 1,51,000 crore! Urban infrastructure will need a further 2,50,000 crore.

During the initial years of planning in India, the level of confidence in effective government intervention in housing was high. But budget allocations did not match up to dreams.

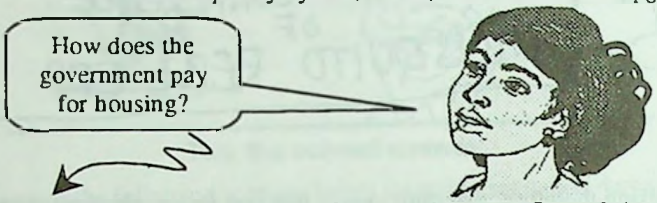
The falling budget outlay for housing ...

	II Plan	V Plan	VIII Plan
% of Total Budget	2.5%	1.5%	1.47%

Private investment in housing has also not kept pace, though the ratio of private to public investment has shifted in favor of the private sector.

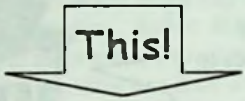
PLAN	Public Investment	Private Investment	How much larger is Pvt?	% of Total Investment
II	300	900	Pvt is 3 times Pub	19%
VII	2500	29000	Pvt is 10 times Pub	Only 9%

Source EPW: Social impact of reforms, Vol 35, No.10, March 4-10, pg. 845



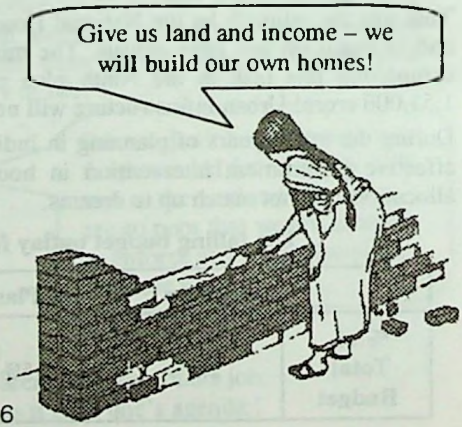
Through a number of central and state schemes. One of the largest central schemes specifically directed to the economically weaker sections is the Indira Awas Yojana. State housing schemes come under the minimum needs programmes. But these schemes don't build very many houses when you compare it with the need!

Then what should be the approach?



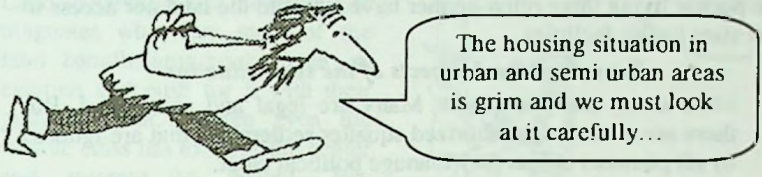
The Rural Housing Approach

1. In rural areas where land is more easily available, a traditional structure using local materials can be built by the family itself. If there is a demand for a better all-weather construction, and they have the income most families will suitably upgrade their homes.



2. The approach should be seen as
    a. Providing land
    b. Helping the rural households to upgrade their existing dwelling units periodically
    c. Ensuring minimum wages and employment
    d. Enabling access to credit at reasonable rates.
3. Building a concrete structure for these dwellings is not the priority and the problem of rural housing should not be equated with this.

The Urban Housing Situation



In 1947 our total population was 33 crore. Of this 14% was urban. In 2001, urbanites form 33% of the population. That means there are 33 crore of them - the same as the entire population at independence! By 2025, the urban population will cross the 50 percent mark.

How is this population distributed?

6 Mega Cities (Bombay, Calcutta, Delhi, Madras, Bangalore, Hyderabad) each have more than 40 lakh people each. Another 40 metropolitan cities, 300 large towns (population > 1lakh) and 3396 small towns together make up the rest. Note that almost 60% of the GDP will be from urban India by 2001.

Source: Suresh V, Managing Director HUDCO, Address on Directions for Rural and Urban Development in the New Millennium.

Urbanites !

84% have at least partial access to potable water.

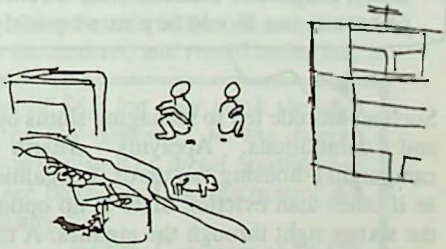
Only 46% have access to sewerage and sanitation services.

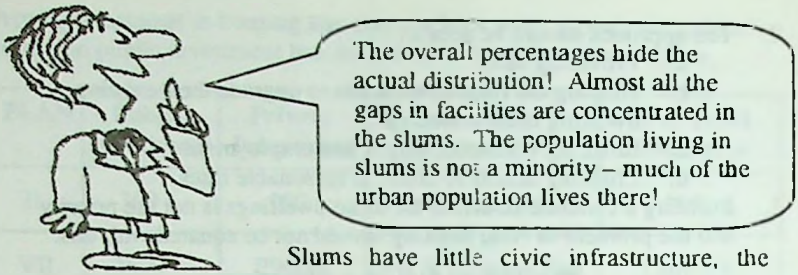
31% have no access to latrines.

28% have no access of any sort of waste collection.

One fourth have no electricity.

Pollution and an unhealthy environment affect most urban areas.

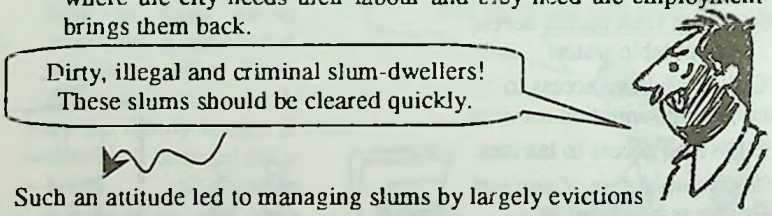




Slums have little civic infrastructure, the most rudimentary (informal) housing, and the people living there often neither have rights to the land nor access to any state health facilities.

Recognize the 3 aspects of the slum situation

1. Most slums are not illegal. Many are legal and recognized. But there are also many authorized squatter settlements that are ignored by all planners unless they manage political clout.
2. Many slums that are legal today started illegally and through a long struggle gained the right to live in security and dignity. Often this was gained through long negotiations with politicians.
3. Even in the worst of such settlements and even on pavements community structures & bonds emerge. These communities build their own homes and play an important part in the economy and their location is often important for this role. Even if removed, this relationship - where the city needs their labour and they need the employment - brings them back.



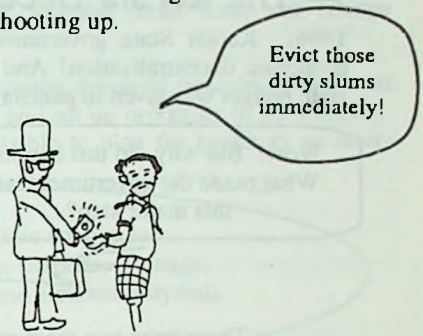
Such an attitude led to managing slums by largely evictions and demolitions. Applying criteria of aesthetics (beautifying campaigns), housing standards & legalities these settlements are treated as if other than eviction there is no option. This was the main trend in the sixties right through the eighties. A number of states in the 1982-84 period passed anti-encroachment legislation presumably to check

unauthorized construction by commercial interests but given the nature of power was more used against the poor. By changing trespass from a civil to a criminal offense the law criminalized millions of people and exposed them to further exploitation and harassment.

Greed – An ugly side of 'Aesthetic' Evictions

Selective development of infrastructure and location of government and commercial offices lead to land prices shooting up.

Land speculators and the real estate magnates who own most of the land benefit immensely from an eviction and push for it with their political clout. Often even the middle class has to leave the center and migrate to distant, low infrastructure suburbs to survive.



Effects of SAP on the Housing Situation

The National Campaign for Housing Rights states that the accelerated unemployment that accompanies SAP, especially when coupled with sharply rising prices, the impact of cuts in subsidies on social services such as health, the impact of privatization and abrogation by the State of its responsibilities in planning leads to further increases in land and housing prices, including a sharp increase in the forced criminalization of the poor and an increasing eviction and demolition by private and public landlords in order to reclaim the land for more profitable uses.

The entire process of structural adjustment is only going to worsen these trends.

The Urban Land Ceiling Act of 1976 was the only progressive piece of legislation on urban housing that the government had enacted. Now it has also been repealed to allow "market forces to act". The truth is that like the rural land ceiling act this was never implemented and almost no land was anywhere confiscated or surrendered and resold under this act.

"These are not conditionalities of SAP but they mark the shift from the populist socialism of the Seventies to the brazen marketism of the nineties. The very vision of social housing has been lost. Housing is no longer considered an instrument for bringing about redistributive justice."

- Jai Sen, Convener of NCHR

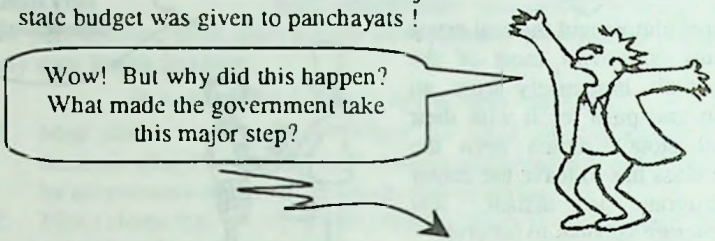
Chapter III

Learning from Success

Case Studies

1. The Kerala Decentralization Experience

1996: Kerala State government goes in for a major political and economic decentralization! And not just in name - 40% of the entire state budget was given to panchayats !

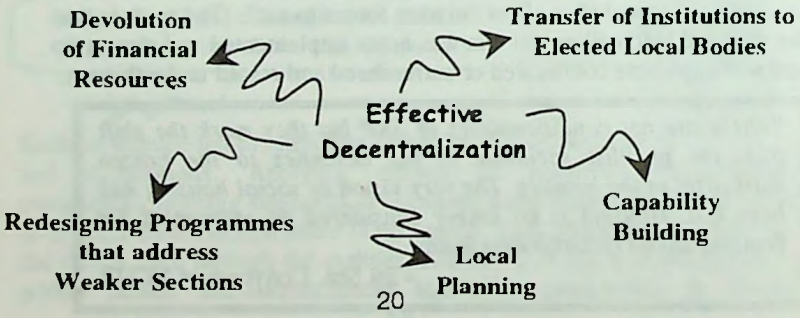


There were two main roots to this radical experiment.

One was within the ruling party itself. There was a need to find a way wherein the government could respond to people's expectations despite being limited to ruling only a state government and despite the inability to make radical changes in assets or income distribution or even in raising resources from the rich.

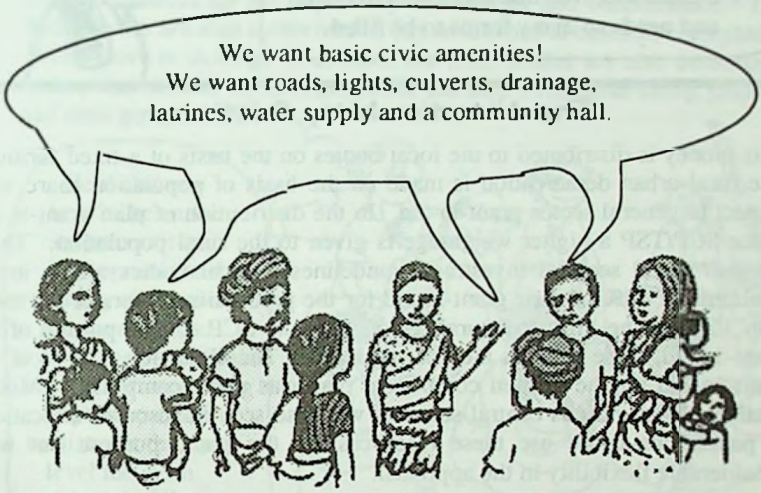
The second reason was a growing intellectual commitment to decentralization as an inherent value, as essential to participatory democracy and to empowering people. Characterizing this latter trend was the KSSP's sustained campaign for decentralization and its active initiatives to promote this goal.

Essential Components for Effective Decentralization



In most states, the government sees the provisioning of these basic amenities as the panchayat's major – often only – function. But the panchayat neither has the funds nor the freedom to plan for their provision. In Kerala, both these prerequisites were provided to the panchayats. But the Kerala decentralization experiment went far beyond this to cover health and education sectors, rural development, poverty alleviation programmes, women's development and welfare programmes, agriculture, irrigation and the small scale and cottage industry sections.

In each of these sectors, decentralization devolved finances, transferred institutions, built local capabilities and set up processes to plan locally. Thus, for the first time, it was possible to plan for health in an inter-sectoral manner.

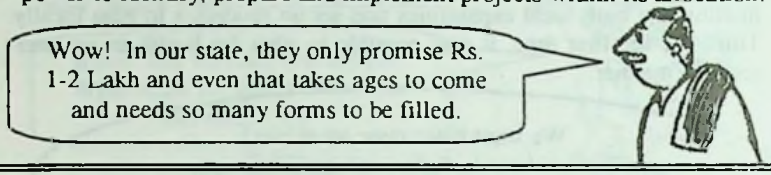


In the first year, the panchayats were only partially effective as they were just learning the system and contending with resistance from established interests at every level. But as the years passed the situation improved. Many of the basic amenities that had remained as demands for over 50 years were achieved in the first few years of this change.

Devolving Funds

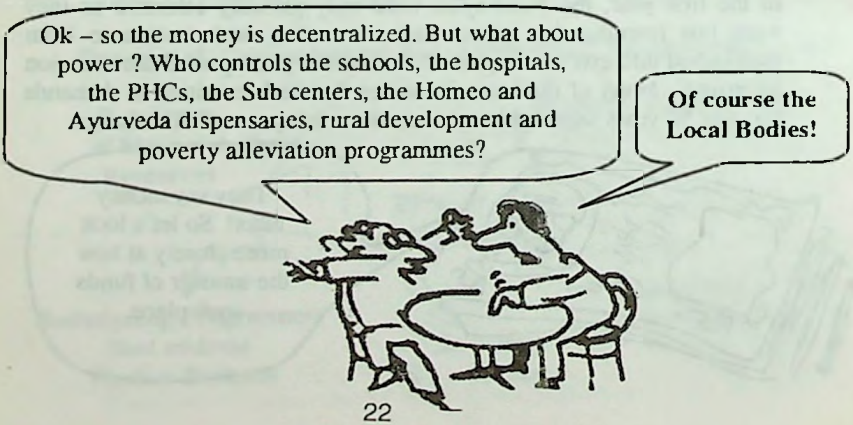
A political decision was reached to **devolve 40% of the state budget** to panchayats. The total devolution to local bodies was Rs.1025-Crore in 1997-98, Rs.1178 Crore in 1998-99 and Rs.1250 Crore in 1999-2000.

On an average, each Gram Panchayat receives Rs.60 Lakh, a Block Panchayat Rs. 90 Lakh and the District Panchayat Rs. 10 Crore every year as plan grant-in-aid. Each Municipality gets around Rs. 1 Crore and a Corporation Rs. 15 Crore. The respective local body has the power to identify, prepare and implement projects within its allocation.



The Allocation Nitty Gritties...

This money is distributed to the local bodies on the basis of a fixed formula. The rural-urban demarcation is made on the basis of population share with respect to general sector grant-in-aid. In the distribution of plan grant-in-aid under SCP/TSP a higher weightage is given to the rural population. There are also broad sectoral investment guidelines. Local bodies are to invest minimum of 40% of their grant-in-aid for the productive sectors & not more than 30% for the infra-structural sector. For the SCP & TSP portion of the grant–in-aid, these ceilings are not applicable. The allocation of 10% of the grant–in–aid for the women component plan was made compulsory. Money available from various central schemes was also seen as resource allocations & panchayats could use these resources for the stated purpose but with considerable flexibility in the approach.

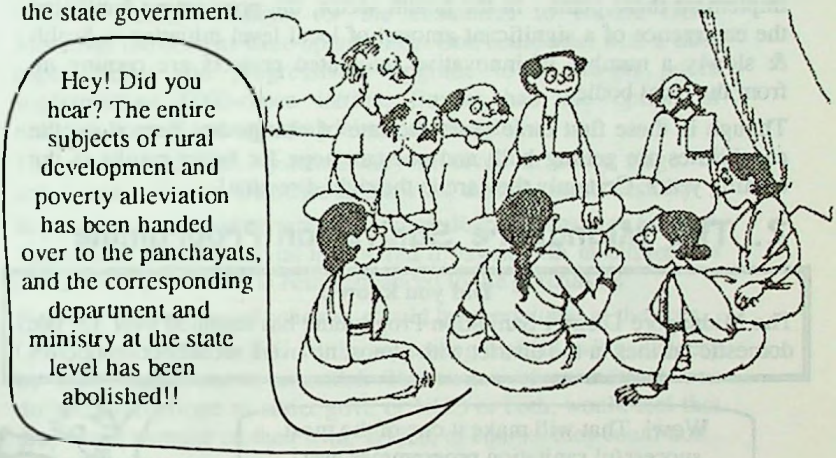


Transferring Institutions

All the staff members including medical officers have been transferred to the local bodies. The state government on behalf of the local bodies manages the appointment, promotion, transfer and salaries. The local bodies have been given all the financial and administrative control of these health institutions. The state government has only technical control over these institutions through the concerned department.

Medicines and instruments are purchased centrally and distributed to the institutions through the District Medical Officers based on the information submitted by the medical officers.

In addition to the plan grant-in-aid, the department provides to the local bodies, finances for the day-to-day functioning and maintenance. The local bodies are also authorized to buy medicines in cases of emergency. When there is shortage of doctors, the local bodies are also authorized to appoint doctors on contract basis, the salary for them being paid by the state government.



Building Capabilities and Local Level Planning

Local Planning requires identification of local priorities and ways to address these priorities. There is also a need to redesign programmes that address weaker sections – to make them more effective. Most ongoing government schemes are flawed in design, being more appropriate for a centrally driven, fragmented approach with a standardized choice of technology, than for a decentralized plan. Often current schemes are only demonstrative with no real chance of success. Adopting these programmes without redesigning them will not help improve their efficiency.

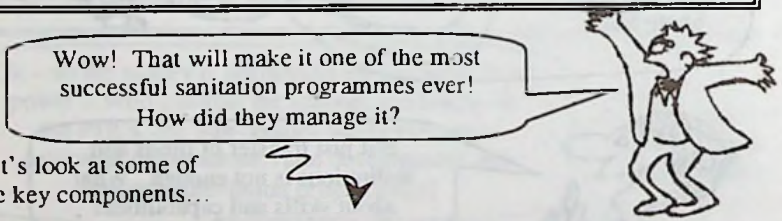
People's Campaign for Ninth Plan has brought in a sense of need for community involvement in development activities. A systematic and very extensive training programme preceding the planning process helped to build capabilities to undertake planning. Helped by the officials in the line departments and organizations like the KSSP, the panchayats drew up cost estimates and designs and proceeded to implement these plans. In the health sector, the programme facilitated the emergence of a significant amount of local level initiative in health & slowly a number of innovative integrated projects are coming up from the local bodies.

Though in these first three years the rate of change has been slow, the capabilities are getting built and one can hope for better results in the coming years. Certainly they are in the right direction!

2. The Midnapore Sanitation Programme

Did you know ?

The Midnapore District Sanitation Programme has installed over 1.5 lakh domestic latrines in the district with almost no overt subsidy component!!



1. There was a partnership between the district administration, the elected panchayats and an NGO - the Ramakrishna Mission.
2. The programme followed the massive mobilization of the total literacy campaign in Midnapore district and this programme itself had a major mobilizational and educational component. Indeed this "IEC" was the main activity the government concentrated on.

3. The delivery of the latrine was organized through the sanitary mart concept. The sanitary mart supplied building material and all components of the latrine as well as all components of domestic sanitation with a little mark-up so that all the components were easily available at affordable prices. Production of the prefabricated components in a production center and running the sanitary mart was developed as a way of providing employment for local youth. These youth were trained and provided some capital and support for the first year. Installation was by locally trained masons. The employment generated by the programme was high. It is important to note that generally the production center, the sanitary mart and the masons were independent enterprises but networked together so that they provided employment for each other.
4. There was no subsidy at all. If some money was available for this purpose, that would be distributed to all customers by subsidizing the pan and trap or some such strategy.
5. There was considerable flexibility in latrine design and rates. There were 8 standard designs for the customers to choose from. Moreover the designs were up gradable. One could start with a 600-rupee latrine and progressively upgrade to a two-pit pucca superstructure 6000-rupee latrine. Buyers had the option of reducing costs by contributing labour or material.
6. The panchayats were systematically involved at every stage. In some areas, they ran the marts themselves, though unsuccessfully.
7. Replication of the programme in other districts was not as easy. Substantial working capital is required if payment in instalments is considered, or if credit is being advanced to the purchasers.
8. No other subsidy-based schemes should be operational in the area.
9. Govt. cooperation in IEC while supporting and allowing delivery by local enterprises is essential. The notion of partnership was difficult to replicate as either govt. or NGO or both, would feel that they could manage on their own. Which, of course, they could not!

The main achievements...

Demonstrating that through a flexible programme which involves the local community, a sustainable, no-subsidy programme on sanitation is possible. Whereas earlier programmes stopped once the subsidy was used up, this programme continued to grow. This programme also generated employment for hundreds (masons, production centers, mart managers etc.) & helped the local economy. This rural employment occurred by opening up & tapping a major rural market built around people's genuine needs, thereby increasing the quality of life.

3. The Site and Service Route

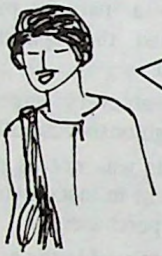
The Bilaspur Asha Abhiyan and other Slum Development/Resettlement programmes

The poor living in slums make an essential economic contribution to the city. They have more than earned their right to secure and dignified living conditions.

How to ensure this happens?

Follow these nine steps to realize Heaven on Earth...

1. Create an institutional structure, usually a registered society, with all families represented and an adequate gender mix.

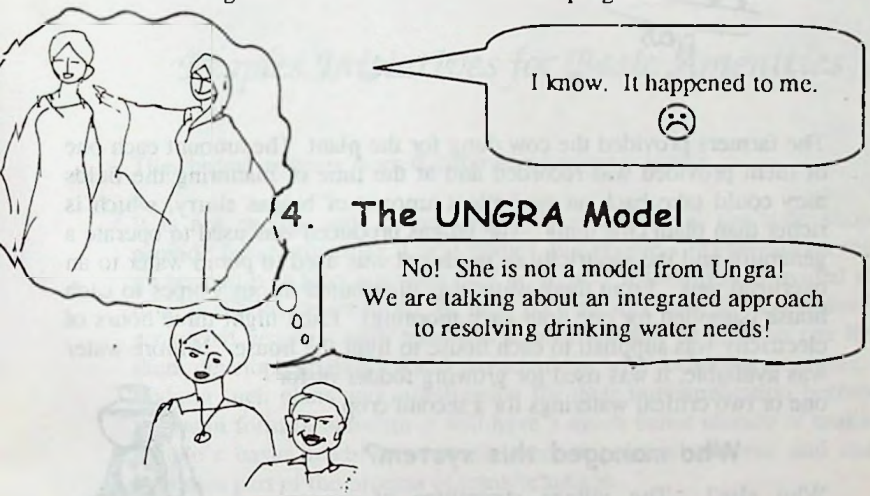


Be careful and identify the REAL residents. Slumlords control most of the land. They are thrice offenders – (1) they have illegally occupied land, (2) they have illegally let it out and collect a rent from what is not theirs and (3) they evict tenants at will for extraction of rent or favour!

2. In any resettlement, give rights only to the real residents and not to benami persons or else the control remains with the slumlords. This is critical - as the slumlords have political and criminal connections.
3. Offer to legalize all the current residents' ownership of land allocating a minimum for each. In return they plan out amongst themselves a way to resettle/relocate their houses in the same space so that everyone gets the minimum space plus proper sewage, waterlines, roads and a playground.
4. The expense for building their house is their own. The government can help with credit given through the same society.
5. The design of both the habitat and individual houses is not directed from outside. Sensitive architects can help people make a good choice. (This has been seen in other programmes like the Mahila Milan programme where 600 pavement dwelling women drew up their own designs.)

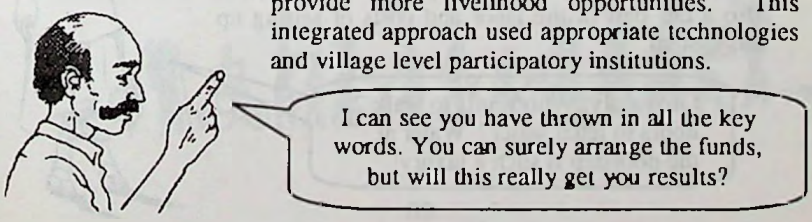
6. Once the construction starts, the families shift as required, till the basic realignment of houses is achieved.
7. The municipality comes in now to lay the sewer, water and electricity lines.
8. After this, other supportive activities like continuing and vocational education programmes, health care, daycare centers for children etc can also be organized so that in a phased manner and under their own guidance they win the basic necessities of a life with dignity and security.

The two critical steps in this is building and sustaining the institutional arrangement at the local level and the granting of land rights to the residents excluding the slumlords who are not resident there. Often enough, this process of excluding the slumlords from the process gets the initiating official transferred out and the programme is scuttled!



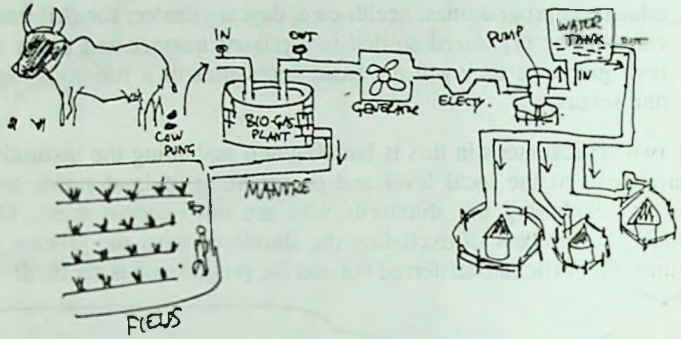
4. The UNGRA Model

Once upon a time, the village of Ungra in southern Karnataka had a severe drinking water problem. Then they came upon a novel idea – an idea that could solve their drinking water problem and at the same time provide more livelihood opportunities. This integrated approach used appropriate technologies and village level participatory institutions.



In this case it was not merely empty words - they meant something... and it did produce results!

It all started with a biogas plant...



The farmers provided the cow dung for the plant. The amount each one of them provided was recorded and at the time of manuring the fields they could take back an equivalent amount of biogas slurry, which is richer than plain cow dung. The biogas produced was used to operate a generator and the electricity so produced was used to pump water to an overhead tank. From there water was distributed through pipes to each house (supplied for one hour each morning). Each night three hours of electricity was supplied to each house to light the house. If more water was available, it was used for growing fodder or for one or two critical waterings for a second crop.

Who managed this system?

Who else? The village committee of course! Outside management just would not have worked. The village committee employed one person to maintain the whole system. In subsequent villages, the village not only offered to provide the land, but also a fair part of the labor and costs of setting up this system.

Obviously! Who wants to walk 2 hours to fetch water? Water at the doorstep is such a luxury!

How does this impact on health?

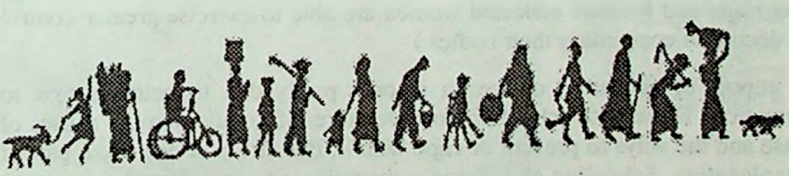
If women are saved from the drudgery of collecting water, fodder and fuel by such collective arrangements, the gain to women and child health is considerable. Indeed, no other single factor contributes as much to child health in a poor household as the availability of the mother's time for childcare, and as much to women's health as the relief from the drudgery and exertion of her daily routine!

In this model we see many of the elements of the alternatives that we had outlined in the previous chapter.

Peoples Initiatives for Basic Amenities

The central message from the above experiences is this...

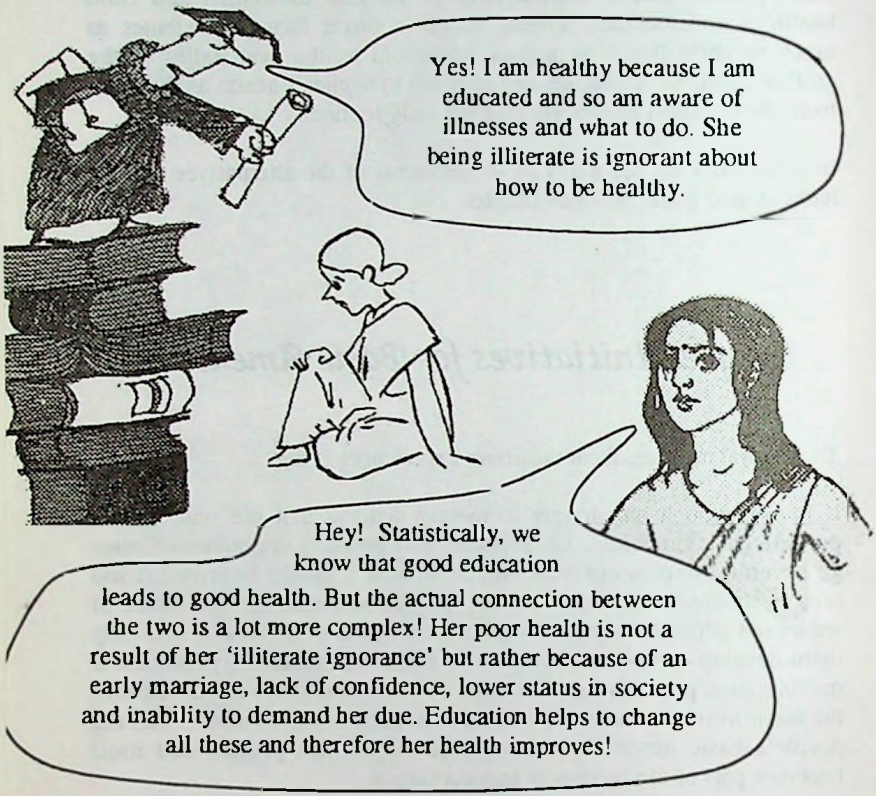
It is not enough any longer to merely demand that the state should provide basic amenities. Local bodies and people's organizations must go beyond it to plan out what they need, how it should be provided and how it should be financed. In this, they should take the assistance of sensitized activists with technical knowledge and skills who can help them develop capabilities and provide them with technology choices. If making such plans and mobilization for their implementation becomes the main form of activism it will have a much better chance of making people's basic needs the central issue of political process and itself becomes part of the process of transformation.



Chapter IV

Basic Education

Societies where schooling is universal have much better indices of health than societies with large illiterate populations.



Most Studies have shown that with number of years of schooling there is a proportional reduction in infant mortality. The impact is most on women and child health and on fertility control. (Possibly because of an increase in the age of marriage and because educated women are able to exercise greater control over decisions concerning their bodies.)

The impact of education on health is only partly due to better access to information. Those with schooling do have more information on the causes of disease and the ways to prevent or cope with it. But this is only a small part of the explanation. Schooling also changes the attitude to oneself and the natural and social environment. The ability to respond to health problems and to seek to change circumstances that lead to ill health, instead of accepting it as part of a natural order of things (or as one's fate) is enhanced by schooling.

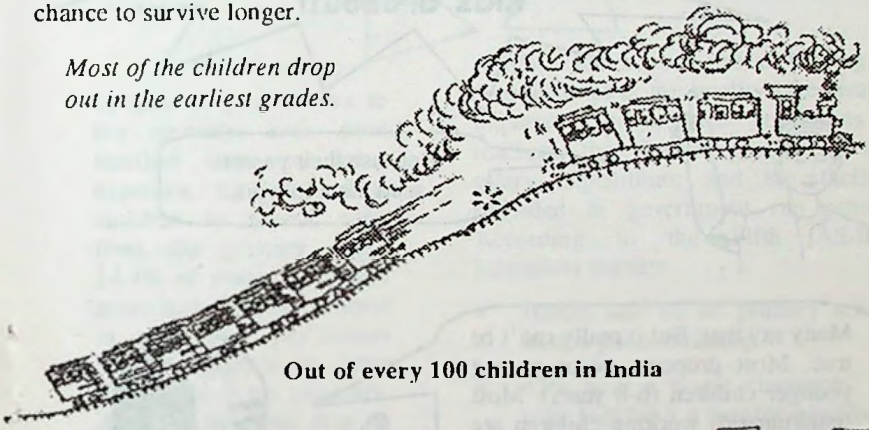
Irrespective of how exactly schooling acts to enhance health, the fact that it does so is undeniable. Moreover in its own right the universal elementary education is a goal for any modern society.

The current crisis in schooling

Access to schooling has no doubt increased considerably over the last five decades. The number of villages without schools is now a relatively small minority. However this does not by itself mean that the goals of universal elementary education has been met. Not even universal primary education is anywhere near achievement. The central problems in school education now are the problems of dropouts and of attainment.

Any discussion on education in India needs to confront the distressing feature of very high dropout rates during the initial years of schooling. The inability of the system to retain children has been the major stumbling block in providing basic education to all. In fact if all children enrolled in primary schools proceeded to complete eight years of elementary education (as the writers of the Indian constitution had desired) the middle schools would have serious problems accommodating them. The ratio between middle and high schools is better, indicating that those who survive eight years of schooling have a higher chance to survive longer.

Most of the children drop out in the earliest grades.



Out of every 100 children in India

50-60 enter primary schools. Of these, about 30-40 soon drop out.

20-25 enter middle school. Of these, a further 10-15 drop out.

5-10 enter higher secondary schools. 4-6 of these drop out.

40-50 do not enroll in schools at all

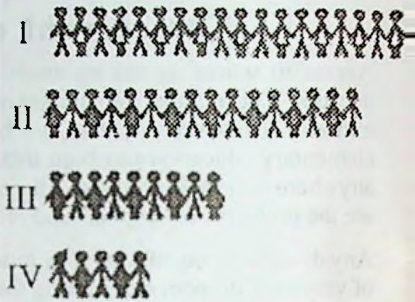
Only 1-2 eventually enter college.

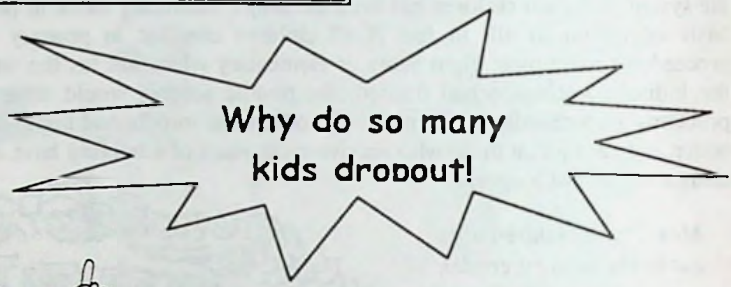
44% of children enrolled in Grade 1 leave before reaching Grade V, and 63% of those originally enrolled do not reach Grade VIII. This heavy rate of dropouts has remained stable over the last three decades.

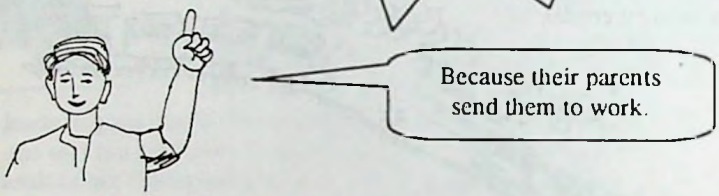
Dropout Rates During Primary and Middle School Years (percent)

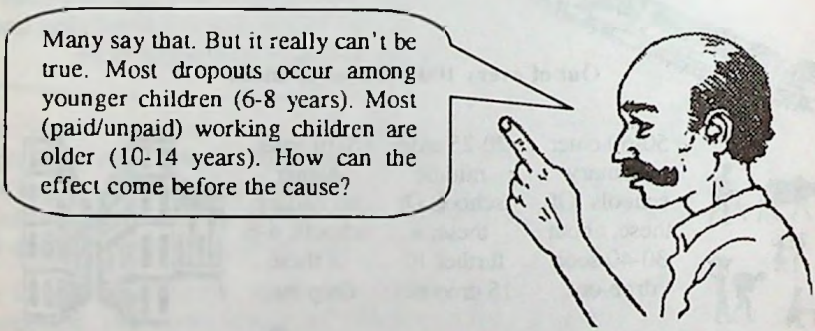
	Std. I-V	Std. V-VIII
1960-61	64.9	78.3
1970-71	67.0	77.9
1980-81	58.7	72.7
1990-91	44.3	63.4

Selected Educational Statistics, GOI. 1995-96



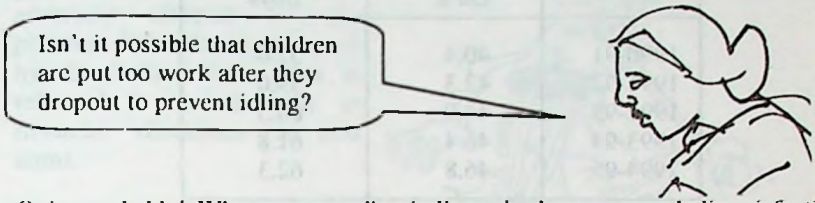






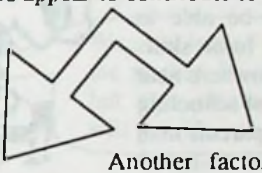
Studies show that children's involvement in work is higher among girls (mainly unpaid domestic work). A study in rural Tamil Nadu suggested that girls spent on an average twice as much time working as boys. Another study in Ballia (UP) showed that in the 10-14 years age group, 15.8% of boys and

34.7% of girls were involved in unpaid domestic work, while 1.8% boys and 1.6% girls were involved in paid work. It needs to be understood that high drop out rates do not necessarily have to do with child labour.



Quite probable! What most studies indicate is that a general dissatisfaction with the education system (and not economic necessity) encourages parents to send their children to work rather than to school. There is also a widely held opinion that the completion of school will not ensure or enhance employment prospects.

Two major factors appear to contribute to the dropout rates.



In spite of govt. claims to the contrary, even poor families have to incur expenses to send their children to school right from the primary stage. 14.4% of students in rural areas and 49% of students in urban areas pay tuition fees in addition to other fees and non-fee expenses. A study indicates that on education, annual household expenditure ranged from Rs.385 in Maharashtra to Rs. 1,200 in Karnataka.

What then is the meaning of the constitutional provision of providing "free" education to all up to the age of 14 ?

Another factor that has a bearing on dropout rates is the quality of education imparted, the service conditions of teachers, the chronic paucity of non-salary expenditure and the facilities provided in government run schools. According to the Fifth All-India Education Survey:

- Barely half of all primary schools have a pucca building.
- 42% have a single classroom. Just over half have a useable blackboard and less than half have drinking water facilities.
- Gender disparity in education is reflected in the lower literacy rate among women - 39.3% literacy rate, for females against 64.1% among males (1991 census). This trend continues with much lower enrolment of girls at all levels, starting from the primary level. (See Table Below).

Enrolment Up to Primary Level
(in millions)

	Girls	Boys
1990-91	40.4	57.0
1991-92	42.3	59.0
1992-93	44.9	60.5
1993-94	46.4	61.8
1994-95	46.8	62.3

Schools as the worst form of Brain Drain...

Lack of Attainment is the term used to describe the huge number of children who sit through 5 years of education without learning to read or write or do simple calculations! One expects 8 to 10 years of education to be able to equip the child with some basic skills and knowledge. If this is nowhere near achieved then the purpose of schooling has been subverted. Many parents note that their child "is not able to learn" and withdraw the child from school. This process on the social scale is a process by which social hierarchies are justified and legitimized.

The poor quality of education is not primarily a function of facilities provided. It is more a resultant of the pedagogy employed. The curriculum and school literature has a distinct urban, upper class and caste bias. This excludes children from poor rural families. Indeed, the children who do not continue in the system are largely drawn from families of landless agricultural labourers and poor peasants.

My parents think I keep failing because I am dumb. Please tell them it is not my failure, but rather the failure of the system. I could have developed competence in all areas of basic education, if the pedagogic approach was appropriate and adequate.

In the case of girls, an important factor leading to their non-enrollment and dropout is Sibling Care. This needs special mention because in this case an easy and effective intervention is possible through day care services.

With this background, let's look at the new policies that are being put in place as part of the liberalization agenda of the government...

Impact of Liberalization

The entire social sector and in particular education has been adversely affected by the policies of liberalization pursued by the Indian State. This is reflected in the decrease in financial allocations in real terms.

But instead, the State and its allied intellectuals portray a positive linkage between the process of economic liberalization and elementary education.

We need less of the State and more of the market. Privatize not only higher but also elementary education. We will provide you some loans.

This neo-liberal path advised for our national policy (in the context of global knowledge wars) is a "survival of the fittest" approach, based on an extension of parental choice in a market of competing schools, colleges and universities. Since the funding for basic education has essentially to come from the State, the idea would be to create a quasi-market within which schools will compete. In a poor nation like India the goal would be to considerably reduce State expenditure by diluting the very notion of schooling, so that a bare minimum access is provided.

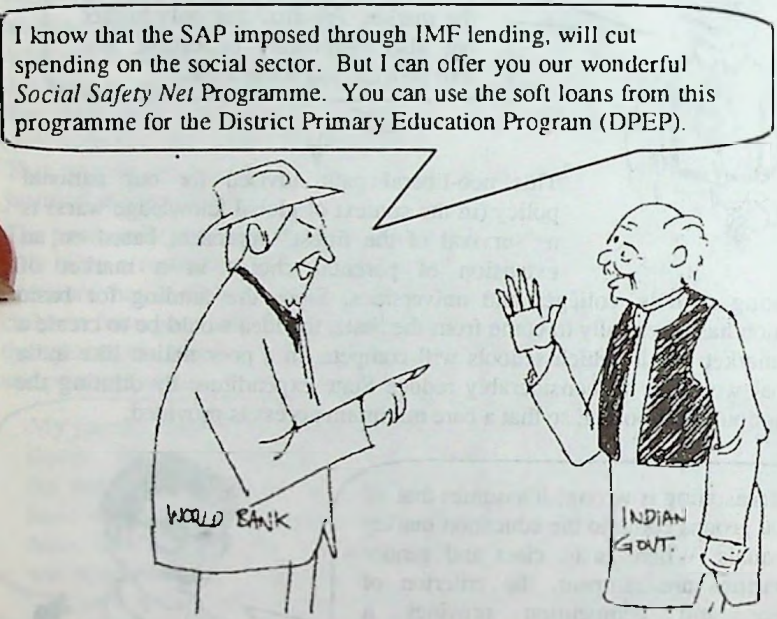
This reasoning is wrong! It assumes that all social groups come to the education market as equals. Where caste, class and gender disparities are rampant, the criterion of choice and competition provides a mechanism by which the middle classes become the only gainers. And this only helps to deepen the disparities.

The consequences ⇨ The school system is getting further polarized in terms of social class and resources.

- The opening up of basic education to external aid.
- India was spending just over 3 per cent of its GDP on education in 1998. This in spite of the Indian State's repeated affirmation since the 1968 Kothari Commission report, to provide at least the recommended 6 per cent of GDP for education.

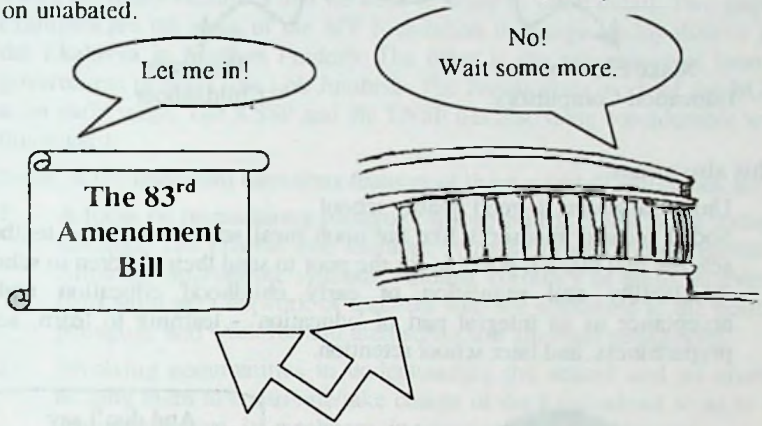
Even as late as 1992, simultaneous with the commencement of the liberalization process, the resolve was forcefully repeated at the Nine Country Summit on Education at New Delhi that the incremental increase in educational allocations would reach the 6 per cent figure by the year 2000.

But still only 3% is spent!



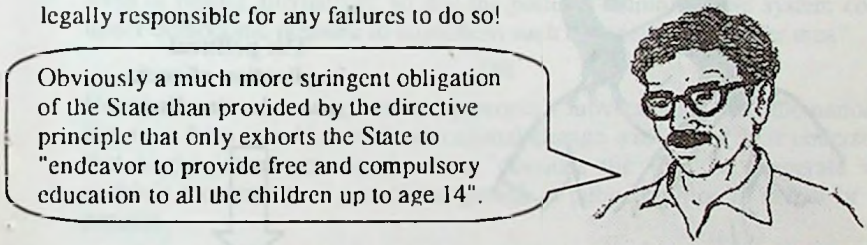
The Central government accepted the money in 1992 and set up the controversial DPEP. Though the funds account for a mere 4-5% of total expenditure on elementary education, it has nevertheless begun to dominate the setting up of agendas for basic education, in a variety of ways.

Clearly, the policy commitments of the Indian State have been overshadowed by the Fund/Bank prescriptions ever since the liberalization process started and the will of the government to fulfill its obligations, both constitutional and otherwise, to help universalize elementary education, is woefully lacking, though the rhetoric goes on unabated.



This proves the lack of will to universalize elementary education !

This bill, though controversially drafted, would provide an Indian citizen the Right to Education, and for the elementary stage, the government would be legally responsible for any failures to do so!



The State was directed to achieve this by 1960, but 40 years later nearly 50% (10 crore) children in the age group 6-14 are still out of schools!

Drafted during the tenure of the United Front govt. (1997), the bill could not be introduced before the ministry fell. The bill was accompanied by a financial commitment allocating Rs.40000 Crore for education in the Ninth Plan. The Eight Plan had allocated only Rs.20000 Crore! The passing of the bill with such a financial commitment would have been a major landmark in the government's commitment to basic education. The ministries that followed have quietly shelved the bill, informally citing inability to commit the kind of funds envisaged!

Policy Recommendations

Enshrine Basic Education as a fundamental right and undertake all the legislative, administrative and financial tasks needed to achieve this.

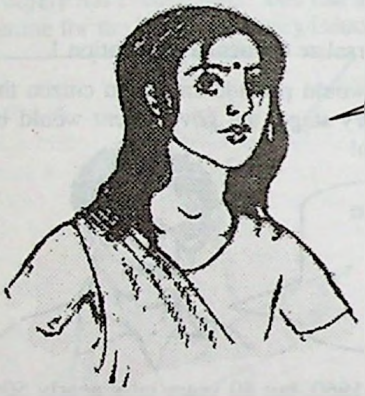
This Means

Make Elementary Education Compulsory

Eradicate Child labour

This also means:

1. Universal access to good quality school
2. Social security measures like the noon meal scheme and free textbooks scheme that make it possible for the poor to send their children to school
3. Availability and regulation of early childhood education and its acceptance as an integral part of 'education' - learning to learn, school preparedness, and later school retention.



And don't say "No Funds for this". Find the funds!

The political implication of such an understanding

Plan economy with the central objective of finding the funds required for providing such education

Instead of planning education according to the funds available in an economy planned with different goals in mind!

Peoples Initiatives for Basic Education

Democratic movements have over the years been able to keep the policy recommendations on the agenda. To a large extent the expansion of schooling is a result of this. This task has to be sustained and strengthened.

But there is also urgent necessity for other forms of people's initiatives to address the main crisis of schooling - the issues of quality and of dropouts. There are many examples that we need to study in some detail. Two important examples are the work of the MV foundation in Ranga Reddy district and of the Ekalavya in Madhya Pradesh. The other is the experience of innovative government projects like Lok Jumbish. The Jeevanshala work of the BGVS is at an early stage. The KSSP and the TNSF has also done considerable work in this regard.

Some of the important directions features of these people's initiatives are:

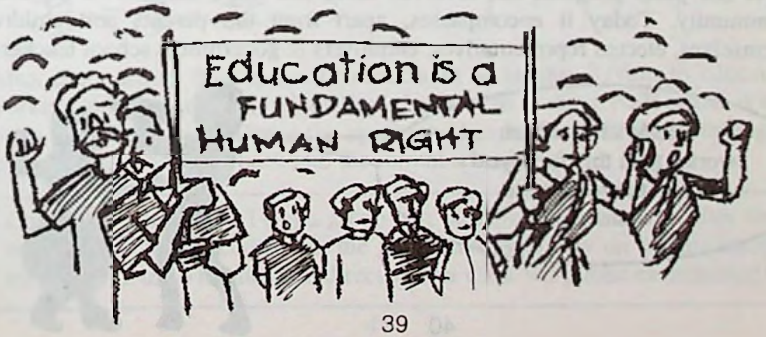
1. A focus on restructuring pedagogy whose central thrust is the training of teachers. The process also includes evolving more flexible,relevant and culturally appropriate syllabus. Another corollary of these interventions is to build up a network of teachers who are sensitised to the politics of pedagogy and work for and themselves use alternate pedagogies.
2. Involving communities in understanding the school and its crisis and helping them to contribute/take charge of the local school so as to make it more effective- in enrolment ,in retention and in attainment.

In both of these directions an important issue to consider is:

Are we looking at these directions as some sort of model building, a better form of posing alternatives, so that the political-administrative system comes under democratic pressure to implement such changes over a wider area?

OR

Do we see a massive replication by people's movements across the nation as the main form in which such educational change will come? It is understood that in the latter scenario the state "develops the will" to cooperate with people's movements as part of the growth of public opinion in favour of this process.



The Ranga Reddy District Child Labour Abolition and Universal Elementary Education Programme A Case Study

More than 100,000 children in 500 villages of Ranga Reddy District of Andhra Pradesh have been withdrawn from work and enrolled into school thanks to the MV Foundation (MVF)'s work with them.

Ranga Reddy district is one of the most underdeveloped districts in the country and lies some distance from Hyderabad in the Telengana region of Andhra Pradesh. Most children in this district were out of school, as is the situation in most such districts. 90% of such out-of school children worked in the farm sector as cattle-herds or farm herds or in domestic work. A large number of boys were working as bonded labourers. 10% of the children work in urban slums –in biscuit factories, in plastic and dye factories.

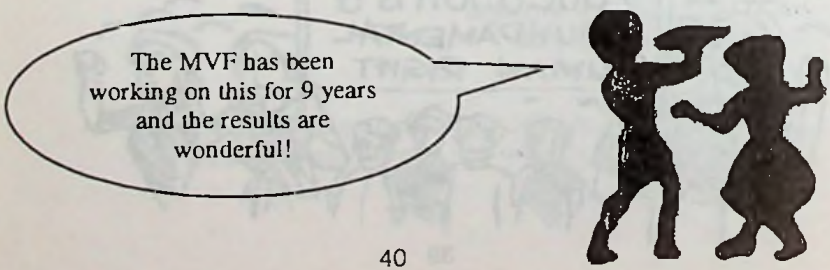
Relying mainly on community initiatives, the MVF program motivated parents and children to utilize the formal school as a medium for the child's advancement. Based on the principle that every child out of school is a working child, the program does not make any distinction between one form of child labour and another. It's one point agenda is to ensure no child goes to work and all go to school.

The strategy adopted
(Essentially based on age group and gender)

Older children in the age group 9 - 14 years are run through a bridge course, which utilizes what they already know to help them catch up with regular school children their age.

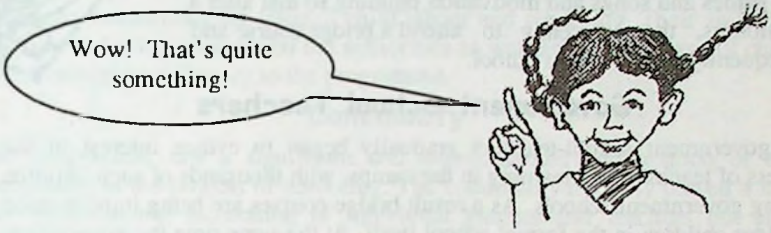
Younger children (6 to 8 years) are directly admitted to schools. In all cases, there is a detailed follow-up program, which ensures minimal drop out. For the girl child the approach, though broadly similar, is more intensive.

Over the years program has involved more and more sections of the local community. Today it encompasses, apart from the parents and children themselves, elected representatives, employers & government school teachers.



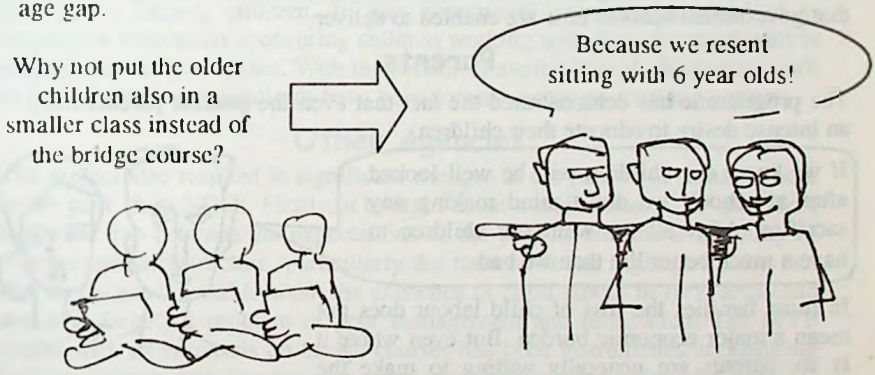
What has been Achieved!

- The programmes operates in 2000 villages in this district.
- 160 villages are child labour free and in 400 villages all children below age of 11 years are in formal schools.
- Over 4000 bonded labours have been released .
- Over 10,000 youth participate as volunteers in this programme.



Bridge Course

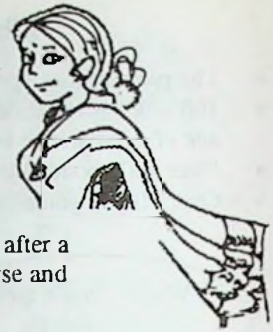
This is central to the MVF strategy. Children released from the work force, often as bonded labourers enter a 2 or 3-month residential camp conducted by specially trained youth where they receive an innovative bridge course. At the end of this period most children join class 4 or 5, in regular school. These children are in the 9 to 12 age group. Younger children, in the 6 to 8 age group can be put back in school without a bridge course, as there is a much smaller age gap.



Also, the teachers find such a class difficult to handle. Trying to educate a working child at the end of a hard day's work in an evening NFE center is also not a desirable option. Hence the approach is to build the child up through a bridge course and get it back into the formal school.

Children in the 12 to 14 age group can be enrolled in class 5 after the three-month bridge course but the preference is to stay on in residential mode for 12 to 15 months and directly clear class VII public examination!

Don't go around thinking it was all easy! Getting the children to attend the bridge course requiresd a lot of work at the level of the community and the family.



It is also helped by a few months of NFE center programmes. In these NFE centers however the focus is on games and songs and motivation building so that after a few months, they are ready to attend a bridge course and subsequently to go back to school.

Government School Teachers

The government school-teachers gradually began to evince interest in the process of teaching and learning in the camps, with thousands of such children joining government schools. As a result bridge courses are being implemented for older children in the formal school itself. At the same time the government teachers have thus an extended domain to cover even those children out of school. A forum for Liberation of Child Labour with the membership of 1300 teachers has been formed to work - for abolition of child labour. The teacher's active involvement in enrolling children and introducing innovative methods of teaching to retain them into schools has raised their self esteem and resulted in genuinely empowering them as teachers. A well organized supportive community plus local appointment of additional teachers on a part time basis (when class room strength increases temporarily to clear the back log), ensures that government schools now are enabled to deliver.

Parents

The programme has demonstrated the fact that even the poorest parents have an intense desire to educate their children.

If we know our children will be well looked after at school, we don't mind making any sacrifice. After all we want our children to have a much better life than we had.

In most families the loss of child labour does not mean a major economic burden. But even where it is so, parents are generally willing to make the extra sacrifice. There are several instances where cattle and other livestock have been sold once the child was enrolled in school.

Why didn't parents do this earlier?

The programme showed the parents that their children could learn – this enormous increase in their confidence in the capabilities of their children was a very important factor for the success of the programme. Indeed the parents are beginning to enjoy parenthood in the process of their children becoming students.

Youth Activist

The youth activists played the significant role of relentlessly pursuing every child's journey to school. In withdrawing 100,000 children from work and in negotiating their entry into school, the youth activist who identified himself/herself as a voluntary social worker and member of a social movement, made the critical difference. Being themselves first generation literates, they understood the predicament of a child labour. They exposed all the myths surrounding the issue of child labour and schooling. Their ability to question and bring pressure on the authorities as well as on employers of child labour brought a militancy to the programme.

Community

The programme saw a significant and unprecedented participation of the community in the process of schooling. The community not only played a key role in sustaining motivation of individual parents and teachers but also contributed significantly in financial terms. In most schools rather than wait for the government to supplement the infrastructure, the community came forward to support additional teachers as well as to contribute funds for expanding the school building. Much of the success has been the result active participation of the community in managing the programme.

Community pressure was also important in changing the attitude of the employers towards children. As the worker role for a child became a less and less acceptable within the community, employers found it more and more difficult to employ children. In fact community pressure has resulted in employers voluntarily sponsoring children working with them for enrolment in schools and bridge courses. With the decline in availability of children to work in their fields, larger landlords have been forced to change cropping patterns

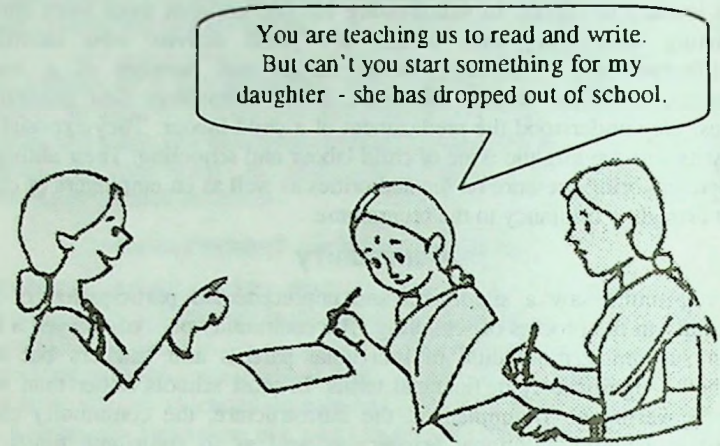
Other Agencies

The project also resulted in significant changes in the pattern of thinking both in the govt. & in NGOs. Firstly, it brought about a realization in AP that there is a wide gap between the expectations of the parents and the availability of educational infrastructure, particularly the teacher. It has highlighted the fact that nothing is inevitable about the existence of child labour in rural areas and that it is largely a problem of poor management and motivation. The MVF model with its emphasis on bridge courses has been instrumental in inspiring large-scale programs like the back-to-school programmes run by AP Govt.

The MVF Model has also highlighted the severe limitations of the Non Formal Education approach that has symbolized much of the govt.'s policies in the past. The program has also highlighted that the best way to get support for withdrawing children from work is to enroll them in full time formal schools. This is evident from the programs for child labor drawn up under the NCLP programs, which has a strong component of education.

The MVF model has inspired similar ventures in Tamilnadu, Karnataka, Orissa, Madhya Pradesh, Rajasthan and Calcutta.

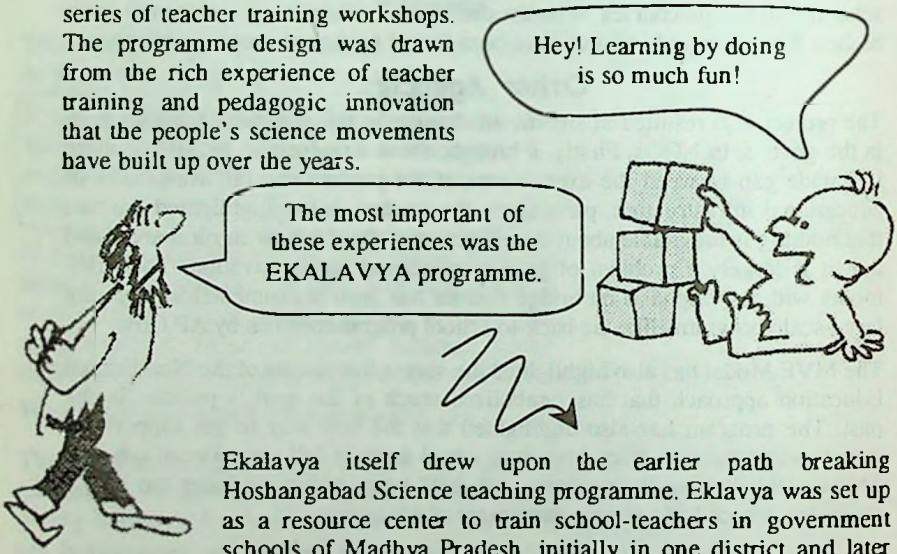
During the Literacy Campaigns...



Responding to this demand from the literacy classes for better school education services, the BGVS started a number of initiatives for quality improvement in school education and for addressing the needs of drop out and working children.

Improving the Quality of School Education

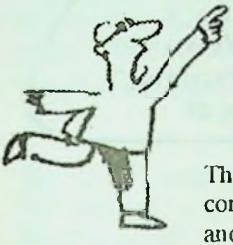
In 1994, the BGVS initiated the nation wide ***Joy of Learning*** campaign and a series of teacher training workshops. The programme design was drawn from the rich experience of teacher training and pedagogic innovation that the people's science movements have built up over the years.



Ekalavya itself drew upon the earlier path breaking Hoshangabad Science teaching programme. Eklavya was set up as a resource center to train school-teachers in government schools of Madhya Pradesh, initially in one district and later expanding to over 15 of districts.

The focus was initially on science teaching in the middle and high school but later expanded to other subjects and to primary schools.

The teacher training camps the guidebooks for the teachers and the syllabus developed, not only made a considerable improvement in the quality of education but went on to become a model in content development and pedagogic innovation and teacher training for many subsequent programmes.



And don't forget the work of David Horsborough and the innovative schools set up by the volunteers trained by him.

They are another major source for pedagogic innovation and content development. The Narasimhans in Chittor district and the Digantar school of Jaipur are some examples of this.

These experiences were also drawn upon by the BGVS. Today, across the country, the Science Movement led initiatives like teacher training, production of creative supplementary training material and conduct of supplementary educational activities (like Children's Festivals), contribute to quality improvement in school education. The understanding that inspires these sustained, patient & expanding efforts is that underlying issues of quality is the larger question of educational goals - whether education is seen as empowering & developing the creative talents of the child or whether it is geared to producing unquestioning citizens in an unequal & unjust society.

The Jeeevanshala Approach to Non-Formal education

For out-of-school children, "non-formal education of a different kind" was mooted. The Jeevanshala had the twin objectives of providing life based education to non-school going children, while ensuring that they move back to regular schools. The spirit of the mass campaign was central to its implementation though the programme looked at a block as the unit. The pilot programmes were started in Wyra block (AP), Samalkha (Haryana), Navada (Bihar) and Akkallua (Maharashtra). Village level surveys identified the out of school children and their current educational level. Then followed dialogues with panchayats & mass mobilization through kalajathas, village festivals & childrens festivals. This enthused the community and gave it the confidence to participate in this initiative. Organizational structures where the village could participate were set up. Then the NFE centers started functioning. In a few villages, Jeevanshalas were completely supported by the panchayat. In the above 4 blocks 1000 to 2000 students now attend the NFE centers. At the beginning of the campaign and after that periodically children who could attend formal school were put back in school. Only those who needed to continue in these centers did so.

Chapter V

Securing People's Livelihoods

The impact of structural adjustment policies on livelihoods

Proper nutrition, food, water, sanitation, medical benefits and other such factors that make for a healthy life are all a function of steady employment and an income that is commensurate with the rise in prices of goods and services.

But money is only one part of the story - the conditions and nature of work that people do also has a profound impact on their mental & physical health of people.

Security of livelihood, the conditions of work and the nature of employment depend on both environmental and macro-economic factors. The casualization of labour after economic reforms & the expansion of the unorganised sector have led to precarious conditions of work and the lack of social safety nets for a large section of the population. This has had a direct impact on the quality of life. At the same time the structural adjustment policies have led to increase in prices of food grains & move to privatise all services. In the era of fluctuating incomes these developments have worsened living conditions.

Degradation of the natural resource base has led to declining productivity of land & degradation of water sources, affecting our food security & drinking water. Deforestation has led to increasing heat & pollution levels.

This chapter looks at livelihood issues – particularly how they affect health.

Employment Insecurity

The rate of employment has declined from 1.44% in 1991 to 0.67% in 1997. The post-reform period has seen an increase in the unorganised sector and therefore a growing level of job insecurity. The worsening conditions of work are also reflected in the nature of employment that people are seeking.

What is a Successful Economy?

To many economists the central measure of success in economics is growth. This means more production and more total income. The measure of this is the GDP which is the sum total of everyone's income.

To the majority of the ordinary people a successful economy means: Their livelihoods are safe and there is an expansion of employment opportunities.

If a modern oil mill starts functioning & increases the production of edible oil by a factor of ten, the GDP would rise. But since such a mill would destroy the livelihoods of thousands of rural families, they would hate such growth.

Let's say the production of luxury cars has increased India's GDP. A modern car factory employs only about 600 persons - far far less than the number of peasant families the factory would displace. But GDP would increase enormously because of the factory. Remember that the government acquires land for such a factory compulsorily and so the farmers cannot refuse to sell. Of course, some persons would get employed as drivers and car mechanics, and even for selling toys to hang in the cars. But the quality of these jobs is different from ones lost. More importantly, the employment of many is now centered around the luxury consumption of a few!

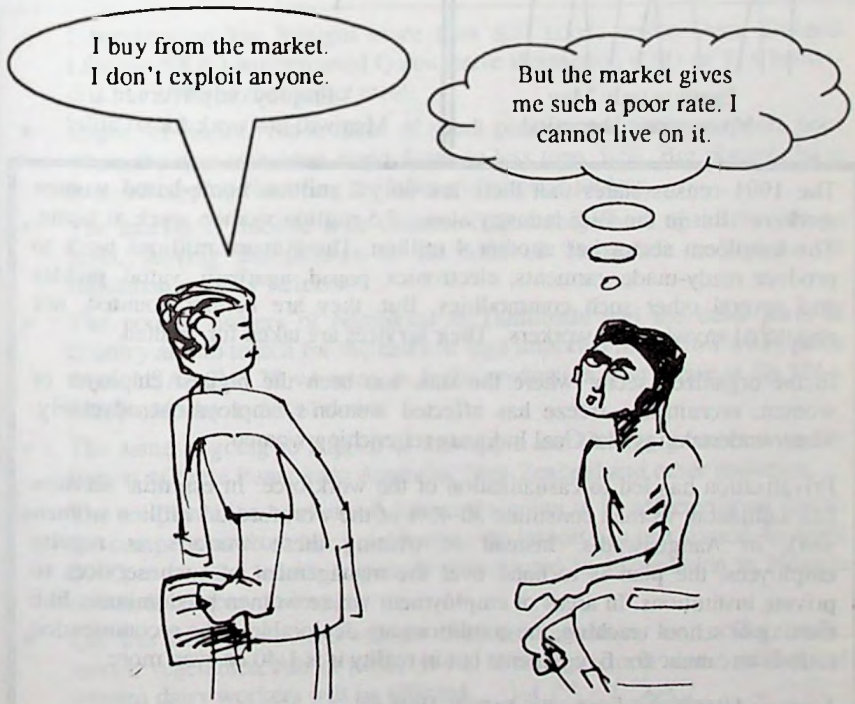
Some of the major features of employment insecurity are:

Shrinking of the Organised Sector

The growth of the organised sector has experienced regression in the last 2 decades. Whereas the growth rate of the organised sector was about 2.5% in the 1970s it came down to around 1.5% in the 1980s and was around 1% in the post reform period i.e., 1990s. Between 1990 and 1998 the employment in the organised sector decreased from 9.4% to 8.5 %. This means that less than 10% of the population had access to social benefits like provident fund, medical and paid leave, maternity benefits, medical reimbursements etc.

Casualization of Labour

Given the above-mentioned fact, it is clear that about 90% of the people in the country depend on employment in the unorganised sector. However workers in the unorganised sector also need to be differentiated according to the duration and security of employment. The National Sample Survey has divided the work force into three broad categories: the usual workers, the weekly workers and daily workers who work on a person-day basis. A usual worker is one who works most of the 365 days in one year. This type of worker can be divided into principal and subsidiary workers. The principal workers are those who have stable employment throughout the year. The nature of work that they do can be divided into three - regular, self-employed and casually employed. Casual employment denotes regular work at piece-meal or informal terms. The post-reform period has seen a growth in casual employment. The percentage of people under regular employment has decreased from 61.4% to 54.8% between 1972-94. In the same period the people availing of casual employment increased from 23.2% to 32%. This means that increasing number of people are faced with restrictions on demanding any formal benefits of employment since the relationship between the employer and employee is usually non-contractual and informal in character.



Feminisation of the Labour Force

Casualization of labour has increased for women at a higher rate and about 60% of the women work in the casual workforce. In contrast less than half of the male workers belong to the casual workforce. The work participation of women has increased from 22% to 28% between 1991-97. Evidence from India, Malaysia, Sri Lanka and other countries suggest that more and more women are being employed in services that require cheap labour. These occupations include home-based domestic work and on construction sites. The trend in the post-reform period is increasingly towards the temporary and contractual employment for women on unfair wages and with inappropriate and inferior conditions of work including lack of maternity benefits and childcare.

Employ only Men.
No maternity benefits!

Employ only Women.
Men will not work for so little!

The 1991 census states that there are only 1 million home-based women workers. But in the Bidi industry alone, 2.5 million women work at home. The handloom sector has another 4 million. These apart, millions work to produce ready-made garments, electronics, papad, agarbatti, vattal, pickles and several other such commodities. But, they are neither counted, nor registered anywhere as workers. Their services are taken for granted.

In the organized sector where the state has been the biggest employer of women, recruitment freeze has affected women's employment adversely. Many undertakings like Coal India are retrenching women.

Privatization has led to casualization of the workforce. In essential services like sanitation, women constitute 30-40% of the workforce. 1 million women work in Aanganwadis. Instead of treating these workers as regular employees, the plan is to hand over the management of such services to private institutions. In areas of employment where women predominate, like nursing or school teaching, the conditions are deplorable. The recommended ratio is one nurse for five patients but in reality it is 1:40 or even more.

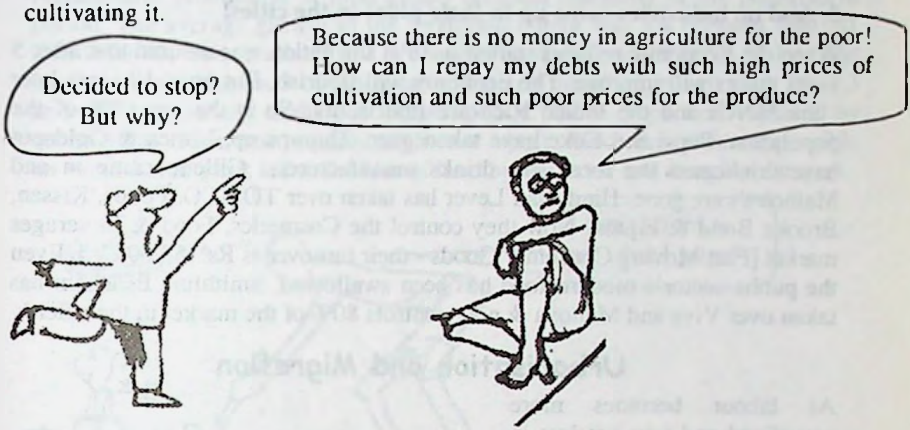
Source: Alternative Economic survey-1998-99

Retrogression in Employment

Job insecurity is one of the factors that lead to unstable lifestyles and ill health. Job insecurity increases as existing jobs in industrial and agricultural sectors declines. Let's look at some of the major causes of loss of livelihoods...

1. ` Farmers can no longer farm !

Because they have lost their land, or because they just decided to stop cultivating it.



- Liberalization has brought more than 800 goods under Open General License (OGL) and removed Quantitative Restriction (QR) on 714 items – this has affected the farmer most.
- Import of Rubber made lakhs of small planters and rubber tappers poor when the cost of rubber came down to less than 50%. Big planters have stopped tapping rendering the laborers (tappers) jobless.
- The market is flooded with Chinese Garlic (big ones) up to the village level, leaving the farmers in the hills of Tamilnadu and plains of Rajasthan poverty stricken.
- The poultry owners of Namakkal in Tamilnadu and the other parts of country are no match for the chicken legs imported at a throw-away price from USA. (Rs. 28 whereas in India production cost alone is Rs.32/-). Many units have closed down.
- The same is going to happen to the Apple and Orange growers with the import of these items from Australia, New Zealand and other countries.
- The tea plantation workers of Assam are going to be affected soon due to the competition from our neighbors as the import has just started. In April 2000, more than a lakh of people participated in an agitation in Nilgiris demanding a ban on imports.
- QR has been removed even for fish, fish products, tea, coffee, milk, spices, vegetables, rubber products etc. In milk products alone, millions of women dairy workers will be affected.

2. And non-farm rural employment has been destroyed!

In the past, there were numerous trades, handicrafts and artisans at the village. Now they are all closing down. Gone are the oil presses & wheat mills. The blacksmiths disappear as the corporates make implements. Gone are all the small bakeries & milk product-makers. Now one can buy Australian wheat & fruit juice and European diary products, but at the cost of these rural families!

3. And no industries come up in their place in the cities!

When the Economic reforms started in 1991 the nation was assured that after 5 years things will improve. The Economy will flourish. But now, 10 years later - the MNCs and the Indian Rich are flourishing. So is the top 10% of the population. Pepsi and Coke have taken over. Thumps up, Limca & Goldspot have eradicated the local soft drinks manufacturers. Gillette came in and Malhotra's are gone. Hindustan Lever has taken over TOMCO, Ponds, Kissan, Brooke Bond & Lipton. Now they control the Cosmetics, Food & Beverages market [Fast Moving Consumer Goods - their turnover is Rs.15,000 Cr.]. Even the public sector's modern food has been swallowed. Smithline Beachem has taken over Viva and Maltova & now controls 80% of the market in their field.

Urbanisation and Migration

As labour becomes more casualized and jobs are lost in rural areas there is growing urbanization. This urbanization is not due to industrial growth in the cities. Rather it is distress migration of the rural poor to urban areas, seeking wage employment in service sectors, in construction labour or other forms of daily wage labour. Thus urbanization is largely the growth of the urban poor.

A report on *India's Urban Sector* (1998) by the National Institute of Urban Affairs has shown that there has been an alarming increase in the rate of urbanisation in the last two decades. The rate of migration has increased from 15.2 in 1971 to 17.4 in 1991. All indications are that they are increasing. The number of people living in urban areas has doubled from 78.9 million in 1951 to 159.5 million. Though no substantial estimates are available for the post-reform period, all reports indicate that these trends will only increase with reforms. The increase in the urban population and the regression in the economy of the 1990s have also led to insecurity of wage employment compelling the poor to accept below poverty wages and to work overtime.

Natural Resources and Employment Security

Employment opportunities are affected by Ecological Degradation and by the changes in access to these depleted natural resources and by the changed pattern of use of these resources. Some examples of these are given below:

Agriculture

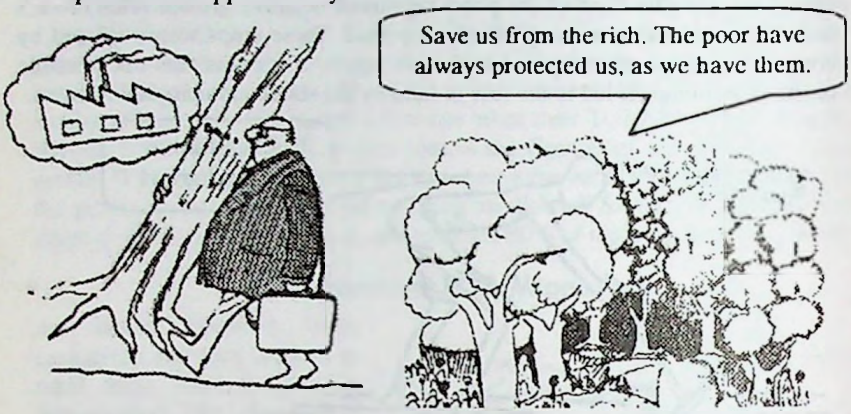
Agricultural production of food grains declined markedly in the post-reform period. The average growth of the foodgrain output was 3.4 between 1980-81 and 1990-91. This declined to 1.4 between 1990-91 and 1997-98. Pulses and coarse cereals (the food of the poor) registered negative growth rates of -1.3 and -0.7 respectively in the post-reform period. These crops were replaced by commercial crops that required high-cost inputs. Since this was not possible on small-holdings, it led to the loss of land by the small and marginal farmers.

The increasing casualisation of labour in the rural sector in the post-reform period can be attributed to this factor. Further, the degradation of these lands is also taking place at a fast rate, as the small farmer cannot afford to experiment with new technologies. The lowering of ground water level and the problem of irrigation has also led to degradation of marginal lands. 40% of marginal agricultural lands are degraded and small and marginal farmers own many of these holdings. Therefore many farmers are forced to depend on seasonal employment to make the two ends meet.

Forests and Watersheds

Apart from providing seasonal employment, energy and fodder inputs to the rural poor, the forests are also protectors of the ecological security of the country. They protect the water flow from the hills into the plains and also save lands from soil erosion and degradation. Because of this it has been recommended that 33% of the area in the plains and 66% of the area in the hills should be kept afforested.

However, this has not been the case in our country. In 1987 only 23.8% of the total area was recorded as forest and this has declined to 19.7% in the 1990s. India has lost 90% of its frontier forests and 57% of what remains is endangered despite the introduction of Joint Forest Management and other programmes. The failure to evolve programmes that will arrest deforestation will affect not only the health of water sources and agricultural lands but will also impact upon climate and productivity. Further the erosion of the forest base will lead to the shrinking of supply of fuel-wood and fodder that give the rural poor some supplementary income.



Decline in Real Wages and Increasing Poverty

The real wages (adjusted against inflation and price rise) of the workforce have generally declined in the post-reform period. This means that income poverty has increased.

Let's look at some data...

1975: a little more than 50% of India below poverty line.
1997: 37.2% below poverty line
This means annual rate of decline of poverty – only 0.9%!

Why?

Because the post reform period saw a considerable slowdown in the decline of the number of people living below the poverty line. In fact in 1995-97, instead of declining the numbers below poverty line increased!

Let's see how this relates to changes in the real wages...

The latest economic survey shows a decline of 2.1% in the real wages of the agricultural labourer (the bulk of the workforce). In the industrial sector too, the workforce has seen an average decline in real wages of 2.45% between 1989-93.

Grim Facts

- 400 million people live in poverty.
- 6 Crore people (16% of the population) have a daily income of only three rupees!

- The first Human Development Report prepared for India

Starvation deaths are increasing:

- In 1994, in Amaravati (Maharashtra) there were 613 such deaths
- In 1996 the number increased to 829.
- The recent spate of suicides by cotton growing peasants in Maharashtra, Punjab etc. are yet another example of increasing poverty.

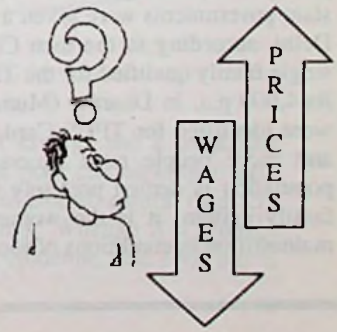
And what is the government saying about all this?

The government is refusing to accept it. It says "There is No Alternative! If the economy grows somehow things will become OK."

Outrageous! The evidence against SAP is so clear now - refusing to see it will only increase poverty and lead the country towards ruin.

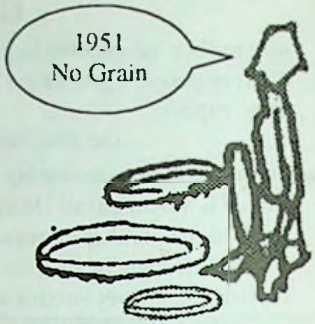
Rising Prices of Essential Commodities

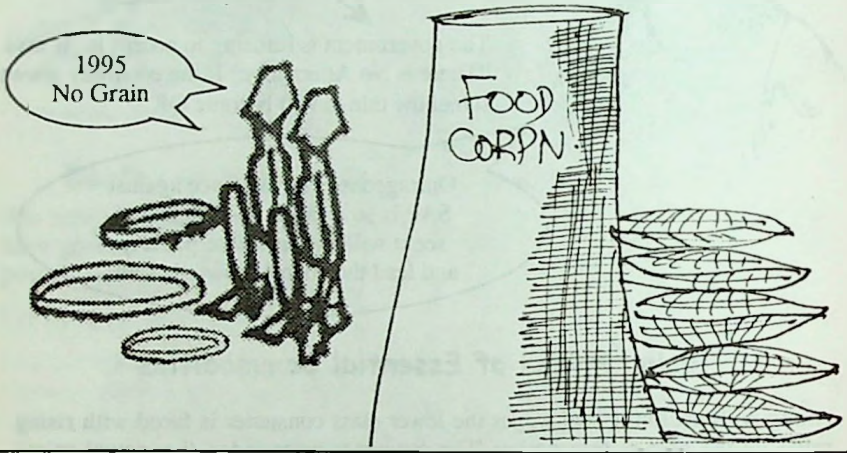
Along with declining real wages the lower class consumer is faced with rising prices in the post-reform period. The consumer price index (i.e, actual prices adjusted against the purchasing power of the consumer) has risen to double-digit figures for industrial workers, agricultural workers as well as urban employees in the service sector. The inflation rates recorded for the year 1998-99 are 13.2%, 11.0% and 11.3% respectively. The percentage of increase in inflation since 1991 is 1.6% for industrial workers, 3.9% for agricultural workers and 0.3% for urban service sector workers. The inflation for industrial workers and the workers in the service sector is partially relieved through access to the PDS system – but this is also under threat today.



Dismantling of the Public Distribution System

At the best of times the outreach of the PDS was limited, especially in rural areas. This coverage had decreased from 15.3% in 1951 to 9.1% in 1995. Now the problem is further compounded by marked increases in PDS prices and a curtailing of its outreach. It is true that the PDS often did not reach the really poor, but instead of extending its outreach, the current approach has only weakened it further. Now the food corporation godowns are overflowing with grains, even as the poor starve. Add to this, the increased prices of kerosene & LPG and the cost of food rises further. 64% of the rural household expenses & 54% of the urban household's expenses go to food alone.



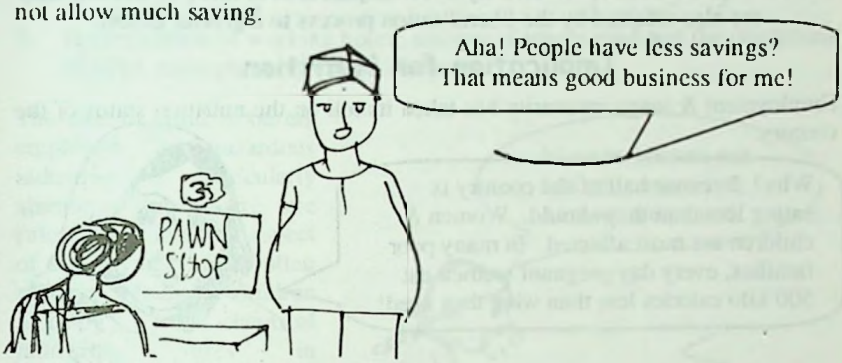


When the Targeted Public Distribution Scheme (TPDS) was announced for giving cheaper food grains to people living Below Poverty Line (BPL), the state governments were given a freehand to lower the limits of BPL. Thus, in Delhi, according to the then Chief Minister, Mr. Sahib Singh Verma, not a single family qualified for the TPDS. In Maharastra, this limit was lowered to Rs.4,000 p.a. In Dharavi (Mumbai) Asia's largest slum, only a few families were identified for TPDS Card. In the face of growing inflation, when more and more people need access to cheaper food grains, large sections of population is denied precisely the same. Given the predominant patriarchal family system, it is the women who eat last and are first to suffer from malnutrition in conditions of food scarcity.

- Alternate Economic Survey -1998-99

Savings and the Capacity to Cope with Unforeseen Circumstances

Given the increasing cost of living, the decline in real wages, and the slowdown in decline in poverty, the ordinary person's capacity to save is minimal. There is some possibility of forced savings under the provident fund for those who have regular employment in the organised sector. However, this prospect does not exist for workers in the unorganised sector. There are no estimates for the amount of savings in this sector and it is quite safe to assume that the correlation between the cost of living and decline in real wages does not allow much saving.



In urban areas, poor people are borrowing more to spend on health rather than for any other purpose. In the organised sector too, the Pension and Provident Fund schemes are being subverted through the reform process.

Recently, the Government has decided to risk the provident fund money in the stock market in order to enhance its income! Provident fund is supposed to be secure – to protect the employee in need. Taking that and playing the stock market is really a complete breach of faith.

In the absence of savings and a weakened social sector – the poor can no longer cope with misfortune, of health, natural disasters or declining fortunes. Whether it is drought or cyclone or an epidemic, the poor pay a terrible price!

Impact of Current Trends on Health

We have seen how in the post-reform period, the capacity of people to provide a secure life for their families has been eroded considerably.

Now what does this imply for the health of the society and its citizens?

An important point to note is that though the impact on the whole population has been quite adverse, the severity of the impact is seen more in women who are also affected by the liberalisation process to a greater extent.

Implication for Nutrition

Employment & wage insecurity has taken its toll on the nutrition status of the country.

Why? Because half of the country is eating less than they should. Women & children are most affected. In many poor families, every day pregnant women eat 500 kilo calories less than what they need!

This has led to a high incidence of low birth weight babies.

52% of severely malnourished women, 42.2% of moderately malnourished and 37.1% of mildly under-nourished women have low birth weight babies.

Study by Madura Swaminathan says...
1991-92: 44.2% couldn't afford a full meal.
1993-94: 47.7% couldn't afford a full meal!

I don't know about you, but for me the reforms have been really bad!

As far as children are concerned, the NNMB data on nutrition of pre-school children in urban areas reveals that ***only 10% of such children have a normal nutrition status***. The rest are faced with mild, moderate or severe malnutrition. The decline in severe malnutrition has slowed down after the reforms. If we see the entire post-reform period till 1995 than the decline in severe nutrition is only by 1.5 percent as compared to 4 per cent between 1979 and 1990.

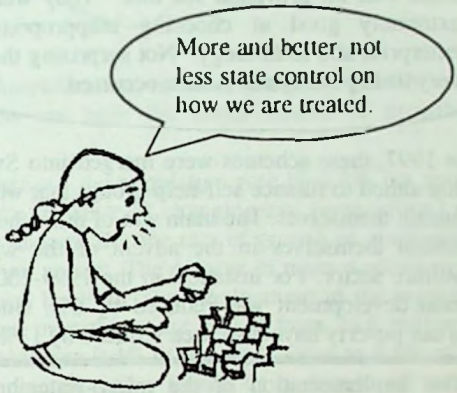
Conditions of Work

One of the most destructive impacts of economic liberalisation has been the withdrawal of the state from the social sector.

What this means...

1. The state will no longer even attempt to provide welfare services to labourers in the informal sector.
2. Social security benefits are confined to a very few people in the unorganised sector.
3. No regulation of working hours, amount of wages paid and the conditions of work amongst unregistered labourers.

The case of child labourers employed in hazardous industries is particularly alarming since there are rules governing this aspect of employment. The often reported deaths of children working in chemical industries, fires in congested workplaces and other such incidents only show that we need better state interference and not less of state control.



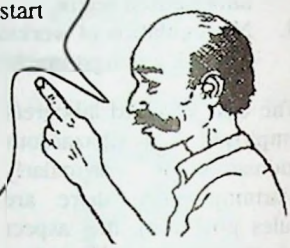
In the wake of the expansion of the unorganised sector, women have also suffered immensely. A study by the National Institute of Urban Affairs shows that on an average most women spent 7 hours outside the house and 4 hours working inside the house thus making their workload 11-12 hours per day. This puts a triple burden of working inside the house, outside it and looking after children. Most women do not even get maternity benefits and start working one month after their child is born. This also jeopardises the health of the child. Now with mobility of labour and increasing tendency of people to live in nuclear families, women need more institutional support to survive these stress conditions.

These are only a few examples of the ways in which the employment and wage security impact upon the health of a nation and its citizens.

Poverty Alleviation
Government Schemes and Allocation

Till 1997, the Integrated Rural Development Programme and the Jawahar Rozgar Yojana were the main poverty alleviation schemes. However it was often felt that these schemes did not meet their targets because a central authority administered them and all planning was done in a centralised way. The main focus of these schemes was to bring about rural development through the creation of employment opportunities.

But most beneficiaries identified were not below the poverty line. The grant given was insufficient to start an enterprise. A new enterprise requires training and management support and markets. But there was no provision for this. They were extremely good at choosing inappropriate enterprise and technology! Not surprising that very little poverty alleviation occurred.



In 1997, these schemes were merged into Swarna Jayanti Swarozgar Yojana that aimed to finance self-help groups that would also run micro enterprises to sustain themselves. The main aim of this scheme seems to be to help people to sustain themselves in the advent of the withdrawal of the state from the welfare sector. For instance, in the 1999-2000 budget the funds allocated for rural development was reduced by 6%. Budgetary allocations to deal with urban poverty have also been reduced by 13%.

The implementation of the micro-watershed programmes is to be the responsibility of the NABARD - a Central agency - for which an allocation of Rs.50 crore is made in the 1999-2000 Budget.

The NABARD is to seek the help of *Gram Panchayats, Local Self help Groups and NGOs* for implementing the programme. The fact that the programme is not compulsively routed through the Gram Panchayats (via the State governments, with earmarked allocations) raises suspicions.

India has more than 5 lakh villages, and the number of Gram Panchayats is close to 40,000. A beginning is to be made in 100 districts (which have not been specified). Let us assume these 100 districts would have some 10,000 Panchayats. A Gram Panchayat may have (on an average) 5-10 villages. Pro rata, this works out to Rs.50,000 per Gram Panchayat, or Rs.5000 - 10,000 per village.

It is not clear as to what kind of watershed programmes are conceived of, with the allocation of such meager funds.

- Alternative Economic Survey, 1998-99

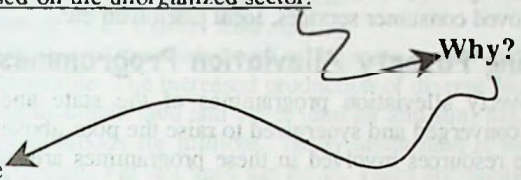
Chapter VI

Fighting Back

Building Alternatives for Securing Livelihoods

The Focus

When we plan for community action or people's initiatives (as distinct from advocacy and agitation action) in the area of livelihoods such action needs to be focused on the unorganized sector.



Growth consequent to the industrialization, or more precisely growth in the organized industrial sector has not been the major source of growth in employment.

Look at employment in the nineties - the population rose by 1.8% per annum and the growth of the workforce (because of changing age composition) was even higher – at about 2% per annum. But the rate of growth of employment in all sectors was less than 1% per annum. The number of main workers would have reached at least 333 million by 1998. But employment in the organized sector is seen to have increased over this same period from 26.8 million to 28.3 million, which is a decrease from 9.4% of the work force to 8.5% of the workforce. This, despite the nineties being touted as a decade of market driven, globalization based growth.

Where are the millions then employed? Mainly in the unorganized sector - the micro sector and in primary production. It is here that we must start work to build an alternate path of development. A path where everyone is assured a livelihood with dignity and without drudgery.

Reconceptualizing the Micro Sector

1. Providing livelihoods means transforming this sector from being an unorganized sector to being a powerful, organized and networked sector. It must develop the power to withstand competition from the global multinationals and assure a decent quality of life to those dependent on it for their livelihoods.
2. Micro enterprises producing goods and services can be considered not as measures for poverty alleviation, but as nuclei of future economic formations. Micro can become macro and even global in a different way,

through a system of interrelations extending to all fields of social existence - production and exchange of goods and services, finance, marketing, intermediate production etc.

3. Building a macro network of micro enterprises requires large scale transfers of skills - for better finance, better management, better marketing, better technologies and so on. This is a challenge.
4. Building markets would require capturing markets from larger players as well as creating new markets through redistributive growth and new products. The impact of the media in favour of the larger players can be counteracted through consumer education, better product quality, cheapness, improved consumer services, local patriotism etc.

Redesigning Poverty Alleviation Programmes

The plethora of poverty alleviation programmes of the state and central governments can be converged and synergized to raise the poor above poverty line sustainably. The resources involved in these programmes are not small. But they have seldom been used intelligently. Practically only a few have risen from BPL to APL making use of these resources. Yet it can be done. By a judicious and intelligent combination of governmental subsidies, institutional loans and own small savings (through savings groups) substantial capital can be raised to set up small and medium community enterprises. But of course they may require considerable assistance to do so - assistance for technology, for marketing, for management etc.

Organizing and Networking

The creation of such a large network of enterprises needs the creation of organizational networks. One form of organizing could be Geographical Neighborhoods. Women, dalits, agricultural laborers, peasants are other platforms for organizing. In recent times, the potential of small neighborhood women's groups to come together for savings and household credit needs and then move on to serving financial needs of home based occupations has become universally recognized. These groups help poor women develop capabilities at a pace and rate of growth which they find comfortable and which they can balance with their existing commitments. Many more such organizational forms for other sections and other purposes based on these general principles are possible and necessary. We should also study the co-operatives of Gujarat and other places and suggest viable, vibrant models. Amul is one that has to be analyzed and seen whether this can be applied to other sectors.

Banking on Biomass

70% of the population still depends on agriculture. So the basis for much of the increased manufacture is on the increased production of biomass. Biomass has an enormous capability both as energy source and as raw material for manufacture. Biomass, unlike other minerals as raw materials, is renewable. Production of food, fodder, fiber, energy and chemicals and materials based on biomass is now technically feasible and socially desirable. The increased production of diverse biomass to suit various needs with available land and water (and air and sun) has also the potential to generate livelihoods for millions. Today much land is wasted and almost all land is degraded. Yet this need not be so. There are enough examples to show that with the local community's involvement and with a combination of people's wisdom and science and technology even the worst land can be greened and enough food fodder and fiber and fuel becomes available for a life of dignity, free from drudgery. One example is Ralegan Sidhi - Anna Hazare's successful experiment. There are more like that – Pani Panchayats, Kerala experiments, Auroville experiments and so on. The challenge now is to replicate such examples a thousand times. The challenge is also to integrate such wasteland development and agricultural development not only with provision of livelihoods to millions who live of the land but also with small-scale manufacture and local infrastructure development so that many more livelihoods can be created.

Community Control over Natural Resources

Such a massive attempt at creation of livelihoods in the primary sector needs a more equitable access to the natural resources on which primary production rests. Land is one asset. Water is another. Forests are a third. The seas and rivers are a fourth. Bio-diversity is another natural resource on which life depends. There was a time when all of this common and used for the good of all. These resources could not be sold or purchased. They were venerated. Slowly land and then water got privatized. Forests were taken away from the people who lived on them and protected them - often in the name of conservation. Or people were taken away from the forests (by dams for example). The seas were plundered by greedy industries without any care for the future. Once biodiversity was recognized as a resource the privatization of this resource in large seed-banks and their disappearance in the wild got accelerated.

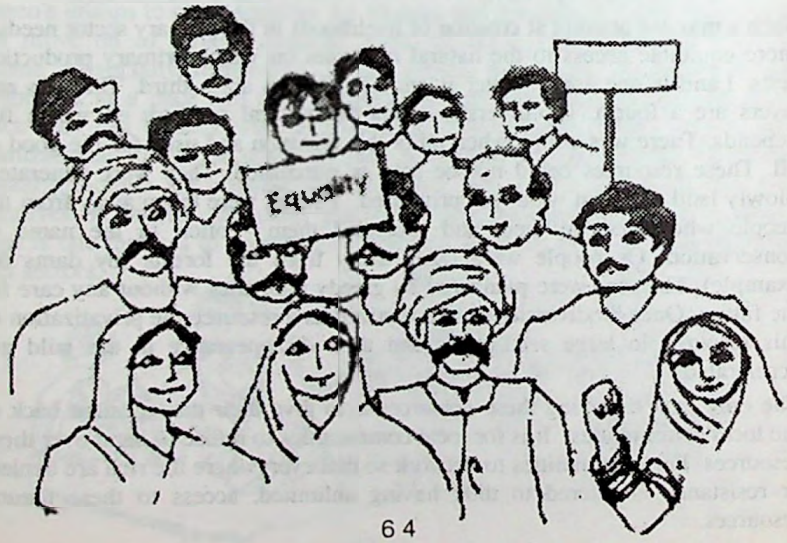
The only path to saving these resources is to give their management back to the local communities. It is for local communities to refuse to hand over these resources. For communities to network so that everywhere the rich are denied, or resistance is offered to their having unlimited, access to these natural resources.

Ensuring Equitable Access within Communities

This is true in primary production also. We need a massive effort to bring back the productive capacity of the land in a sustainable way. But it must be an equitable way also. It must be a way where marginalization of weaker sections decreases. If for example a water users committee is formed to manage a tank or a watershed, then it becomes essential for us to ensure that the dalits and other landless get not only wages from such work but also a part of the assets created and a share in the decision making process. These are not impossible demands. On the contrary time and again it has been shown that this is the only way of showing results that are sustained. Any other way is neither desirable, nor in the long run, feasible!

Democratic and Ethical Framework

Whenever attempts are made to generate and improve livelihoods in the unorganized sector one must remember the problems of initiating such attempts within a system that is based on competition and greed. In such a system, livelihoods that are generated can be more drudgery prone, more unfair to women, it can employ child labour to cut costs and be more exploitative of the work force than in the organized sector. Only a conscious effort to avoid this along with more democratic forms of management of these networks can prevent this from happening. Only if such a goal is attempted will such livelihood interventions lead to larger social changes. So there is need for mutual co-operation, change of mindsets and change of concepts.



What is to be done?

A "Health for All Now" movement should have amongst other things, a component to provide support to the disadvantaged and unorganized poor in defense of their livelihoods.

Micro-enterprises:

Each state can set up, to begin with a group of competent professionals who will study in-depth the prospects and problems of local micro-enterprises in the era of global mega enterprises. There should be a number of study teams associated with each state core group to inquire into:

1. Physical and human-resource base.
2. Market surveys & choice of products & size of production.
3. Identification of appropriate technologies, bridging the gaps that may be there, ground level operationalization, continuous up-gradation etc.
4. Marketing, creation of new market, capturing of existing markets, non-market-marketing etc.
5. Institutional frameworks needed to promote and preserve micro-enterprise initiatives and collectives.

This could be a beginning with a one year programme started towards the latter part of the year. There could be a number of state, regional, and national level consultations. There could be 15 to 20 state level groups and four, five subcommittees in each group. Towards the middle of the 2001, we can have a tentative plan for the "fight back initiative". What is the guesstimate of money available for such community initiatives from:

a. Government sources b. Own savings c. Institutional financing ?

What could be the size of the market in macro terms created by:

a. Expanding consumption (by increasing incomes of the poor)
b. Replacing larger players

The numbers involved are huge, very huge!

Agriculture:

The scope for intervention in the primary sector is just as large. For intervention in primary production there are a number of models to learn from and replicate in tune with local requirements. What one needs is a massive replication and a coordinated campaign much on the lines of the current campaign for health. After all the impact of structural adjustment on the agricultural sector is as damaging if not even more so than the health sector!

The tasks before us are two-fold:

1. Bringing back Land Reform, Access to Common Property, Basic Human Rights & Right to Information into the political agenda.
2. Creating alternative models of development, networking them and campaigning for a responsible pattern of consumption.

Only a proper combination of these two aspects can lead to a social transformation.

Book Titles in this Series:

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-Understanding what globalization is all about and how it affects the health of the poor.

2. Whatever happened to Health for All by 2000 A.D?

-an understanding of the making and unmaking of the Alma Ata declaration.

3. Making Life [illegible]h Living!

-Meeting the ba[illegible] of all-Inter-s[illegible]toral issues in health care

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A World Where We Matter!

Towards the People's Health Assembly Book—4

A World Where WE Matter!

-health care issues of women, children and the marginalized sections of society.

Prepared and Published by
The National Coordination Committee
for the

Jan Swasthya Sabha

Towards the People's Health Assembly Book-4

A World Where We Matter

First Edition : May 2000

Authored and Published by :
National Coordination Committee, Jan Swasthya Sabha

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National Coordination Committee Members

- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- All India Women's Conference (AIWC)
- Bharat Gyan Vigyan Samithi (BGVS)
- Catholic Health Association of India (CHAI)
- Christian Medical Association of India (CMAI)
- Forum for Creche & Child Care Services (FORCES)
- Federation of Medical Representatives Associations of India (FMRAI)
- Joint Women's Programme (JWP)
- Medico Friends Circle (MFC)
- National Alliance of People's Movements (NAPM)
- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Ramakrishna Mission (RK)
- Society for Community Health Awareness, Research and Action (SOCHARA)
- Voluntary Health Association of India (VHAI)

Participating Organizations

Over 1000 organizations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Sabha campaign as participating organizations.

About the Jan Swasthya Sabha

Governments & international agencies have forgotten the goal of **Health for All by 2000 A.D.** But we, the people, cannot forget it. It is time to strengthen & expand people centered initiatives - to find innovative solutions & to put pressure on decision makers, governments and the private sector.

There is a need to reiterate that attaining **Health for All** means ensuring everyone has access to affordable quality medicare, safe drinking water and sanitation, adequate nutrition, clothing, shelter and employment and no one is discriminated against on the basis of class, caste, race or gender. People need to be made aware of the links between globalization and the worsening health of the people. When structural adjustment policies work to undermine the vision of Alma Ata, renewing the Health for All call is an imperative.

With this understanding a large number of people's movements across the country have jointly initiated a national campaign called the Jan Swasthya Sabha. This has three broad objectives:

- To re-establish health and equitable development as top priorities in policy making with primary health care as the strategy.
- To forge a local, national and global unity of all democratic forces to work towards building long term sustainable solutions to health.
- Reinforce the principle of health as a broad inter-sectoral issue

The campaign has a four-tier structure. 2000-3000 blocks in 200-300 districts mobilize people on **Health For ALL – Now!** and conduct block level enquiries into the state of health services. These enquiries culminate in block seminars highlighting the findings & helping formulate people's initiatives for primary health care. Then, each district has a district level mobilization culminating in a District Seminar. All this builds up to the Jan Swasthya Sabha to be held in Calcutta from Nov 30th – Dec 1st 2000. Four trains with representatives from various parts of the country will arrive at the National Assembly. The Jan Swathya Sabha – with over 2000 representatives – will call for a reversal of structural adjustment policies and a renewal of the *Health for All* pledge. The assembly will also send its representatives to the international People's Health Assembly being held at Dhaka from Dec 4th-8th, 2000 where similar representatives from other countries will gather. Following the Jan Swasthya Sabha, each interested block or district follows up with health intervention and advocacy.

The Jan Swasthya Sabha is being coordinated by a National Coordination Committee consisting of 15 major all India networks of peoples movements and NGOs. This book is the second book in a 5 book series brought out by the NCC for guiding the block, district and state seminars.

Contents

Chapter I

The Marginalized and the Vulnerable

Get out! Don't you know this has been declared a reserve forest?

No restrictions on milk product imports! No more protection for cottage industries!

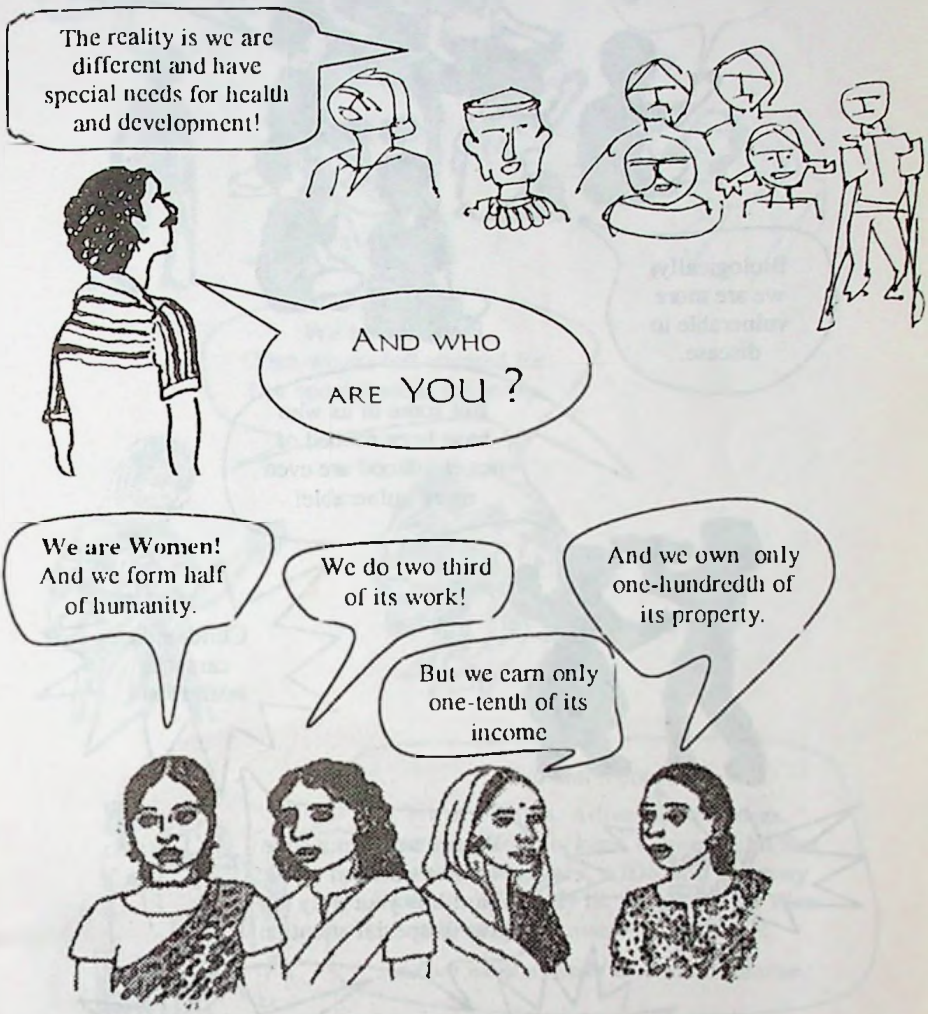
You must use this injectable contraceptive. It is part of the national scheme.

You have 24 hrs to shift out of here! We are cleaning the beach for tourists.

But nobody even asked us! This hurts us! We need...

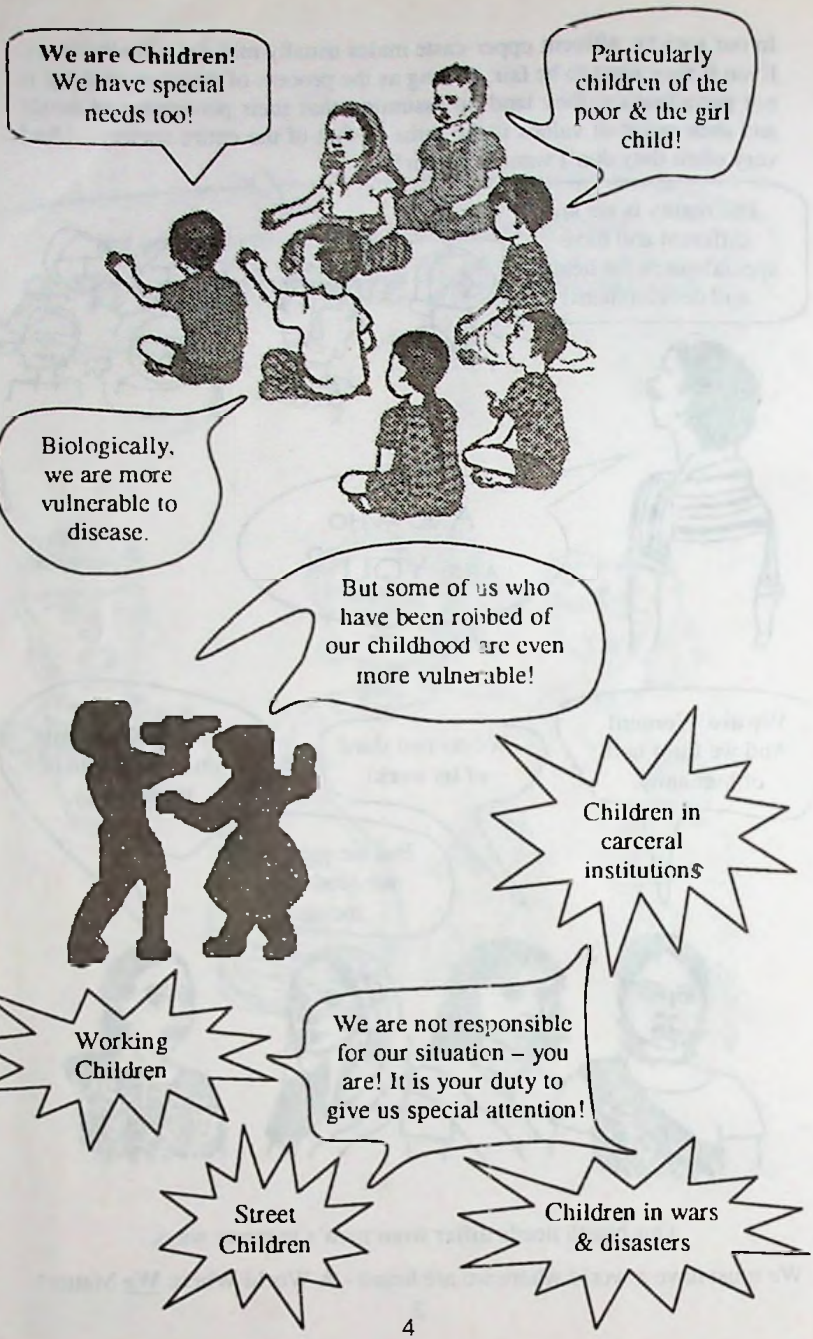
A World Where We Matter !

In our society, affluent upper-caste males usually make all the decisions. Even if they want to be fair, as long as the process of decision-making is not participatory, they land up assuming that their perception of needs and their sense of values is the same as that of the entire society. (And very often they don't want to be fair!)



Our health needs differ from men's in many ways.

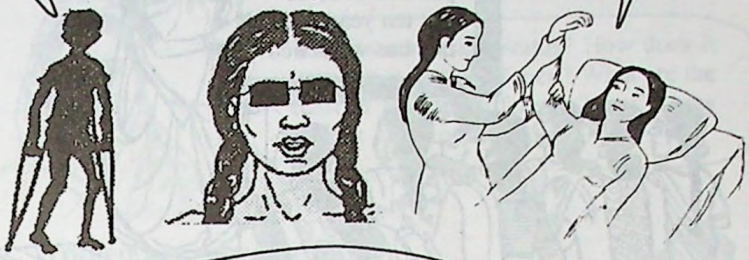
We must have a world where we are heard - A World Where **We** Matter!


We are Children! We have special needs too!
Particularly children of the poor & the girl child!
Biologically, we are more vulnerable to disease.
But some of us who have been robbed of our childhood are even more vulnerable!
Children in carceral institutions
Working Children
We are not responsible for our situation – you are! It is your duty to give us special attention!
Street Children
Children in wars & disasters

People call us disabled. But **We are actually Differently Abled!**

We too contribute to society!

And society should provide for our special needs!



We are the aged.
Often we are left uncared for.
Our special needs are many.

And that's not all!

We are Dalits, Adivasis, Prisoners, Unorganized Workers, Commercial Sex Workers, Beggars, AIDS and Leprosy Patients, Mentally ill, Disaster and War affected and many many more!

And we want a world where WE matter!

How Structural Adjustment affects Women and Children

Racial & Gender imbalances have persisted

Income gaps have widened

Access to social services has shrunk

In the last ten years...

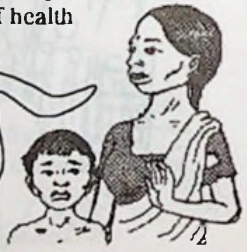
Traditional systems of knowledge & health has been further threatened

Morbidity & mortality has increased amongst vulnerable sections of the population

Within the health sector there has been a failure to implement the Primary Health Care policies. The main deficiencies include:

a) A retreat from goal of national health and drug policies
b) A lack of insight into inter-sectoral nature of health
c) A failure to promote genuine involvement of communities
d) An inequitable privatization policy reducing state responsibilities.
e) A narrow top-down, technology oriented view of health

These changes affect us – poor women & our children – the most! Things were bad before, but there were some social services that helped us cope. Now, the government is saying, "It is entirely your lookout!"



Chapter II

Women's Health

Focusing on the Poor

What is our health status? How does it compare with that of men? What are the reasons for the difference? Let's now look at some of the issues...

Women are more prone to death and disability!

What is the proof?

Just Look at the Sex Ratio!

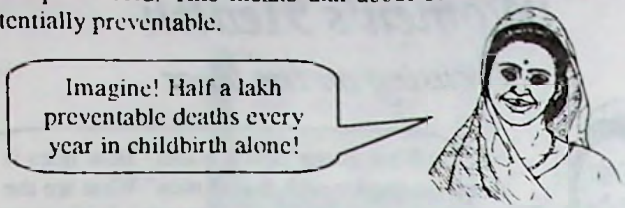
The sex ratio is already low, and declining! It now stands at 929 women per 1000 men. In 1941 it was 945 per thousand. Even in a state like Tamilnadu which seems to be doing better with a sex ration of 972 per thousand we see that even here there has been a decline from 1012 in 1941 to the present level! How's that for proof!

In most developed countries, the ratio is over 1000 women (about 1010) for every 1000 men. This means if anything, biologically women have a small advantage in terms of longevity & survival. But the Indian situation is reversed - till the age of 45, women face a greater risk of death than men.

Or Look at the Maternal Mortality Rates....

The risk of death is greatest during the child-bearing years when deaths associated with pregnancy add on to other causes. In India today the maternal mortality rate is over 400

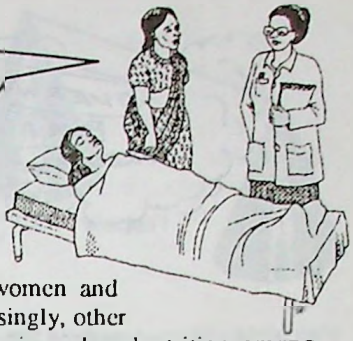
per lakh. This is as compared to less than 10 per lakh in the entire developed world. This means that about 390 of these 400 deaths are potentially preventable.



State	Sex ratio	Maternal Mortality	Infant Mortality
Andhra	972	436	66
Arunachal	861	-	47
Assam	925	534	78
Bihar	912	470	67
Goa	969	-	23
Gujarat	936	389	64
Haryana	874	436	69
Himachal	996	456	64
J&K	923	-	45
Karnataka	923	450	58
Kerala	1040	87	16
Madhya Pr.	932	711	98
Maharashtra	936	336	49
Manipur	961	-	25
Meghalaya	947	-	52
Mizoram	924	-	23
Nagaland	890	-	NA
Orissa	972	738	98
Punjab	888	369	54
Rajasthan	913	550	83
Sikkim	880	-	52
Tamilnadu	972	376	53
Tripura	946	-	49
Uttar Pr.	882	624	85
West Bengal	917	389	53
All India	929	453	72

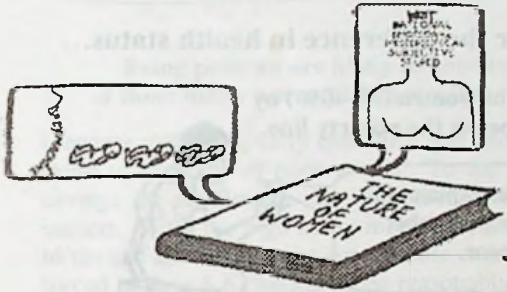
Source: Sex Ratio is based on the 1991 Census, Maternal mortality on UNICEF's reports and the Infant Mortality Rate is from the National Population Policy Annexure and is based on Govt. Statistics 1998.

Or look at the morbidity rates!



Women's morbidity, is higher than of men. In one study in rural Maharashtra (by FRCH) the difference seen was 730 women as compared to 513 men were sick at any given point of time (i.e, 19.7 women and 13.8 men per 1000 population). Not surprisingly, other health indicators such as levels of anemia and malnutrition among women remain unacceptably high. Almost all women are anemic.

Why are we more prone to death and disability ?

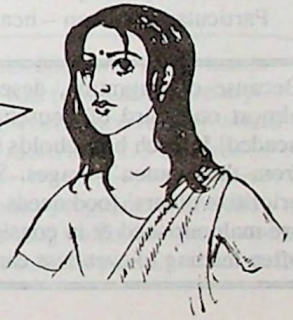


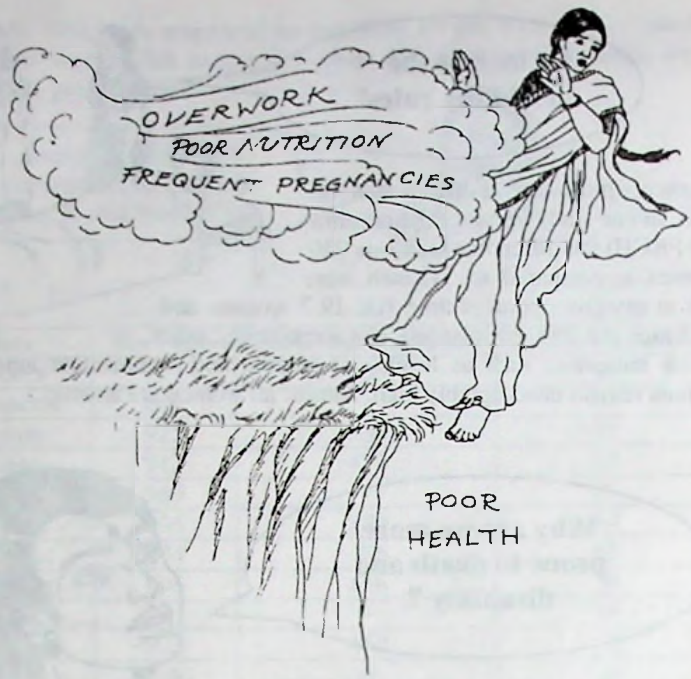
Because nature has made you weak! It is natural that you fall ill more often. This inequality is biological!

No!

That's a rotten theory - our poor health is not biological!

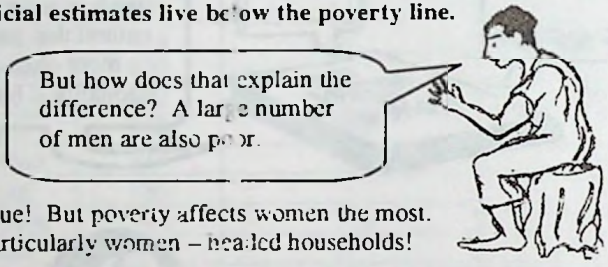
The real answers lie not in the patriarchy of nature but in the nature of patriarchy!



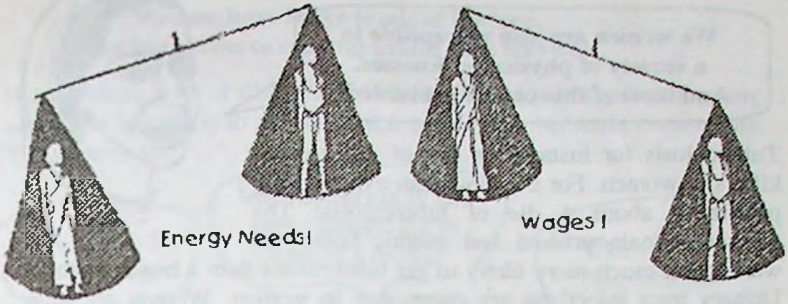


The real reasons for the difference in health status...

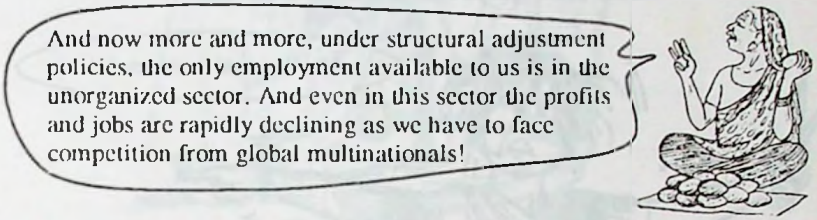
A sizeable proportion of women (30-40%) by official estimates live below the poverty line.



Because of migration, desertion or death or factors like alcoholism, almost one third of households in rural areas are effectively woman headed! In such households the major income, often the only income is from the women's wages. Since women are paid less and since they prioritize others' food needs over their own, women in such households are malnourished & in considerable suffering! And so they fall ill more often leading to even less earning and further suffering!



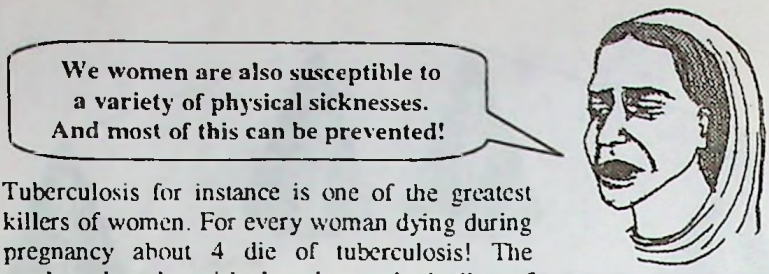
Women are paid less than men for the same work and usually hired only for lower rated work, (eg weeding) which are called women's work though they maybe as strenuous! And most women's work is in the unorganized sector, where there are no maternity benefits and no savings provisions and where working conditions are abysmal.



Being poor we are likely to have more children, many of them below normal birth weight or still born or aborted.

Frequent childbirth, early childbirth and excessive childbirth is a major cause of ill health of poor women. To the poor, children are the only savings for the future. In a patriarchal society only the male child matters. Given the high infant mortality rates, and the high rates of still births and abortions, to be sure a male child survives a woman is often forced to have 5-6 children to be reasonably sure of having a surviving male child during their old age. At any rate the bearer of the child has little say on the decision to have a child.

So many pregnancies and the accompanying morbidity leave women too weak to fully participate in society.



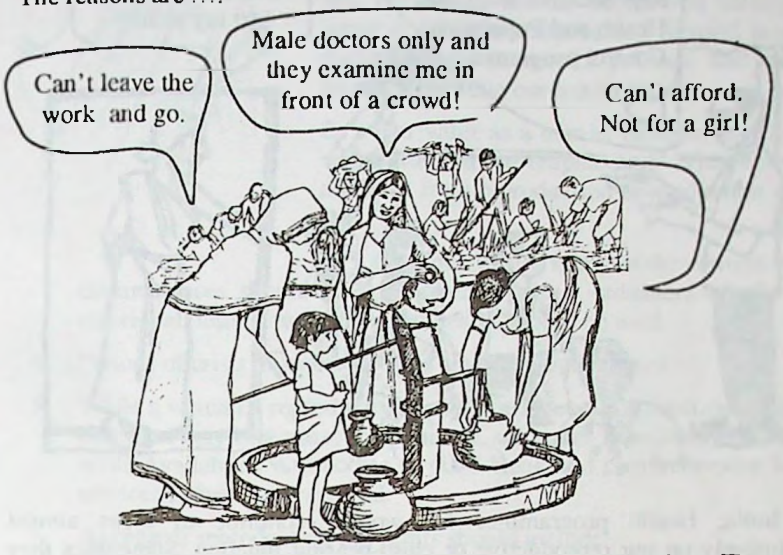
Tuberculosis for instance is one of the greatest killers of women. For every woman dying during pregnancy about 4 die of tuberculosis! The weakened malnourished and anemic bodies of women are much more likely to get tuberculosis than a healthy person. Urinary tract infections are commoner in women. Women are more likely to get HIV! And of course all pregnancy related diseases affect only women!

We do exhausting work at home in poor environmental conditions. And at work, we have the dirtiest, most tiring jobs with inadequate remuneration and rest.

Women have neither weekends nor holidays! Just the sheer exhaustion of over work along with the poor conditions of living and working is enough to cause disease. In the house, the kitchen and the woman's space is often the poorest. Privacy is inadequate and toilets non-existent. The work place is usually cramped with no special understanding of a women's needs. Because men make the workplace though women work in it.

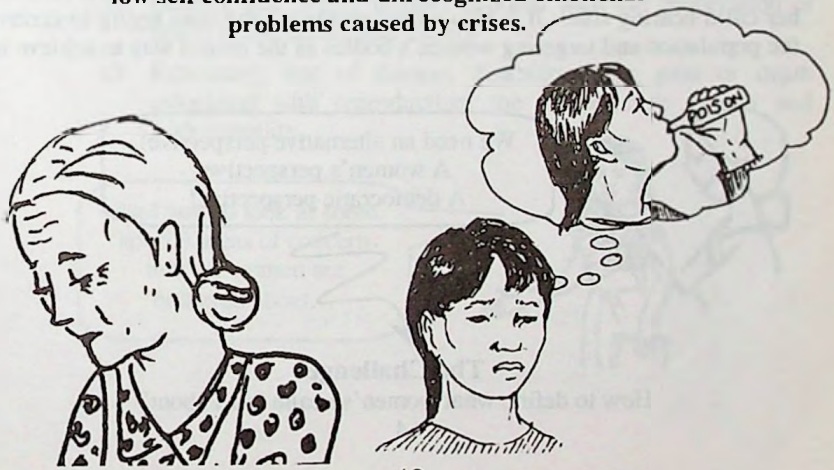
Women have lower levels of literacy, and less access to existing health care services.

For the sane level of illness a girl child, an adolescent girl or a young woman is less likely to go to a health center than her male counterpart. The reasons are ....

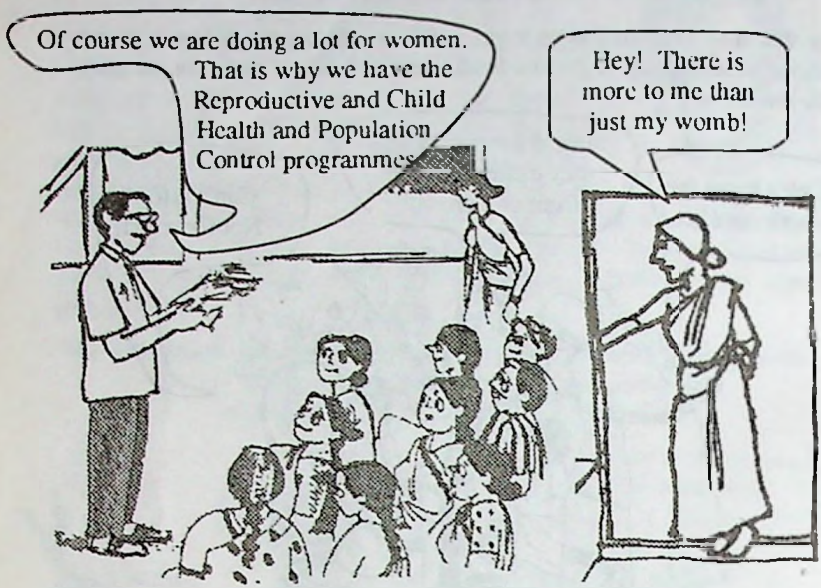


And many more reasons including shame & lack of information. These issues affect even educated women, though to a relatively lesser degree.

Life in this situation makes for a poor self-image, low self esteem, low self confidence and unrecognized emotional problems caused by crises.

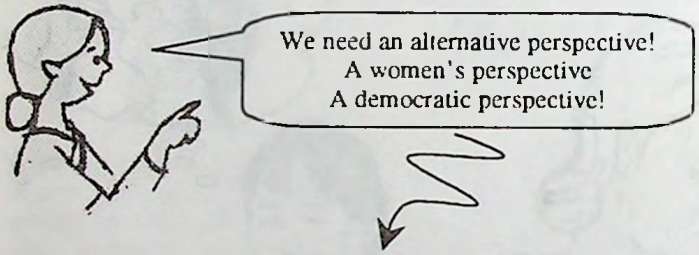


But do health programmes address these issues?



In India, Health programmes for women continue to focus almost exclusively on our reproductive or child-bearing function. Sometimes they mention the girl child or the adolescent girl but often these are more in the form of token gestures. !

This is an old problem - the way a patriarchal society values women only for her child bearing role! It is also a new problem - the state trying to control the population and targeting women's bodies as the easiest way to achieve it.



The Challenge

How to define what women's health is all about?

Our Health Ourselves!

The foundations...

1. We are human beings situated in society and our health has to be viewed through an integrated holistic approach. Several medical, societal, socio-economic, political and cultural factors determine our health status.

2. Our value as a human being of dignity and worth needs to be emphasized. This has to be delinked from reproduction or production of any type.

3. Our total health needs in the context of our circumstances should be considered. Positive indicators of physical, emotional, intellectual and social health should be used.

4. Periods of crisis in women's lives should be recognized.

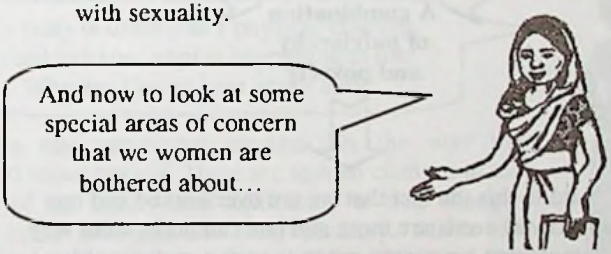
5. While a woman's reproductive system influences the functioning of her body and may be a cause for ill health, we suffer from other diseases as well! Availability and access to good basic and comprehensive health services is therefore essential.

6. As regards reproduction our rights should include:

   a) Regulating our own fertility safely and effectively, by conceiving when desired, terminating unwanted pregnancies, and carrying wanted pregnancies to term

   b) Bearing and raising healthy children with the cooperation of males in the family and society

   c) Remaining free of disease, disability, fear, pain or death associated with reproduction, the reproductive system and with sexuality.



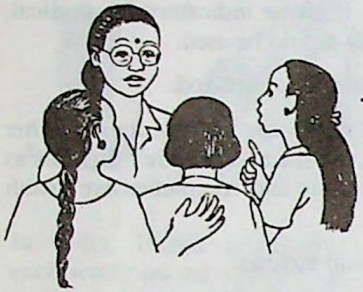
Some Special Areas Of Concern

Nutrition and Health

Malnutrition is much more common in the girl child than it is the boy. The resulting stunting of growth is itself a health hazard throughout life but more so during pregnancy, when the risk of death during pregnancy is multiplied many times over. Stunting also means the irreversible underdevelopment of the child.

Girls are again at high risk for malnutrition during adolescence! Once again this is a major period of considerable growth and organ formation and the inadequate nutrition leaves the young woman further stunted.

Iron intake of girls is about half of the recommended allowance especially during adolescence and the condition of anemia worsens with further losses due to menstruation.



Distribution
Women eat last, and least. They are denied the more nutritious food and within the prevailing culture, often deny it themselves.

Taboos
Even during pregnancy, childbirth & illness, taboos ensure that women get less food, even when it is available!

A combination of patriarchy and poverty

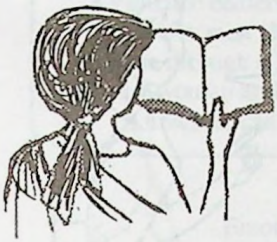
Add to this the fact that we are overworked and our nutritional needs are more and one can understand why malnutrition amongst women is such a major problem!

⇒ In spite of the Mother & Child Health and Anaemia Prophylaxis Programmes, 85% of pregnant women are Anaemic !

⇒ 20% pregnant women are stunted i.e., high-risk mothers with less than 4' 10" making their childbirth difficult.

⇒ 50% pregnant women fail to put on appropriate weight due to
* Inadequate Food
* Eating last and least;
* Double and triple burden;
* Unjust sharing of food and work;
* Caloric deficit;
* Inadequate care and nourishment in the matrimonial home.

Education



Female literacy rates are less than half the rate for rural males! For dalit and adivasis women it is even lower.

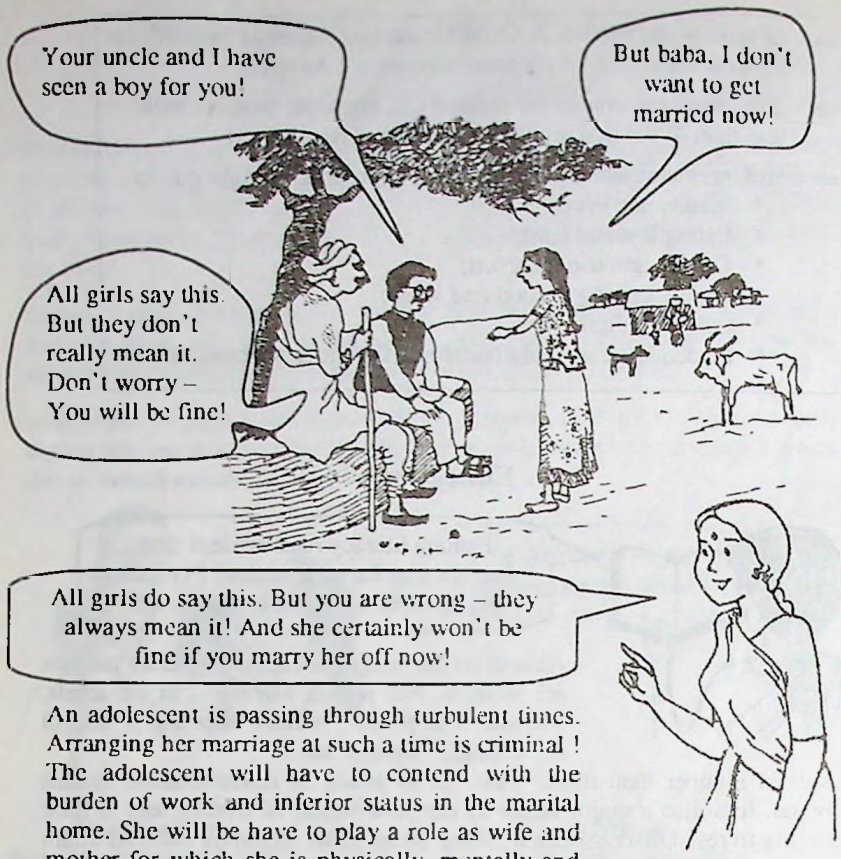
Almost 60 per cent of India's non-literate citizens are women. Not just in literacy – at all levels, whether it is primary school, secondary school or college, women are fewer in number than men. This is an index of discrimination against women. It is also a major factor in the poor health of women and in their inability to resist discrimination. Many social goals including reduced infant mortality or fertility control are closely linked to educational levels of women!

Adolescence & Early Marriage

The onset of puberty is a time of crisis for women.

My body is undergoing physical changes.
I need to know what is happening to me!
Why am I being kept in the dark?

There are also emotional changes, in the way the adolescent views herself. There are sudden changes in the attitudes of the family and community to her, changes that are often irrational and discriminatory, which she resents and is completely unprepared for. One discriminatory change for example is the way she is restricted from outdoor activity!



An adolescent is passing through turbulent times. Arranging her marriage at such a time is criminal ! The adolescent will have to contend with the burden of work and inferior status in the marital home. She will be have to play a role as wife and mother for which she is physically, mentally and emotionally unprepared. The cost to her health and well being is enormous. Early marriages, pregnancies and motherhood result in acute health risks leading to maternal and child deaths.

Violence

Violence against girls and women is pervasive among all social classes and castes in India, battering them at every stage of life. Violence against women is rooted in the tradition of

discrimination that has been going on for centuries. Rape, sexual harassment, murder, dowry deaths, sati, physical and psychological abuse, female foeticide and infanticide are among the numerous forms of violence against women that are increasingly being reported in India.

Most violence related injuries are perpetrated by men against women – violence is a gender issue! Gender violence cuts across all socio-economic groups.

Let's try to understand this violence against women...

Violence centers around Power and Control. A man chooses to use violence because through it he can exert his power on the woman and try to control her. He knows he can get away with it.

Emotional & psychological abuse can be as debilitating as physical abuse. Mental torture, Fear of violence, Terror, Depression, Loss of confidence, Effect on children.

Violence within family is as injurious as assaults by strangers.

Alcohol exacerbates but does not cause violence against women.

Power And Control

Most violence risk is from men women know.

Most violent men are not mentally ill.

There are societies free of violence against women.
Male violence is social not biological!

Remember, women face violence of different forms all through their lives!

VIOLENCE WOMEN FACE OVER THEIR LIFE CYCLE	
FOETUS	Sex selection and Female Foeticide
INFANT	Infanticide and Malnutrition
GIRLHOOD	Socialization into a *'female'* Unfair sharing of work & food, Sexual Abuse, Physical and Mental Violence
ADOLESCENCE	Early & sometimes forced marriage Pregnancy Confusion about unexplained bodily changes
ADULT WOMEN	Marital rape & wife-battering Sexual harassment at workplace Dowry Harassment Infertility/failure to produce son Desertion High Maternal Mortality Medical violence - needless Hysterectomy, Caesarians Hazardous Contraceptives like Quinacrine
OLDER WOMEN	Desertion and Neglect – Emotional Security Lack of Financial and Social Security Misuse of Mental Health Act

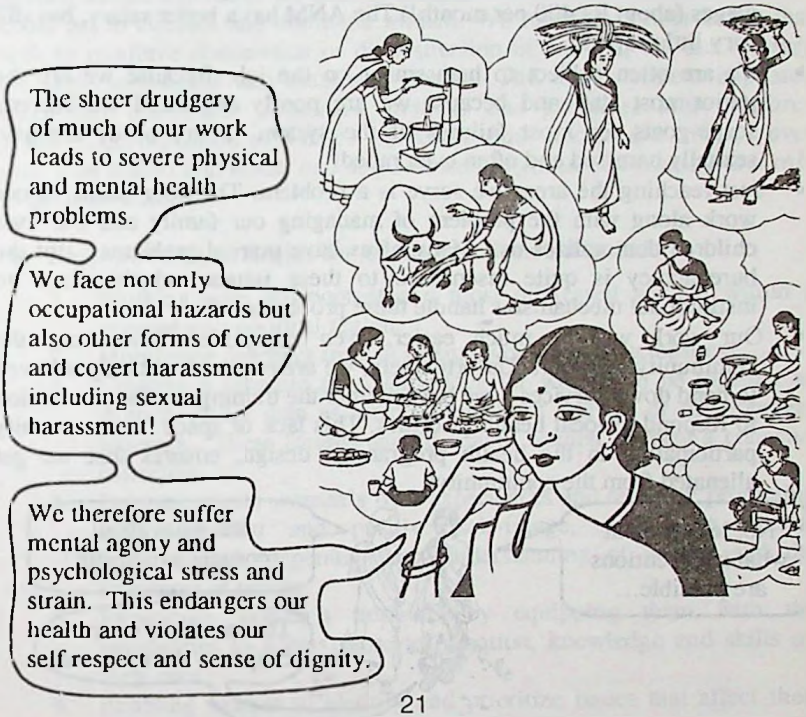
This Gender Based Violence affects our health seriously. Some of us commit suicides, others are murdered. But many more of us are affected in less dramatic but still equally serious ways!

The Physical and Mental Consequences of Violence

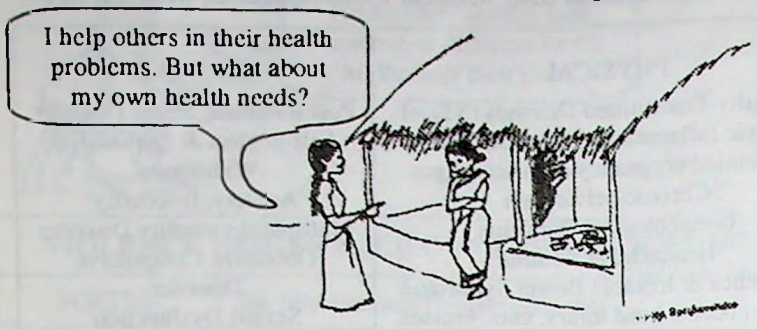
PHYSICAL	MENTAL
Sexually Transmitted Diseases (STDs)	Post traumatic Stress Disorder
Pelvic Inflammatory Disease (PID)	Self-neglect & Depression
Unwanted pregnancy & miscarriages	Withdrawal
Chronic pelvic pain	Anxiety, Insecurity
Gynecological Problems	Multiple Personality Disorder
Headache & Asthma	Obsessive Compulsive Disorder
Diarrehea & Irritable Bowel Syndrome	Sexual Dysfunction
Broken bones, head injury, cuts, bruises, Rupture of ear drum and jaw dislocation	Eating, Drinking Disorders
Injurious Health Behaviour like Alcohol, Tobacco, Drugs & Sedatives	Suicidal Tendency

In addition, we also suffer the social consequences of such violence.

Occupational hazards



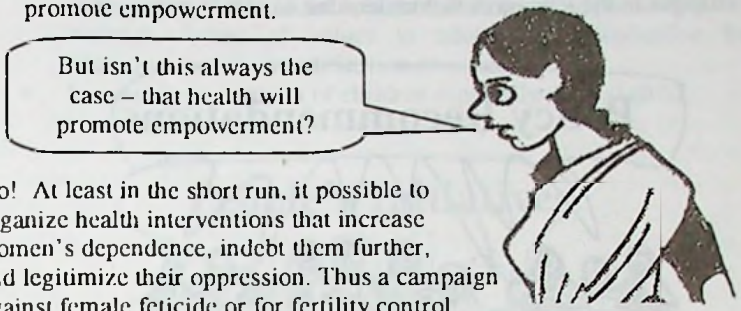
The health of women health care providers



- We women, have been the most important health care givers from times immemorial, tending to our family and our community - both in traditional cultures and in modern times.
- We – as Dais, ANMs, Nurses or Anganwadi workers - continue to provide most of the care, but our contribution is not adequately recognized and often undervalued. The Anganwadi worker for example has an enormous list of work, but very little support and very little as wages (about Rs 400 per month!) The ANM has a better salary, but still very little support.
- We are often subject to harassment on the job. Because we are the junior-most staff and because we are poorly organized we become scape-goats for most failures of the system. Many of us are also sexually harassed and often even raped!
- Just reaching the areas we serve is a problem. The poor status of our work along with the problem of managing our family and our own children demoralizes us. Many of us have marital problems. But the bureaucracy is quite insensitive to these issues and there are no institutional mechanisms handle these problems either.
- Our work will be much easier, even enjoyable, if we have the community's support. Unfortunately, we are required and only allowed to hand down services – we have neither the training nor the permission to respond to local health priorities. This lack of space for community participation in the health programme design, ensures that we get alienated from the community!

Interventions
The Notion of Empowerment

❖ Our health will improve sustainably only if we are empowered. Therefore health intervention should go hand in hand with interventions for our empowerment – in fact the health intervention should itself promote empowerment.



No! At least in the short run, it possible to organize health interventions that increase women's dependence, indebt them further, and legitimize their oppression. Thus a campaign against female feticide or for fertility control could act to threaten and dominate women. We reject such approaches that seek to reinforce domination or domestication of women. On the contrary we seek approaches that empower women. The empowerment approach essentially *challenges structures, systems and practices that reinforce gender discrimination and helps women to gain access and control over their own bodies and minds and helps women to gainsocial status and a role in decision-making!.*

❖ Empowerment Strategies can be many and should include:

1. Working with the poorest and most oppressed women within a selected geo-political region.
2. Mobilizing, learning from & raising women's consciousness.
3. Creating a separate *time and space* for women to be together as women, rather than as mere recipients of welfare or development schemes. These forums should enable women to form a cohesive collective.
4. Beginning with women's own experiences and realities: promoting self-recognition and positive self-image, stimulating critical thinking and deepening their understanding of gender and the structures of power.
5. Expanding women's horizons by equipping them with the capabilities to access more information, knowledge and skills on their own.
6. Enabling women to identify and prioritize issues that affect their lives for action and to make informed decisions.

- Enabling women to formulate their own vision of an alternative society, including alternate models of social and economic relations and alternate development theories.
- Strengthening women's independent and interdependent struggle for change in the material conditions of their existence, in their personal lives and in their treatment in the public sphere.
- Facilitating the formation of women's mass organisations at local, regional, national and international levels in order to bring about changes in the structures that undermine women's status.

All policies that affect our health should be subjected to review and new policies evolved where there are inadequacies and lacunae at present. In particular we demand that:

1. A National Population Policy should be formulated only after an open & widespread debate with attention to the comments & criticisms already communicated by various concerned groups. The new population policy should adhere to the commitments made at Alma Ata, CEDAW and the Convention on the Rights of the Child, firmly steering clear of all coercive measures and disincentives.

2. The highest priority to be placed on education, health care, food and employment of women and all programs and policies of the state should respect our social, reproductive and economic rights.

3. Suitable legislative and administrative measures to urgently address the following concerns:
   - Increasing privatization of health care and the rise in prices of life-saving drugs.
   - Increasing maternal deaths in abortion related cases.
   - Increasing lack of food, malnutrition, feminization of poverty.
   - Growing illegal use of women for contraceptive research.
   - Increasing emphasis on Reproductive health without integrated strategies to tackle social issues of male legal responsibility, sexual violence, issues of values in adolescent reproductive health education, and commodification of women.
   - Increasing prostitution of children especially the girl child.

1. Identify in your area, major causes of mortality and morbidity in women and girls and seek women's assessment of women's and communities' need. Also critically analyze the roots of ill health and current trends.
2. Sensitize the public, health department, schools & panchayats about women's social reality & expose the myths that sanctify discrimination - gender stereotypes (like women are women's worst enemies), the role of XY Chromosome in Sex Determination etc.
3. Prioritize the meeting of Basic Needs (Basic Health, Education & Housing) and social security for women within all local planning and developmental work.
4. Familiarize yourself with all govt. welfare & health programmes, Government schemes for girls and women and other opportunities for growth. Disseminate such information to other women.

5. Familiarize your community with health facilities available locally, especially the extensive maternal and childcare services that are available through the primary health center network & the ICDS schemes. Ensure full utilization of existing facilities & build public opinion for expanding such services and improving their quality.
6. Share experiences about using different approaches and strategies and using government and NGOs initiatives. (Like the Sathin Programmme, Dangar Dais, Total Literacy Campaigns, Mahila Mistrys, Anti-arrack movement, Barefoot Handpump mechanics)
7. Understand and Document Traditional Systems, local health practices, local health culture, Traditional System of Medicine, existing health facilities, health situation & referral system.
8. Prepare an Essential & Rational Health Care Package that provides health education as well as prevention & also easily accessible, affordable and safe essential curative care. Train village health workers to reach such information and skills to poor women. Train health personnel in prevention and rational management of health problems and understanding their roots.
9. Develop a good Management Information System & register marriages, pregnancies, childbirths, deaths, acute communicable disease outbreaks (malaria, cholera) & collect disease data with gender dimensions (like Suicides, TB and Malaria) in your area.
10. Help women get their legal/social rights eg. register marriages, ensure joint pattas to home, land, joint guardianship of children, Stree Dhan received at marriage as a norm.
11. Identify Occupational Health Hazards for women (specially during pregnancy) in different occupations in the region including hazards due to domestic work eg. cooking, smoke.
12. Initiate Income Generation Programmes. Ensure minimum wages. Equal wages for equal work, maternity benefits etc., and save money and family resources on liquor and inessential drugs.
13. Develop labour saving devices/technologies/work organization so as to decrease disease and work burden, enhance incomes, cooking fuel alternatives & smokeless chulha, recycling of water, conservation of waste water as well as conservation of rain water.
14. Organize women workers in the unorganized sector – Sewa has done. Promote organization of dais, midwives, ANMs etc.
15. Make credit and loans at low cost interest easily available to prevent families falling into clutches of money lenders. Build women's financial security. The credit cooperative network is one of the most powerful and effective of such interventions.
16. Provide legal literacy, legal aid and use legal tools to assist women in crisis situations and women facing violence. Develop mechanisms for counseling and providing support to the violence affected.

Chapter III

My Family, Myself!

and The Family Planning Programme

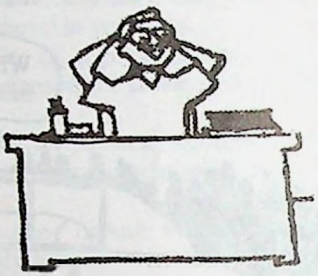
The Genesis of the Indian Family Planning Programme

Hey! What happened to the land reforms, jobs, health, education, water and food for all that you promised during the freedom struggle?

We are indeed making a lot of development gains. But uncontrolled population growth is eating it all away! The poor are breeding so irresponsibly.

How do we stop the poor from breeding?

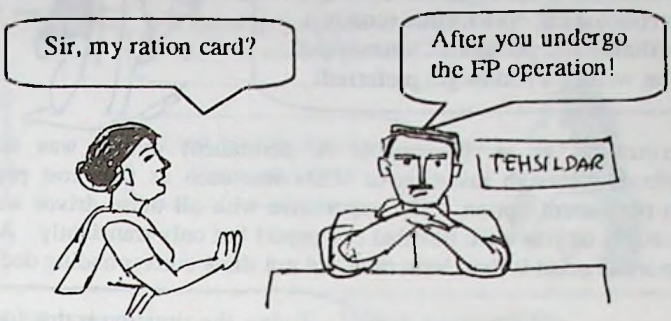
Let's start a population control programme!



Thus began the Indian family programme policy - one of the earliest and largest family planning programmes in the world. Its budget is equal to the entire health budget of the country. Politically, it has always been a top priority. Yet it has failed. Why?

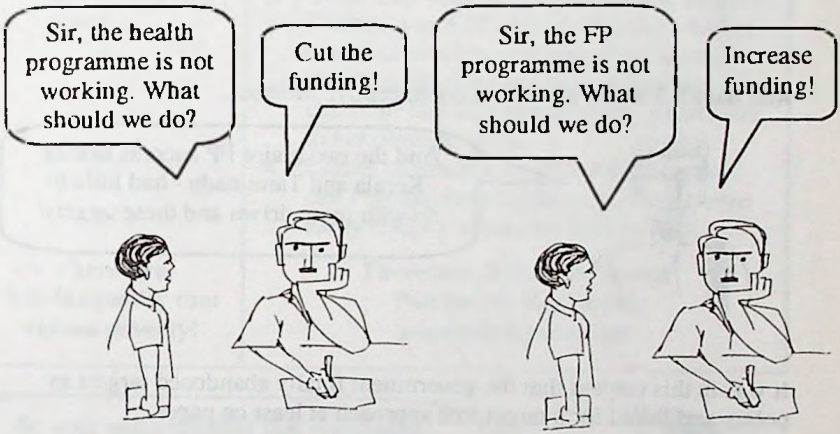
Naturally it failed. It had to! Because the theory that development is being eaten away by population increase is a false premise to start with.

Targets were also distributed to everyone possible - from the village patwari and schoolteacher, to all government functionaries.



History of Family Planning in India...

In the 1960s, the targets were for IUDs. For some time in between vasectomies was the focus. But during the emergency period this was done so ruthlessly and it backfired so badly that for all purposes it has been off the menu ever since! Then came the Tubectomy drives, and now we are in the era of Laproscopic Tubectomies. In between, there were also some efforts at popularizing oral pills, and lately, a stress on implantable/ injectable contraceptives.



Health - The poor second cousin to Family Planning!

Wherever the approach is purely administrative action driven by targets, technological options that require a verifiable and permanent intervention on women's bodies get preferred!

Sterilization as an irreversible & permanent option was seen as preferable, though insertion of IUDs was seen as the most preferred non-permanent option. The experience with all these drives was that generally targets were fulfilled (on paper) but only transiently. And the important point is that, birth rates did not show corresponding decline!

Today, the situation is that female sterilization accounts for three fourths of contraceptive prevalence. Male methods, including vasectomy and condoms, account for only 6%!

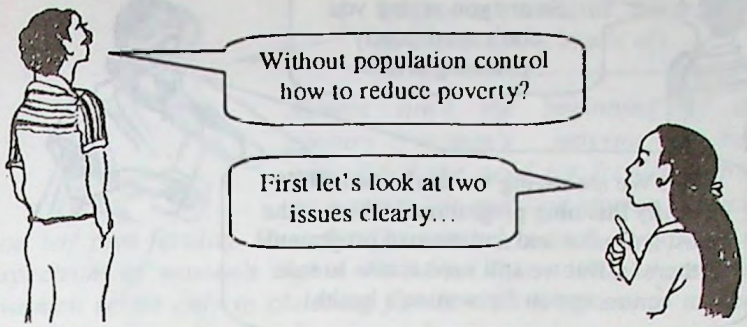
Though they are known to be safer!

And only 5.5 % use reversible contraceptive methods.

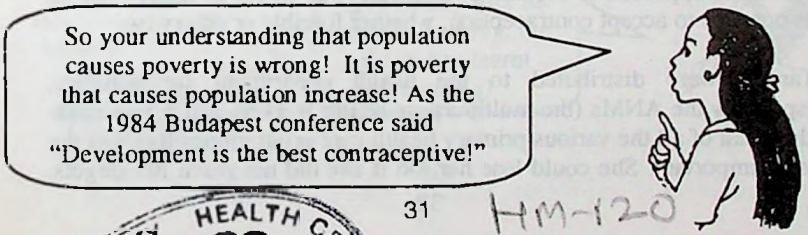
And the two major FP success stories - Kerala and Tamilnadu - had little to do with these drives and these targets!

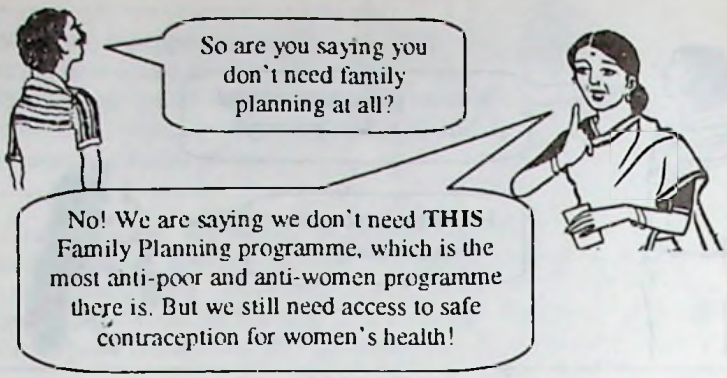
It was in this context that the government finally abandoned targets as policy and called for a target free approach at least on paper.

Hey! How about the safe contraception you were talking about?



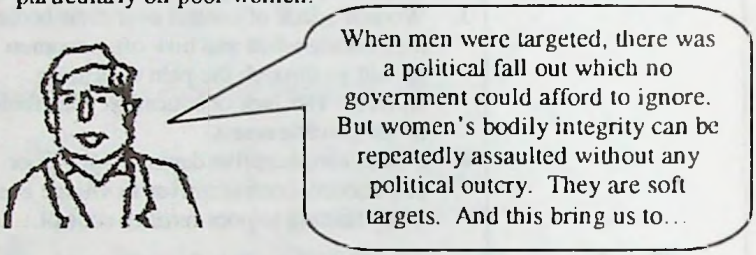
What causes poverty?	What causes population increase?
1. Concentration of wealth and power in the hands of a few. 2. Economic & Ideological structures which help perpetuate and sustain this power.	1. Wide spread poverty & lack of economic security! Why? Because to the poor, children are not a liability: they earn! With each mouth comes two hands! 2. Lack of social security – children are the only old age insurance they can afford. Combined with high child mortality rates this means, to be sure of a surviving **male** child, they need to produce several children. 3. Women's lack of control over their bodies – men decide when and how often women should go through the pain of bearing children! Her lack of education contributes to her powerlessness. 4. Unmet contraceptive demand – the poor can't access contraceptives in village even today leading to poor fertility control.
Therefore, it is Inequality that causes poverty!	**Therefore, it is Poverty and Patriarchy that cause population increase!**





How is the Indian Family Planning Programme anti-poor ?

1. By functioning as an ideology of oppression – making the poor feel individual guilt & responsibility for their socially determined condition, thereby preventing them from organizing and demanding a better deal! But focusing on population as the reason for poverty, the family planning programme diverts attention away from inequality and its inaction on this front.
2. It is also anti-poor because of the way the government coerces unethical and dangerous Family Planning methods on the poor and particularly on poor women.



How the Family Planning Programme is anti-women!

The basic approach to the family planning was to get as many couples as possible to accept contraception, whether forcible or otherwise.

Targets were distributed to the health department functionaries, especially the ANMs (the multipurpose health worker) and it was made clear that of all the various primary health care programmes this was the most important. She could lose her job if she did not reach her targets.

It is not only me sister, there is an entire history to this talk...

Almost since the beginning of this century women's movements have articulated the need for fertility control as a means for enabling women to decide on her own fertility. Here fertility control is seen as part of the spectrum of women's rights. Nor does this notion of enabling women relate only to choosing family size. It relates to a whole number of issues regarding reproduction and reproductive and sexual health rights. These include the right to:

1. *Regulate their own fertility safely and effectively, by conceiving when desired, terminating unwanted pregnancies, and carrying wanted pregnancies to term.*
2. *Bear and raise healthy children.*
3. *Remain free of disease, disability, fear, pain, violence or death associated with reproduction, the reproductive system and with sexuality.*

Education and empowerment enables us to make choices, to take decisions. Enabled thus, no woman would willingly choose more than 2-3 children!

Family Planning - The Right to Safe Contraception !

The right and ability to have the number of children we want, at a time when we want them is Family Planning. This is our fundamental right! Providing for universal access to safe contraception is essential state responsibility.

You mean, after all this FP bashing, the Govt. has learnt nothing?

No! The sustained critique from women's groups and its practical experience of unqualified failure on the field has taught it a few lessons!

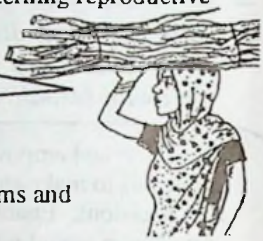
In the RCH programme, in the WB report, in the draft national pop policy, some changes are visible. They indicate what could be a welcome...

Policy Change!

Many features of these changes in the last few years are praise worthy.

1. Policy has moved away from a target driven approach.
2. Importance of addressing all the issues concerning reproductive health care is recognized, at least on paper.

But is it going to better my life and that of millions of my sisters? Will Rhetoric become action?



Looking closer there are some remaining problems and some new ones with current policy directions:

1. The entire approach is still contraceptive centered. The shift from the assumption that contraceptives have to be thrust on unwilling women to an understanding of unmet demand is welcome. But the failure to recognize even on paper the other determinants of population, especially the relationship with poverty and underdevelopment is not.
2. Equating Reproductive Health to just maternal care and fertility control is far too simplistic. Leaving out or inadequately addressing other major determinants like sexuality, cultural values, infertility services or reproductive tract infections, is not acceptable.
3. Provider controlled, long acting, invasive, hormonal methods - like Norplant and injectables which are hazardous for women, are sought to be introduced.
4. There is an assumption that privatization of certain services will provide a better out reach and make it more consumer friendly. For this a number of incentives to private sector are proposed - incentives for the private sector to open health enterprises in remote

areas, use of public facilities, more space in production of contraception, food supplements, more profits from IEC (publicity related) work etc.

Is legitimate for the government to use public funds to promote profits for the private sector? Will not costs of care increase? Will not hazards of irrational care increase?

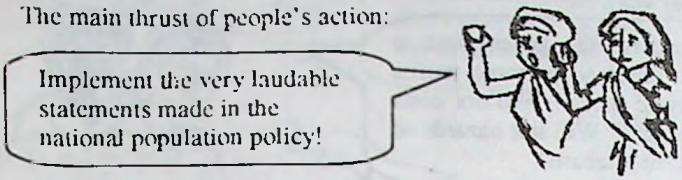
The introduction of Quinacrine for sterilization by the private sector before women's groups forced its ban is an example of this.

5. Though targets as such are removed, the plan is to allow such targets to be set at the local level through a planning process. It is unlikely that when other dimensions of health are not addressed, fertility control planning alone will help. Moreover, a number of disincentives like insisting on a two-child norm for holding elected office in panchayats are being brought in, in the hope that they would be more effective. A move to link ration cards to a two-child norm in Delhi was fought of but utmost vigilance would be needed to keep newer variants of targets from gaining hold.

6. There is a marked shift to the use of loans from international agencies for programmes of reproductive health. There are three problems with this:
   a. It indebts us further & as time passes loan repayments on health loans will become more and more of a burden.
   b. It gives donor agencies almost unlimited control over all aspects of the programme, even if the loan amount is only a small part of what we spend from our own resources.
   c. A large part of these loans flow back to the developed world as profits. The RCH loan of 308.8 million, for eg., allocates 16% ($47.6 million) for surveys & payment to consultants. A good part will be foreign consultations. By insisting on global tenders for supplying materials & by encouraging programmes based on marketable commodities, international big business is able to enter in a big way.

Policy Changes and Peoples Initiatives

The main thrust of people's action:



This policy statement should be seen as part of the outcome of over 50 years of work by concerned academicians, women's movements and NGOs in health action to bring about a better understanding of the population issue. Even in the last stages it was good advocacy that prevented something like the two-child norm for local bodies elections from getting into the policy statement. The weaknesses of the current policy (discussed above) needs be corrected by further advocacy, but it is far more important to ensure that the broad thrust of its statements are reflected in financial commitments, in the design of schemes, and at the level of implementation.

The administration has a tendency to quote and use that segment of the policy statement that suits their real goals. People's organisations too can use policy documents in a similar manner as part of advocacy efforts. In a sense, the policy document is the result of an implicit negotiation between different parties, and pressing to implement it reflects an awareness that only if there is such pressure will the agreed upon negotiation be adhered to!

Since governments are likely to keep their commitments regarding contraception provision but more likely to forget all other dimensions of reproductive health care and women's health issues as well as the inter-sectoral linkages, the thrust of the peoples campaign lies in these areas.

India's population policies are largely influenced by Western understanding of the need to control populations of the third world. Indeed, it would appear that global resources are threatened by such growth and hence imposing control is legitimate and even desirable. This argument is fallacious. First world countries are more of a threat to global resources, due to their much higher levels of consumption. It is estimated that the each child born in the U.S. consumes as much energy as 3 Japanese, 6 Mexicans, 12 Chinese, 33 Indians or 147 Bangladeshis! The total energy consumed by the U.S. is 25 times the Indian consumption despite the fact that the U.S. population is only one fourth of ours. If all the countries were to move towards catching up to the U.S. level of growth the global resources would vanish in no time! It follows that the urgent agenda, much more important than controlling populations, is curbing the luxurious and wasteful consumption of the West !

Chapter IV

Her Name is Today

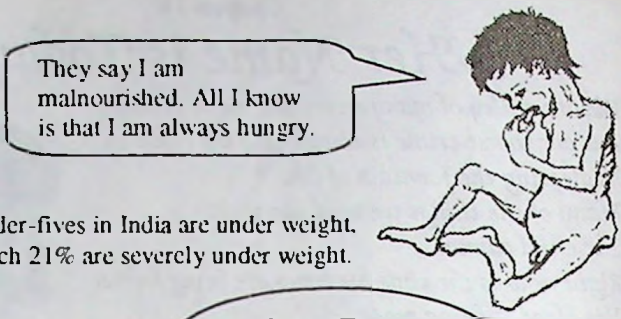
We are guilty of many errors and many faults,
But our worst crime is abandoning the children,
Neglecting the fountain of life.
Many of the things we need can wait.
The child cannot.
Right now is the time his bones are being formed.
His blood is being made,
And his senses are being developed.
To him we cannot answer 'Tomorrow'.
His name is 'Today'.

- Gabriela Mistral, of Chile

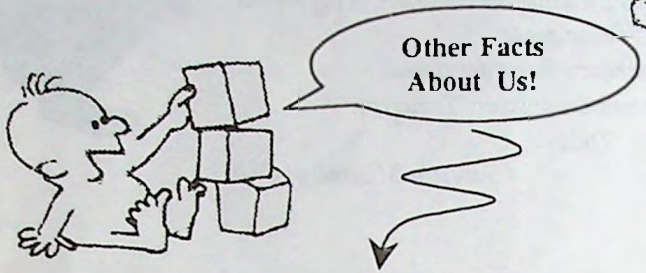
Out of 1000 children who are born like me – 330 have low birth weight, 71 will die before their first birthday and another 37 before they five.

I am one of the lucky few! Only 51% of babies in India are exclusively breast-fed for the first 3 months.

I am also lucky my dai was trained and told me to breast feed my baby. Only 34% of births are attended by trained health personnel.



53% of under-fives in India are under weight, out of which 21% are severely under weight.

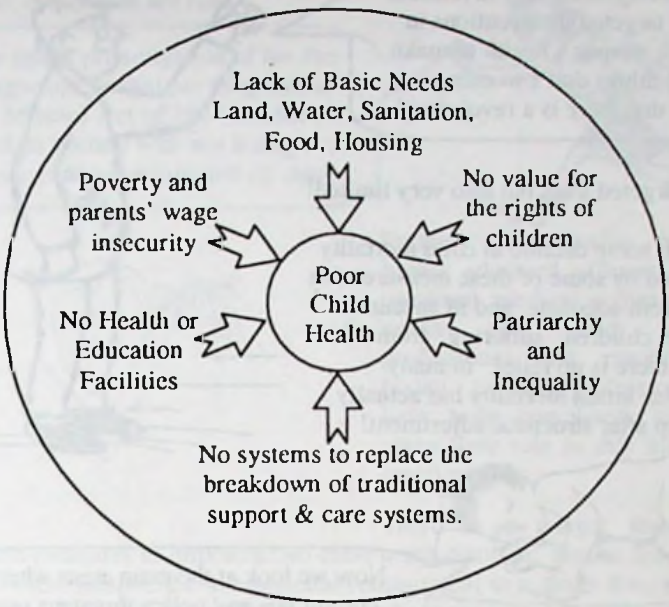


- Infant and child mortality rates are higher amongst Dalits.
- Preschool education is still inadequate in spite of the ICDS scheme
- Elementary school education is far from becoming universal
- In the 6-14 age group, there are 3 to 4 Crore working children!
- For over 1 Crore out-of-school children in the 6-14 age group, health issues are often those of survival in working environments that are hazardous, harsh and completely unacceptable.
- Growing economic disparities, migration, consumerism, breakdown of family support systems and changing values are increasingly making prostitution and sexual abuse of children a major health issue.

The Challenges

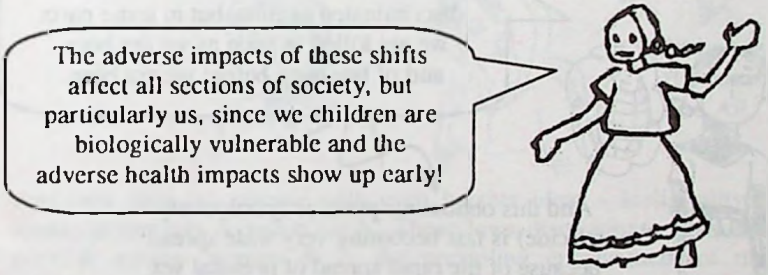
Therefore child health in contemporary India must be seen in the context of the existing class, caste and gender inequities and the effect of current policies upon these prevailing inequities.

The Basic Issues in Child Health

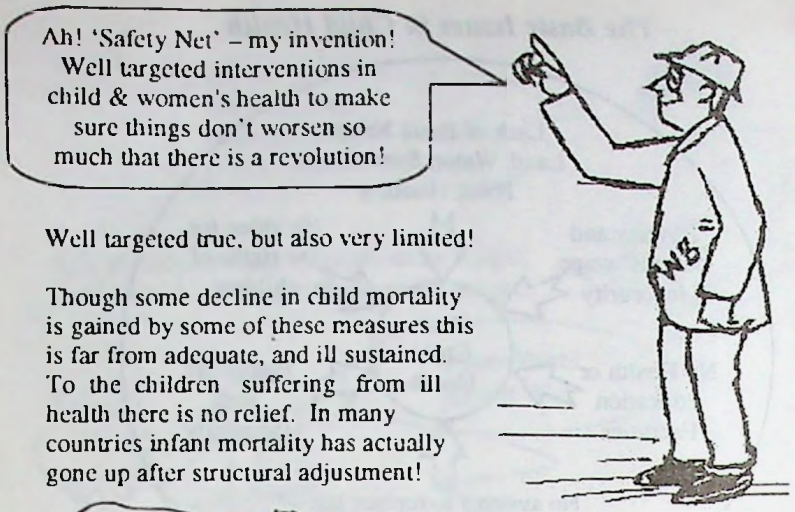


The last decade has seen the new economic policies leading to fundamental changes in the employer-employee relationship and causing shifts such as:

- Women workers from organized to unorganized sector
- Erosion of social security base of working women
- Lack of day care services
- Greater privatization & increasing costs of health care & educational services

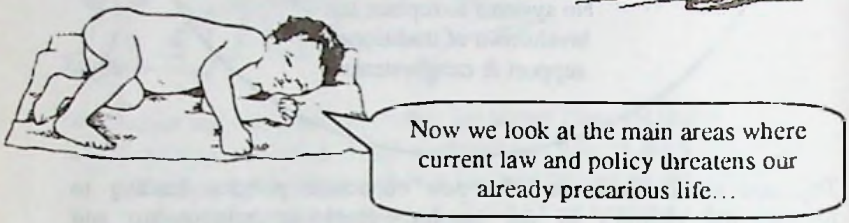


Aware of this, the votaries of the new economic paradigm are trying to make some effort at lowest possible costs to contain the inevitable negative changes in infant and child mortality rates!



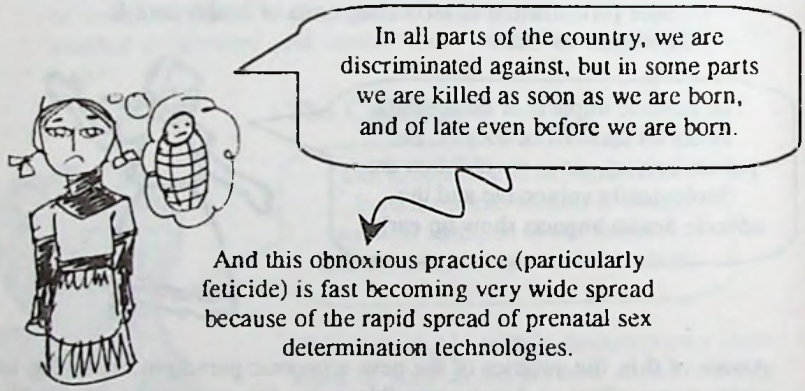
Well targeted true, but also very limited!

Though some decline in child mortality is gained by some of these measures this is far from adequate, and ill sustained. To the children suffering from ill health there is no relief. In many countries infant mortality has actually gone up after structural adjustment!



Issues of Concern

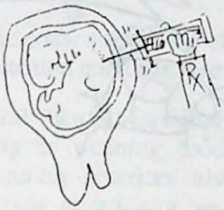
Female Foeticide and Infanticide



Both forms of murder are no doubt due to the male preference of a patriarchal society but the problem is exacerbated in the modern

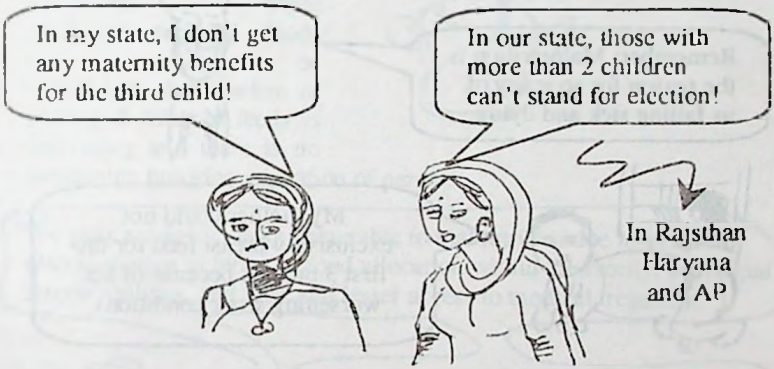
technological context and in the context of how pressures to limit the number of children are read.

The state's promulgation of the Pre Diagnostic Technique (Regulation and Misuse) Act of 1994 has been a token gesture with not a single prosecution even initiated till date.



Further the collusion of a highly educated affluent and unethical medical community needs be noted. The professional and regulatory bodies of the professionals have been completely silent about their role in this illegal practice!

There is a danger that as coercive measures to impose a two child norm continue, female feticide will worsen. Despite the international commitment to a target free, non-coercive approach, widespread propaganda towards a two-child norm along with new forms of penalization are in place!

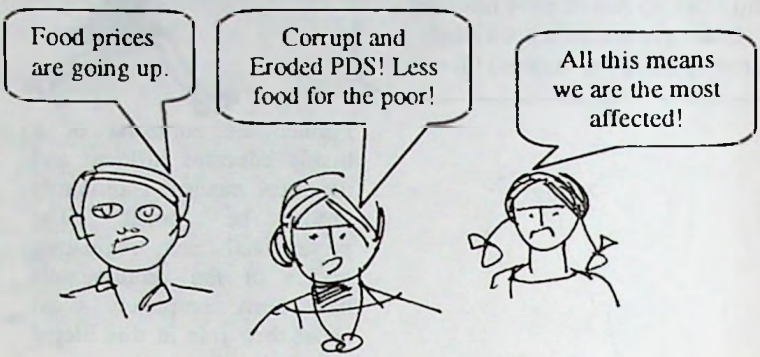


And now they are coming with even harsher ideas - Ineligibility for loans, increments & ration cards! These laws discriminate against the poor & against women & in the prevailing environment of male preference they will exacerbate feticide trends.

Only a planned combination of legal action (especially against erring professionals), and considerable civic action to sensitize professionals & the people can curb this practice.

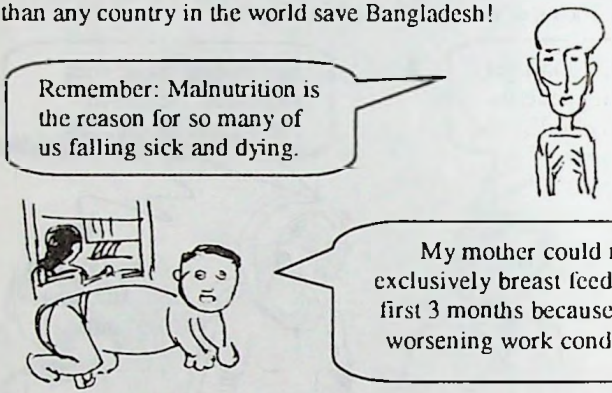
Food Security and Child Malnutrition

Recent trends in agriculture threatens the food security of the underprivileged. Even small farmers are growing cash crops and export oriented crops - but they do not reliably bring in cash!



And particularly children below three and that too girl children!

The continuing malnutrition of the Indian child is not just a health problem – It is a violation of the basic rights of the child! When compared to level of income, India has higher levels of malnutrition than any country in the world save Bangladesh!



The worsening working conditions is a result of growing unorganized nature of women's work – a direct result of SAP and globalization!

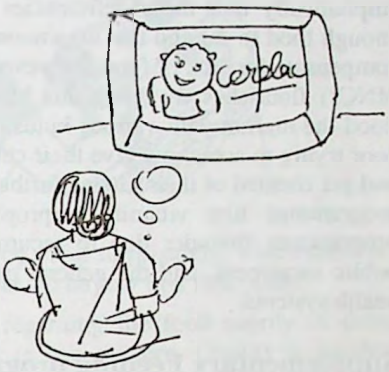
Equally important by decreasing the time the mother has for the child and the consequent worse quality of childcare, there is a direct contribution to malnutrition. In most work places there is no facility for

childcare where the woman may breast-feed her child. Even where laws such as the Construction Worker's Act or Maternity Benefits Act are applicable, crèches do not exist. Maternity leave or other benefits are almost non-existent in most jobs of the unorganized sector.

In this situation, often I and girls like me end up caring for the baby and the bottle is the only convenient option for us!

The consequent risks of diarrhoea, malnutrition and death are well documented.

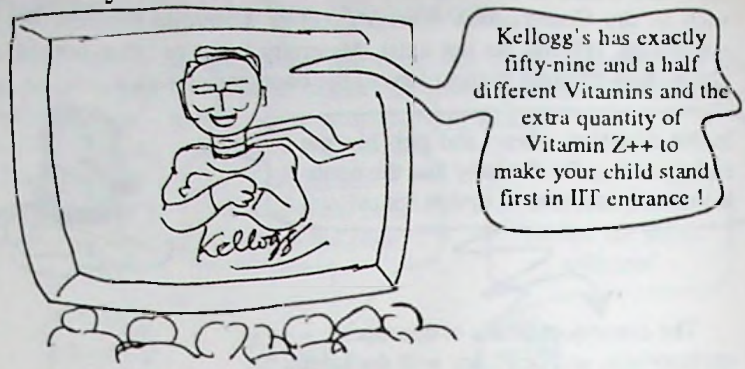
Cultural factors, especially relating to weaning foods & weaning practices also contribute in a major way to malnutrition. The market has a major role in misinforming the poor mother and leading her into costlier less effective breast milk & weaning food substitutes. While packaged formula foods can no longer be advertised, the market of packaged formula feeds is increasing and there is no continuing nutrition education of parents.



We girls are particularly vulnerable to malnutrition due to general discrimination in terms of food allocation within the family, additional responsibilities, and later and lesser access to medical treatment.

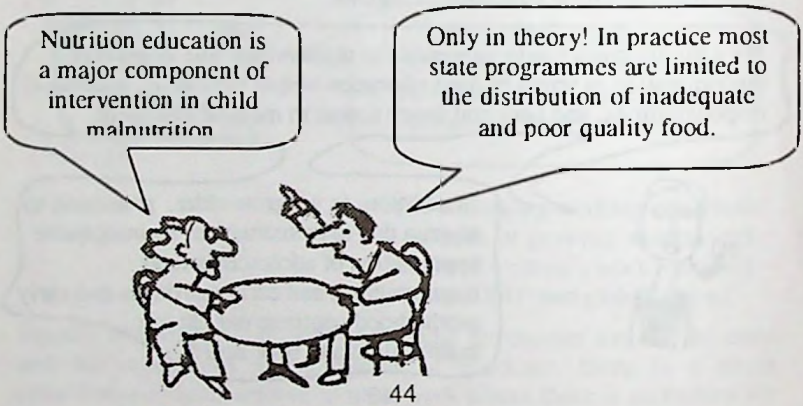
In addition, as we grow older, proneness to anemia due to menstruation, an inadequate appreciation of adolescents food requirements , and early marriages and early motherhood continue our chronic malnutrition and poor health.

Deficiency of Micro-Nutrients

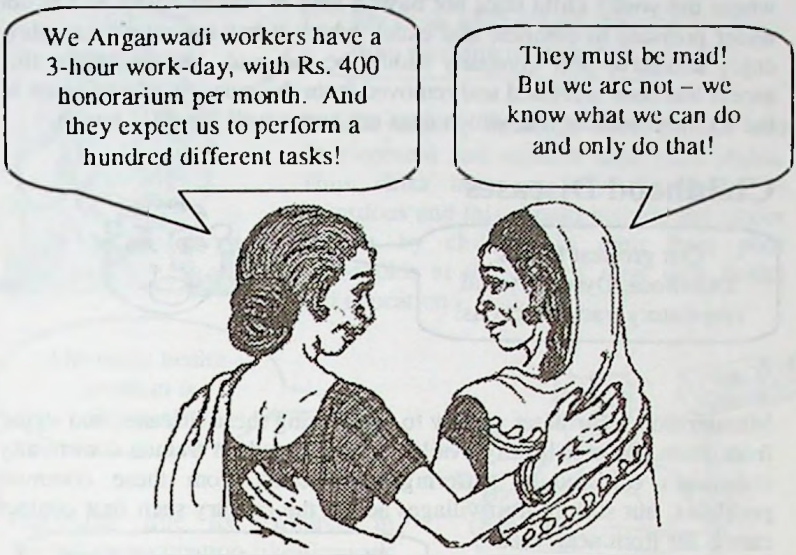


Recently, much research has been done on the role of micronutrient deficiencies in the health of children. It cannot be stated too emphatically that these deficiencies would not occur if children got enough food to eat and that no amount of chemical supplementation can compensate for lack of food. However the pharmaceutical industry (read MNCs) flourishes by using this kind of research and propaganda to flood the market with various kinds of vitamin and mineral tonics. The poor trying to somehow give their children the best cling to these tonics and get cheated of their money further. Meanwhile relevant government programmes like vitamin A prophylaxis and anemia prophylaxis programmes flounder due to recurrent unavailability of drugs, poor public awareness, and the general problems that beset the government health systems.

Supplementary Feeding programmes and Early Childhood Care

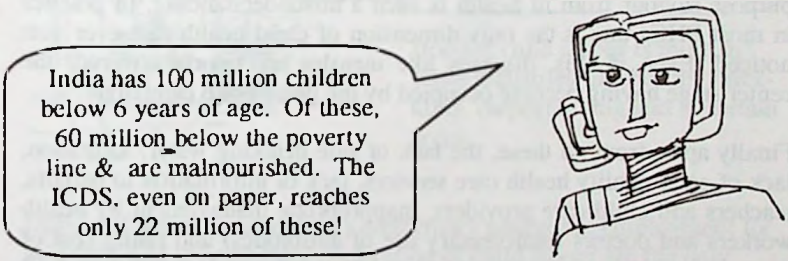


The best example of this is the ICDS: It is the only substantive programme being run for children under six and has the commendable objective of facilitating the overall development of the very young child in a comprehensive and integrated manner.



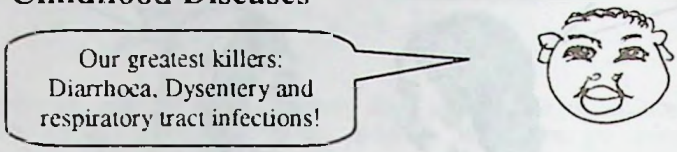
And that is at best distribution of food. Not surprisingly, where there is no community pressure, Anganwadis are largely non functional!

There are a number of concerns regarding the food supply in these schemes. Corruption and leakages is one concern. Quality is another major concern. One more recent concern is the use of American corn soya blend and similar imported foods, which may be genetically engineered. The principle should be to supply fresh locally grown, locally processed, culturally acceptable food for children.

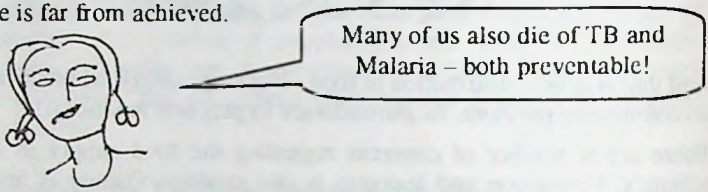


With most women being working mothers, universal day care facilities and social security for caring for children is a minimum social obligation. The quality of such care should go beyond supplementary feeding to early childhood education. Preschool education, but of a sort where the young child does not have a load of school books and is not under pressure to compete and excel, where it has opportunity to play, enjoy and have peer company should be the goal. Unfortunately, this aspect has been sidelined and removed from the purview of education in the 83rd amendment bill, which does not augur well for child health.

Childhood Diseases



Malnutrition contributes greatly to contracting these diseases and dying from them. Prompt locally available care, based on trained community volunteers can reduce suffering and deaths from these common problems, but still in most villages across the country such first contact care is far from achieved.



The control of immunization preventable diseases is a significant advance, but not if it is pushed as a substitute for proper access to child health care. The popular perception of immunization injection as an all purpose saviour from ill health is such a misunderstanding. In practice in most PHCs this is the only dimension of child health that ever gets noticed. Even in this, diseases like measles are poorly covered, the center stage having become occupied by the pulse polio campaign.

Finally apart from all these, the lack of safe drinking water, sanitation, lack of good quality health care services, lack of information to parents, teachers and child care providers, inappropriate management by health workers and doctors (unnecessary use of antibiotics) and rising cost of medicine continue to contribute to the increasing vulnerability and ill health of the young child.

The Working Child

I am only 9. But I live the life of an adult – working from morning to evening!

This invariably damages their growth and development and violates their basic rights. Thus child labor of any description is hazardous and this should include the labour put in by children in their own poor households at the cost of their own health and education.

Our main health problem is Survival!

Especially true for children in dangerous occupation like firework making, rag picking etc. The other important problem is the constant drudgery and strain of their work. The children who survive are often scarred for life by hampered growth, occupational disease and having remained unschooled while their peers move ahead. These are handicaps that rob them of their full potential and leave them with handicaps that can almost never be made up.

Some of us are not just working – we are slaves!

Bonded child labour is more in some industries like beedis, brick-kilns, carpet making and in certain areas.

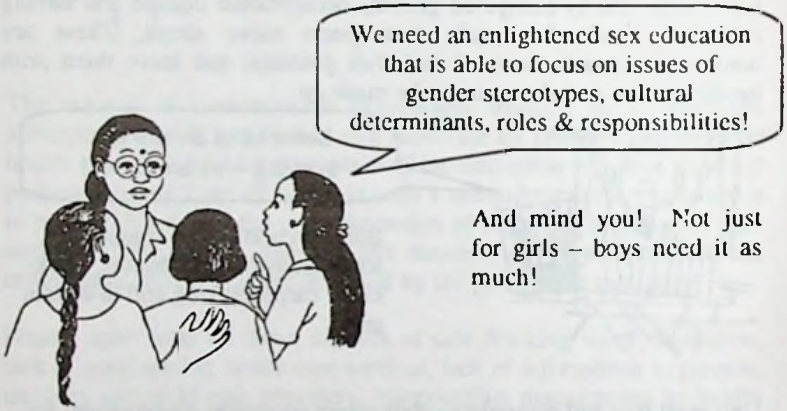
Universal free and compulsory elementary education, employment for all adults and the complete eradication of child labour are the only adequate remedy for the health of these children. Implementation of a comprehensive child rights code that addresses the problem of child labour as a human rights issue is an urgent necessity.

Other emerging concerns

In a situation of growing economic disparities, migration, consumerism, breakdown of family support systems and changing values, the child is under a new set of stresses and risks to physical and mental health.

This is more so with the most vulnerable amongst us - street children & the children within remand institutions. Asia has now become the largest market for the lucrative trade of child abuse, helped by a situation where foreign exchange earnings (which unregulated tourism brings in) is the societal goal.

The growth of the AIDS/STD problem is another emerging concern. Current approaches to AIDS control do little to examine the problem within a comprehensive understanding of sexual relationships.



And mind you! Not just for girls – boys need it as much!

Unfortunately this is not yet on the agenda. Rather, current AIDS control messages, seldom question aggressive and abusive sexual behaviour, subtly reinforcing the view that one could be safe from transmission without such changes in current sexual norms.

Policy Recommendations

Interventions and responses to improve child health should include the following:

1. 'Two Child Norm' policies need to be scrapped immediately and opposed vigorously.
2. Vigorous public campaign against female foeticide and infanticide.
3. Ensuring basic system of care to facilitate breast feeding of children by working women
    a. In the short term Maternity leave to be extended to 6 months and Maternity Benefits Act to be applicable to unorganized sector and establishment of creches at worksites should be promoted.
    b. In the long term social security measures to enable wage security for period of exclusive breast feeding.
4. All supplementary feeding programmes for children to use locally produced, freshly prepared, culturally acceptable nutritious food.
5. Total eradication of child labour with the strategy of universal, compulsory and free elementary education.
6. Strict regulation of pre school education and schools with strict enforcement of school health programmes including counseling services for children and parents.
7. Comprehensive and overarching Child Rights Code.
8. Greater budgetary allocation for childcare services (at least 1% of GDP), ICDS (15 rupees per child per day) and education (over 10% of GDP).
9. Vertical schemes like RCH to be scrapped with strengthening of overall primary health care and its system of delivery. Special focus on maternity and child care through the primary health care system.
10. Since the Integrated Child Development Service is the only social security scheme that has the potential to reach the poor working mother and the vulnerable young child a complete overhaul to improve the quality and outreach of the service is a practical imperative.

Recommendations on ICDS

a. Upgrade facilities and infrastructure.
b. Issue guidelines for locating Aanganwadis and setting their timings to correspond to needs of target group.
c. Redesign outreach to under-threes and pregnant and lactating women & make provision of Daycare centers & Aanganwadis.
d. Revise nutrition programme - distribution system & type of food.
e. Increase emphasis on neglected components of ICDS package, particularly early childhood education.
f. Initiate Convergence of Services at both planning and implementation levels.
g. Revise Training & Evaluation to include critical missing components.
h. Revamp Status, remuneration and conditions of work and number of the Anganwadi Workers keeping in mind their work load and required child – adult ratio.
i. Build in flexibility in management and design of ICDS and include ground principle of partnership between Government, NGOs and People groups.
j. Decentralize to Panchayat Raj Institutions with continuing responsibility for finances and service conditions.
k. Increase overall allocation for Early Childhood Care and develop strategies for alternate source of funding.

Universalize ICDS and coincide it with
removal of identified shortcomings!

People's Initiatives

1. Help organize the local community and women to identify problems of children locally and act collectively to improve their lot. Such people's initiatives should include at least ensuring that every child goes to school and is supported to learn adequately.
2. Assist families to prevent malnutrition and disease in their children by appropriate health education and better utilization of existing services
3. Strengthen day care services for children by community support
4. Assist Panchayats in taking care and entirely taking over all aspects of child support

Chapter V

And they call us children!

I polish shoes at the signal near your house. In every town and city, live a lot of children like me. Robbed of our childhood and adult protection,

we have to negotiate our precarious existence in an adult world of crime, misery, abuse and exploitation.

For me and 40 million street and working children like me, survival is the name of the game!

I am a child on the street. I work here as a ragpicker. But I have a family and a home.

I am a child of the street. I have neither family nor home. But I have a lot of friends and we all live here on the street.

We children of the street have run away from oppressive and traumatic homes. We have seen it all - conflicts, anguish and abuse much beyond our tolerance level.

There are also children are on the streets who have lost their parents or have been abandoned by them.

Most street children are deviant and delinquent. Little rowdies!

No, we are not! We are often more gifted than other children. We had the spirit and strength to rebel against our oppressive condition. Most other children lack this courage.

Studies show that not more than 6% show delinquent behaviour.

Most of us (more boys than girls) belong to the age group of 7 to 18 years. We come to towns & cities from various parts of the country, with a wide range of religious, cultural and linguistic backgrounds. But being smart, we quickly learn to communicate in the principal languages spoken in our area!

When I first came to this city, I didn't know what to do and where to go. It was frightening. But then I found other boys like me and joined their gang. The gang is now my family – we share what we have and protect each other.

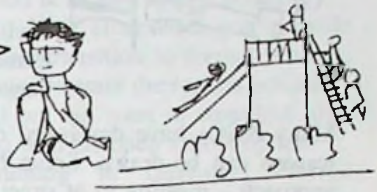
Problems We Face...

Deprived of adult protection, guidance, love and support, we are abused by all and sundry. Almost all of us have been beaten by the police. Both boys and girls amongst us are easy prey for sexual assault and child prostitution.

Being constantly at risk gets on our nerves!

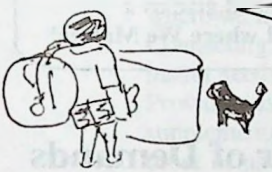
Living without shelter, sleeping under bridges, on pavements, railway stations and in cement pipes – affects us psychologically. We develop a sense of inferiority and insecurity. We also learn not to trust adults. Our life is governed by a 'here & now' attitude. We do dream about our future – but we also know that they will remain dreams!

Because we look *dirty*, we are not allowed to use public parks. We never get to play like other 'normal' kids.



Unable to expend our surplus energy Through play, our life becomes centered around films and gambling. Many of us become easy prey to drugs and die a slow death, unnoticed and unlamented.

Of course there is no question of schools and health facilities for us! Even those of us who know to read, slowly lapse into illiteracy.



We have to earn our living and the jobs that we get are of the worst sort like rag-picking– dirty, unhygienic and hazardous. We only get jobs no one else will do.

Our irregular, unhygienic and inadequate intake of food makes us malnourished and susceptible to a variety of illnesses – infectious diseases, gastrointestinal problems, STDs, scabies, fever and jaundice.

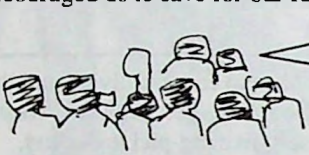
By the way, the life of a street girl is a lot more difficult! Our freedom is snatched away by pimps and molesters. Often we end up as prostitutes.

Interventions

Most government and police officials see street children as delinquents and anti-social elements who need reforming. Therefore their approach has been to 'rehabilitate' the child – focusing on correctional and remedial institutions.

Trying to confine us to institutions is futile. Remember, we rebelled and escaped from houses because they were crushing our spirit.

Many NGOs have developed excellent models from which important lessons can be drawn. Some NGOs have used a totally unstructured approach – meeting us at street corners, railway platforms on specified days and times providing only guidance and some minimal equipment for functional literacy and indoor recreation. There are other organizations which offer semi-institutionalized support – which invite to stay in a house with house-parents on a completely voluntary basis. Then there are organizations that have helped us form cooperatives and encouraged us to save for our future.



Street Children's Charter of Demands

1. **Shelter:** This is our first most basic physical need.
   a. Provide professionally managed night-shelters, preferably run by NGO's, with lockers, bathing, toilet & recreational facilities. Access to such shelters should be voluntary.

2. **Protection:** This is our second basic survival need.
   a. Sensitize police officials at all levels about our rights.
   b. Locate trained volunteer social workers in police stations or clusters of police stations located in areas where we are in large numbers to intercede, intervene & follow-up on our behalf.

c. Encourage senior police officials to provide us with identity cards. This can help prevent police harassment.
d. Ensure early and strict police action when we complain of physical and sexual abuse.
e. Ensure that we - especially the large majority of us without criminal records - are not committed to correctional institutions against our will!
f. Special and readily accessible small savings thrift and banking programmes

3. **Educational and Vocational Training:**
   a. Organize evening non-formal education classes, selecting motivated & trained teachers & an appropriate pedagogy.
   b. But don't condemn us to NFE alone – if you provide bridge facilities to assist our transition to formal schools, many of us will happily enter/re-enter the regular school.
   c. Those of us who dropped out but want to complete high school, should be provided with the open school option.
   d. Organize vocational training in carefully selected vocations with high employment potential for the older amongst us.
   e. Advocate for our employment and assist us in self-employment (credit, subsidy, skills, marketing, etc.) through IRDP, NRY, self-employment programmes for educated etc.

4. **Health Care:**
   a. Mobile health teams or satellite health clinics should regularly visit specified points at specified times in areas where we live and work in large numbers.
   b. Counseling and emotional support services for our mental health needs through professionals or trained volunteers.
   c. Provide us with a Mid-day meal or other such supplementary nutrition programmes. Identify and help those of us who are dependent on drugs, ensure intensive counseling, detoxification and emotional support services to prevent recurrence.

5. **Recreation:**
   a. Encourage Citizens' groups / youth clubs etc. to organize regular and structured recreational facilities like picnics, games, film-shows and camps for us.

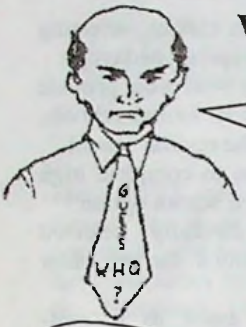
Chapter VI

We are the Differently Abled !

Happy be they who see and love me as I am, as I alone am, and not as some would want me to be.

Argentinian National Association
for the Promotion of Disabled People

What is Disability?



Disability is when a loss or reduction in any physiological function results in a partial or total inability to perform any bodily or mental functions in a manner or within the range considered normal for a human being.

There is a critical problem with this definition. The definition hinges on the word 'normal' !

Blind people often develop the ability to remember the positions of objects. This helps them walks around objects without colliding. During the day, a 'normal' person may have an advantage over the blind person. But at night, the blind person has the advantage.

Why then is only the blind person disabled? Isn't the 'normal' person disabled with respect to the blind person at night?

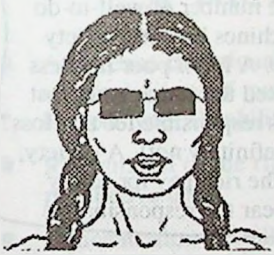
Every human being is good at some things and bad at others. 'Disability' is more the result of an unfair society valuing certain abilities over others and not an intrinsic lack of ability.

Hey! That's going too far. How can you say that a blind person is the same as other nor... err... ordinary people? Also doesn't that mean they don't need any special help – then why this chapter?

I never said that a blind person does not need special help! I am just pointing out that this special help is needed because today's society is unfair to the blind. Their needing help is not 'natural' nor are they inferior to 'other normal' people!

> The struggle for a better life for the disabled is a part of a larger effort to create a world where more value is placed on being human than on being 'normal' – a world where war and poverty and despair no longer disable the children of today, who are leaders of tomorrow.
>
> David Werner

Did you note the two important points David is making ?



1. When we ask for a better life for us, the disabled, we are not asking for pity – we are asking for equality, fairness and only what is rightfully due to us! And by doing this we are also changing the way society is structured.
2. Disability is not an individual problem – it is the result of society's actions and therefore society is responsible for all disability!

But that's nonsense! How can you hold society responsible for your blindness? You may ask society's help, but you can't hold the entire society responsible for your state!

I became blind in my childhood. Because of poor nutrition and particularly vitamin A deficiency. There are 9 million blind people like me in India – and 90% of the blindness could have been prevented. Since I was born in a poor family, in a rural area, I could not get treated. Moreover it was my family's poverty that led to my poor nutrition. I therefore quite rightly hold the society which allows so much poverty and inequality to exist responsible for my blindness!

I was afflicted by polio and I agree with her! There is another example of how society is responsible for disabilities. In Punjab, as part of the Green Revolution, the state supported the purchase of threshing machines by a large number of well-to-do farmers. These machines had little safety regulations in place. A lot of poor landless labourers who worked these machines lost their limbs. Who is responsible for this loss? The individuals? Definitely not! A society, unwilling to make the rich pay for safety provisions, has to bear the responsibility!

Similar is the case with factories, which pollute the environment leading to a lot of disabilities. Or with rich farmers who use up a lot of water for irrigation leaving only contaminated drinking water available to the poor. Or with wars or crime. A world with so much inequality and so little concern for the right of the poor, and marginalized is to blame!

Our Special Problems

- Society treats us with ignorance, prejudice, revulsion & rejection.
- Economic, social, architectural, educational, legal, transport, cultural, health and other barriers hamper the achievement of our full potential.
- We suffer humiliation, segregation and indignity and therefore from low self-esteem.
- As children, we are excluded from school, play, marriage and employment.
- There is a lack of facilities for diagnosis, treatment, education and rehabilitation, except in few big urban centers.
- Problems are compounded for us in socially discriminated categories of gender, class, caste, minorities etc.

Remember that with all these problems we continue to contribute significantly to society!

We Demand
A World Where We Matter!

- Adherence to national commitment to rights, full participation and empowerment of persons with disabilities as enshrined in the Persons with Disabilities Act, 1995.
- Recognition of the rights and potential of disabled to lead fulfilled, productive lives.
- Concentration on abilities, not inabilities of disabled.
- Not charity, but assistance for dignity and self-reliance.
- Detailed house-to-house survey, also opportunity for community education regarding attitudes to disabled.
- Mass education campaign as in Total Literacy Campaigns

- Mobilization and recruitment of voluntary disabled workers in each village
- Training of disabled workers in attitudes and skills for therapy and rehabilitation
- Establishment of village level rehabilitation centers and District Resource Centers
- Resist segregation of disabled in specialized institutions in favour of CBR (Community Based Rehabilitation)
- Specialized institutions such as special schools, residential care centers and sheltered workshops required as resource centers and for the profoundly disabled
- Detailed examination of each disabled person by specialists to identify potentials and required interventions
- Developing low-cost aids and appliances utilizing indigenous materials and local artisan skills
- Organizing medical, including surgical and physiotherapy, interventions by building local competencies
- Supporting formations of self-help groups of disabled persons and their families
- Organizing group care in communities of aging disabled lacking family support
- Special employment exchanges and transport facilities
- Ensuring education of all disabled children, preferably in integrated schools
- Vocational rehabilitation through skills development and active advocacy with potential employers
- Ensuring, as an article of faith, fulfillment of reservations for disabled
- Ensuring access to public places

Respect, not Pity
Rights, not Charity
Equality, not Dependence
Participation, not Segregation

Ali Baquer for VHAI

Chapter VII

The Uncared Aged

Growing old gracefully was an old tradition – a tradition which is fast disappearing!

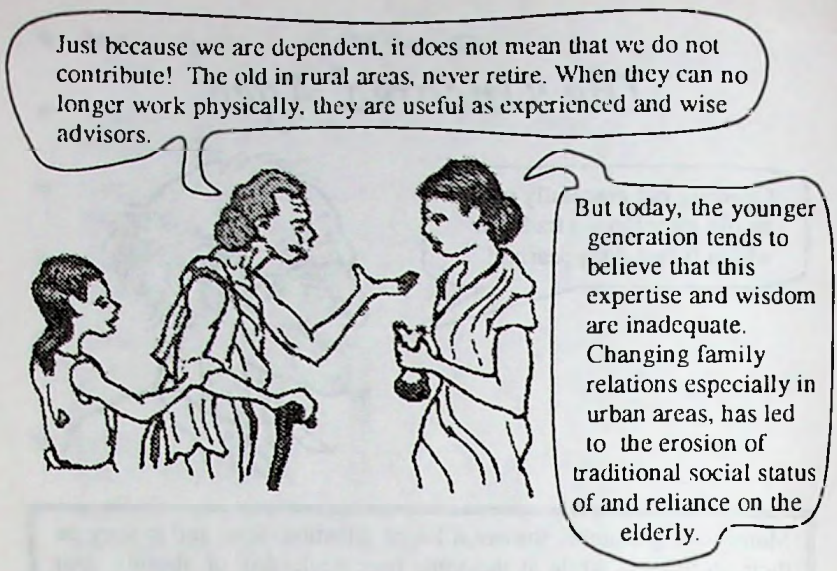
Many young couples shower a lot of attention, love and money on their children – while at the same time neglecting or abusing their parents. They feel that their children will reciprocate their affection. What they don't realize is that their children grow up learning from their parents, how exactly they should treat them later in life!

- Selvi, TNSF activist from Ramanathapuram

The society we live in has always been changing. But the speed with which values and cultures have changed across the globe during the last 50 years and particularly in the last twenty years has been unmatched in history. Today's problems of aging are a result of these rapid changes.

What changes and what problems?

Because life spans are lengthening, 60 + age-group growing at faster rate (38 per cent) than rest of population (19 per cent) leading to high dependency ratio!



These factors lead to:

- High economic dependence of the elderly (33 per cent in rural and 37 per cent in urban areas)
- Loneliness and lack of emotional support
- Vulnerable to geriatric illnesses, causes high physical dependence
- Loss of self-esteem because of lack of socially and economically productive activities for the elderly.
- Problems sometimes compounded by social, cultural practices and gender bias eg., widows of Varanasi.

What is to be done?

1. **Economic Security and Self-reliance:**
   a. ***For Pensioners:***
      i. For retiring government functionaries, regularly monitor timely processing of pension claims; paper-work should commence two years before retirement, special camps may be organised from time to time, latest final disposal should be within six month of retirement
      ii. Ensure single-window payment with simple procedures for pension disbursement; involve citizens' groups and local bodies to control corruption in disbursement

b. ***For non-pensioners:***
   i. Organize drive to cover all eligible elderly, specially the destitute with social security pension
   ii. Monitor & ensure timely payment of social security pensions

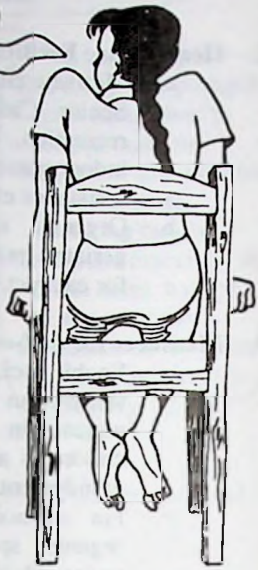
2. **Health Care Facilities:**
   a. Motivate citizens or senior citizens themselves to establish Senior Citizens' Clubs to provide opportunities for recreation, companionship, gossip, reading, periodicals, indoor games etc.; assist with space, financial and material assistance etc.
   b. Organize systematic treatment of common disabling geriatric problems, e.g., diagnostic and treatment camps for cataract, hearing, dentistry, arthritis etc.

3. **Measures for Self-esteem, support Services and Morale:**
   a. Enable socially useful activities for the aged, for their own self-esteem e.g., tuitions, adult literacy classes, visiting patients in hospitals, Red Cross activities, humanizing children's and women's institutions as visitors or foster-grandparents etc.
   b. For economically and emotionally dependent aged, organise sponsorship programme by citizens' / NGOs, under which monthly payment is made and emotional bonds developed with identified aged persons
   c. Involve community, religious and social organizations etc. in all these interventions

4. **Old Age Homes and Alternatives:**
   a. For old people without care of children, enable group living schemes, by convergence of various government and private housing schemes e.g., by earmarking and allotment of suitable land for housing schemes, formation of housing co-operatives, channelizing of soft housing loans, allotment of houses of Indira Aawas Yojana and other housing schemes wherever eligible etc.
   b. For physically dependent and economically dependent aged persons without family support, create institutions, ensure clean cheerful surroundings, simple nutritious food with variation, a daily routine including recreation and minimal productive activity (e.g., horticulture, chalk-making), structured regular friendly visitors, and trained and motivated managers.

How Structural Adjustment affects the Most Vulnerable !

Market economics affects all the marginalized adversely and they in general need special protection if they are not to languish in destitution, indignity and hunger.



However within this large mass of marginalized people, we are the most vulnerable! Groups like the disabled women & children in custodial institutions, street and working children, women victims of violence and desertion, commercial sex workers, drug addicts, alcoholics, beggars, the uncared aged and under trials.

We on the one hand, critically depend on state support to lead lives of even minimal dignity and self-reliance and, on the other, lack organization & pressure groups.

We are often called the last in society. But we want to emphasize that many of us play an important and vital economic role.

I, for example, perform a critical role as rag picker. Most physically handicapped perform important functions within the household or in the market. But because we are so powerless, our needs do not count.

Other groups within this last of society who are unable to contribute economically should be seen as society's victims, to whom society owes compensation. Compensation they cannot claim due to their powerlessness. The willingness of a society to accept its responsibility towards these sections is a measure of the ethics and morality of a civilization!

General Principles of Interventions to Assist the Vulnerable

Interventions for the vulnerable sections should be based on the following principles:

- The central responsibility of the State for social welfare and security of all, especially its most vulnerable citizens should not be minimized. We must work for policies & initiatives that make this possible.

- The distinct nature of the problems, vulnerabilities, handicaps, needs and also the potential of the specific group should be understood. We must build this understanding with the full involvement of the group -not for them but with them

- Locate 'do-able' local solutions with local resources and local leadership and with professional technical help whenever required.

- We must emphasize sustainability and replicability and involving the community and the target group actively in the initiatives

- All interventions should ultimately lead to dignity and self reliance of the beneficiaries, not charity and dependence.

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- Catholic Health Association of India (CHAI)
- Christian Medical Association of India (CMAI)
- Forum for Creche & Child Care Services (FORCES)
- Federation of Medical Representatives Associations of India (FMRAI)
- Joint Women's Programme (JWP)
- Medico Friends Circle (MFC)
- National Alliance of People's Movements (NAPM)
- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Ramakrishna Mission (RK)
- Society for Community Health Awareness, Research and Action (SOCHARA)
- Voluntary Health Association of India (VHAI)

Participating Organizations

Over 1000 organizations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Sabha campaign as participating organizations.

About the Jan Swasthya Sabha

Governments & international agencies have forgotten the goal of **Health for All by 2000 A.D.** But we, the people, cannot forget it. It is time to strengthen & expand people centered initiatives - to find innovative solutions & to put pressure on decision makers, governments and the private sector.

There is a need to reiterate that attaining **Health for All** means ensuring everyone has access to affordable quality medicare, safe drinking water and sanitation, adequate nutrition, clothing, shelter and employment and no one is discriminated against on the basis of class, caste, race or gender. People need to be made aware of the links between globalization and the worsening health of the people. When structural adjustment policies work to undermine the vision of Alma Ata, renewing the Health for All call is an imperative.

With this understanding a large number of people's movements across the country have jointly initiated a national campaign called the Jan Swasthya Sabha. This has three broad objectives:

- To re-establish health and equitable development as top priorities in policy making with primary health care as the strategy.
- To forge a local, national and global unity of all democratic forces to work towards building long term sustainable solutions to health.
- Reinforce the principle of health was a broad inter-sectoral issue

The campaign has a four-ties structure. 2000-3000 blocks in 200-300 districts mobilize people on **Health For All - Now!** and conduct block level enquiries into the state of health services. These enquiries culminate in block seminars highlighting the findings & helping formulate people's initiatives for primary health care. Then, each district has a district level mobilization culminating in a District Seminar. All this builds up to the Jan Swasthya Sabha to be held in Calcutta from Nov 30th - Dec 1st 2000. Four trains with representatives from various parts of the country will arrive at the National Assembly. The Jan Swasthya Sabha - with over 2000 representatives - will call for a reversal of structural adjustment policies and a renewal of the *Health for All* pledge. The assembly will also send its representatives to the international People's Health Assembly being held at Dhaka from Dec 4th - 8th, 2000 where similar representatives from other countries will gather. Following the Jan Swasthya Sabha, each interested block or district follows up with health intervention and advocacy.

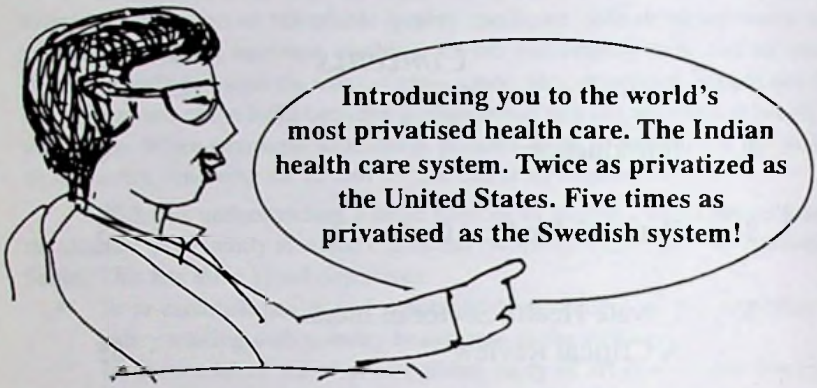
The Jan Swasthya Sabha is being coordinated by a National Coordination Committee consisting of 18 major all India networks of peoples movements and NGOs. This book is the fifth book in a 5 book series brought out by the NCC for guiding the block, district and state seminars.

Contents

Chapter 1

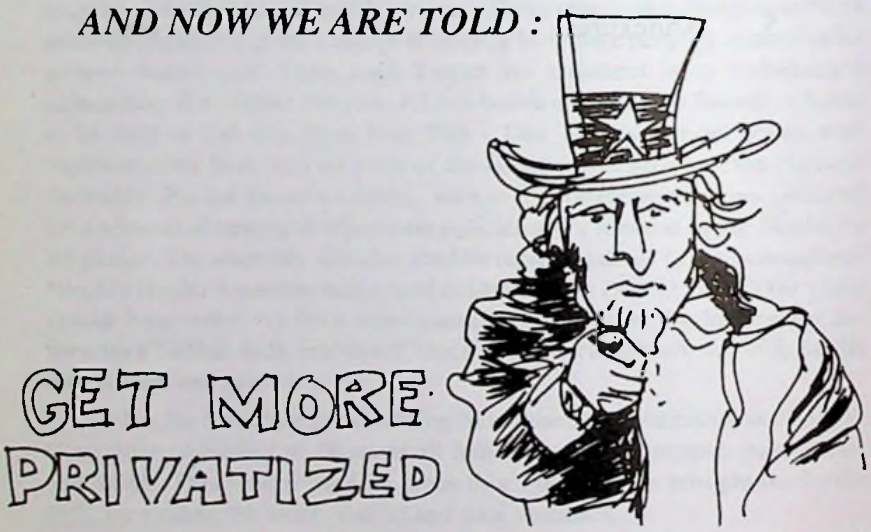
Introduction

THE INDIAN HEALTHCARE SYSTEM

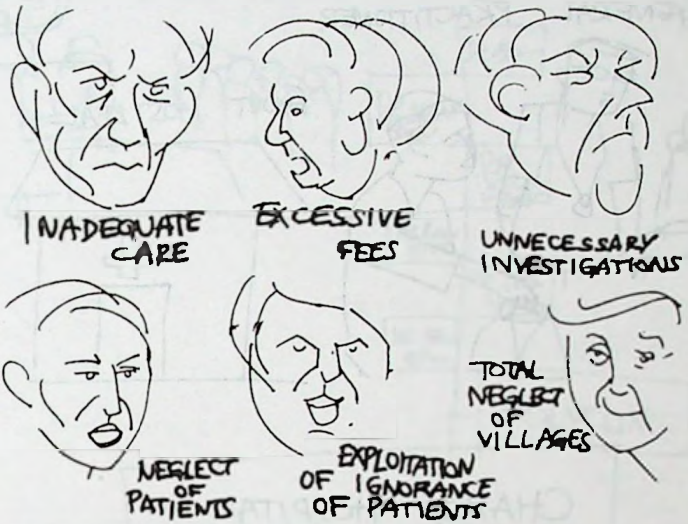


Only 22% of the the health expenditure is public funded in India as compared to 44% in the US, or 95% in countries like Sweden or 75% in all the market economies of the west taken together.

AND NOW WE ARE TOLD :



But there are lots and lots of problems with this simple solution: What are the popular causes for dissatisfaction against doctors and the delivery of health care in India today?



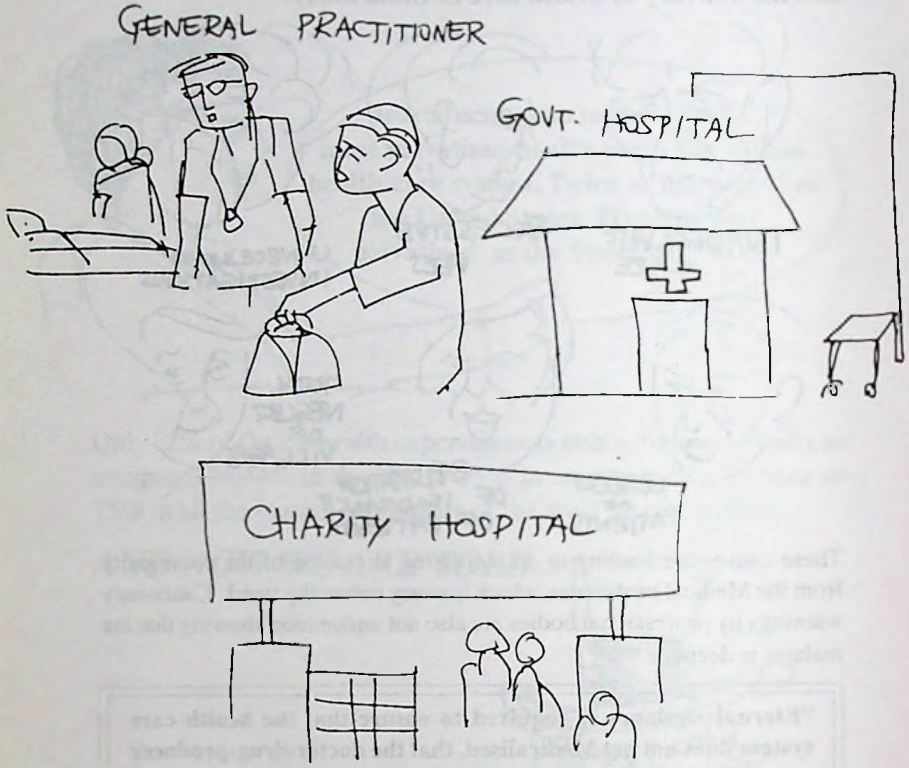
These causes are leading to an increasing alienation of the community from the Medical profession, which is a very unhealthy trend. Cautionary warnings by professional bodies are also not uncommon showing that the malaise is deeper.

> **"Eternal vigilance is required to ensure that the health care system does not get Medicalised, that the doctor-drug-producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill-health."**
>
> **-ICSSR / ICMR Report on Health for All**

While many doctors are sincere and committed to the ethical and scientific framework of their profession and vocation, in today's increasingly corruption influenced socio-economic-cultural political milieu, many are not and this is an increasing area of concern.

The public, the judiciary, the media and civic society are losing confidence in the professional disciplining mechanism and peer group controls which have failed to redeem the situation and hence the move to bring doctors under the Consumer Protection Act in spite of arguments to exclude them.

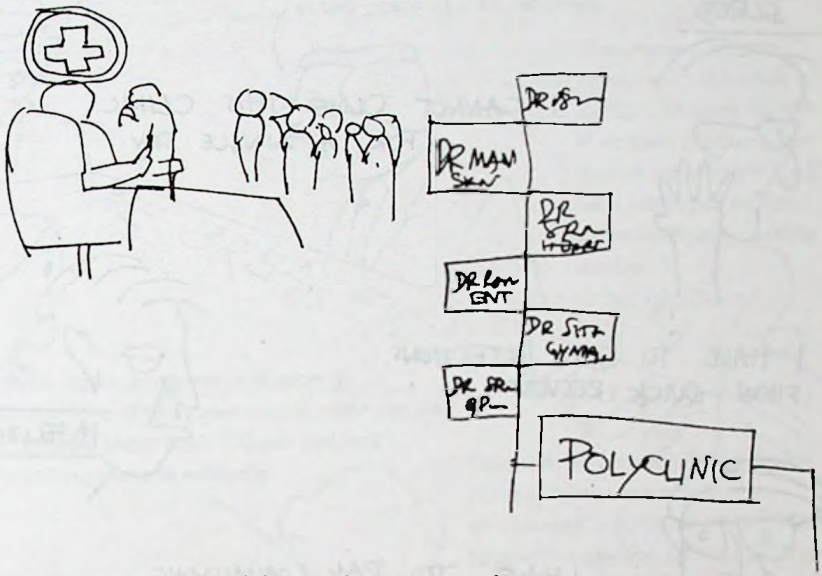
In the first half of this century the image of medical care was largely.



The image of the general practitioner was :

Family doctor and family friend; would come to our homes; flexible payment often deferred; few prescriptions - the compounder made up much of these.

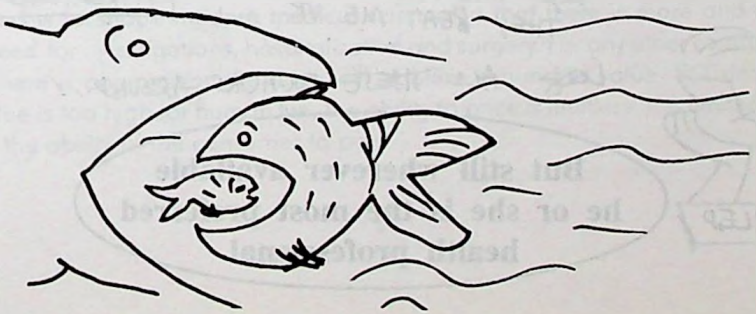
TODAY:



Fiercely competitive private practice

- threatened by numerous nursing homes and polyclinics
- swallowed up by corporate hospitals and insurance companies - and for those who can not pay or are drained of their money a very weak public sector

Picture at the bottom of a big fish swallowing a small fish swallowing a yet smaller fish



The Oridinary General Practitioner today has his problems:

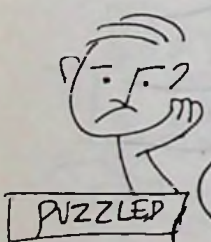
I CANNOT CLOSE THIS CLINIC FOR A SINGLE DAY

I HAVE TO GIVE INJECTIONS. SHOW QUICK RESULTS

I HAVE TO PAY COMMISSIONS...

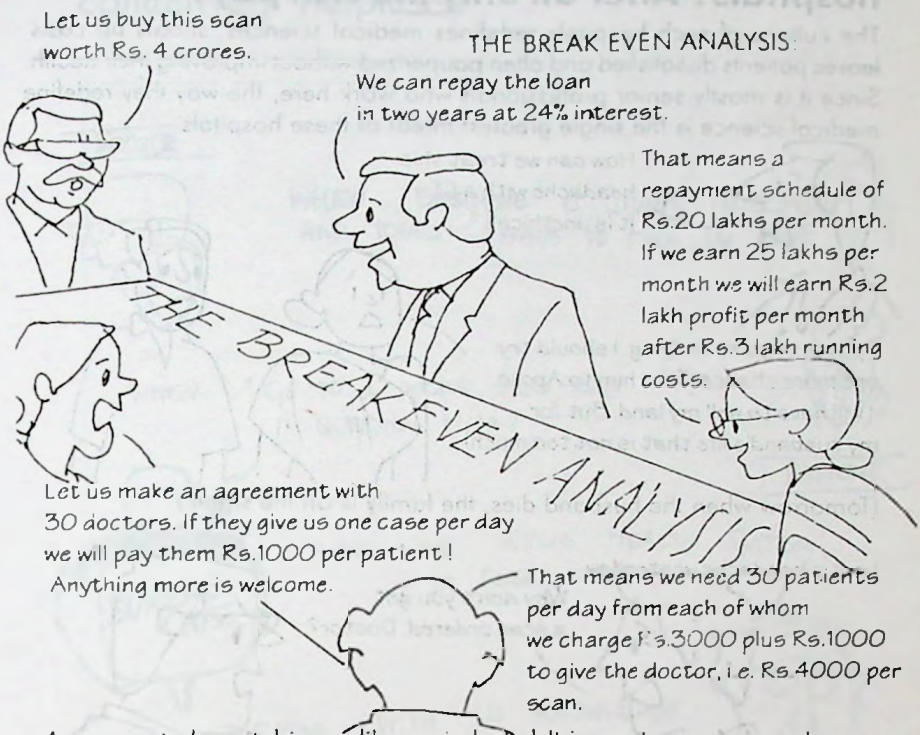
THE PATIENT'S DEATH WAS NOT MY FAULT, BUT THEY BEAT ME UP

LOOK ALL THESE QUACKS AROUND...



But still wherever available he or she is the most preferred health professional.

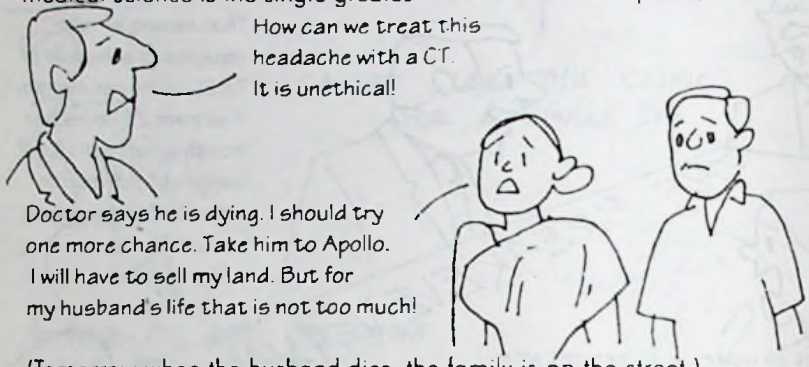
At the corporate hospital it is another story.



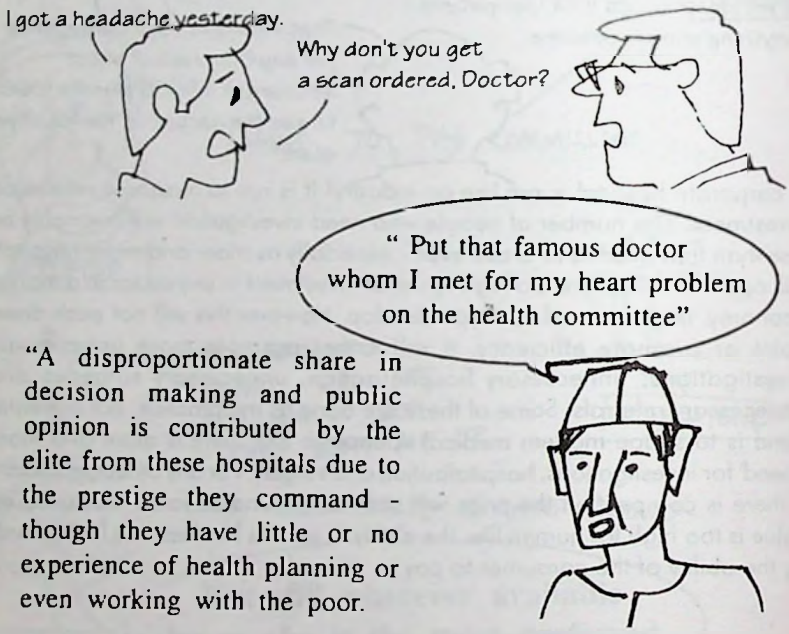
A corporate hospital is run like an industry! It is run to maximise returns on investment. The number of people who need investigation will invariably be less than that needed to break even - especially as more and more hospitals will open. Where there is a high return of investment in any sector in a market economy, more units of that type develop. However this will not push down costs or promote efficiency. It will rather promote more unnecessary investigations, unnecessary hospitalization, unnecessary surgeries and unnecessary referrals. Some of these are done as malpractice. But a greater trend is to shape modern medical science so that there is more and more `need' for investigations, hospitalization and surgery. For any other commodity if there is competition the price will stabilize around its value. But since no value is too high for human life, the ability to price is limitless. It is limited only by the ability of the consumer to pay

But should we get worried about corporate hospitals? After all only the rich pay?

The culture of such hospitals redefines medical sciences, shoots up costs leaves patients dissatisfied and often pauperized without improving their health. Since it is mostly senior professionals who work here, the way they redefine medical science is the single greatest threat of these hospitals.

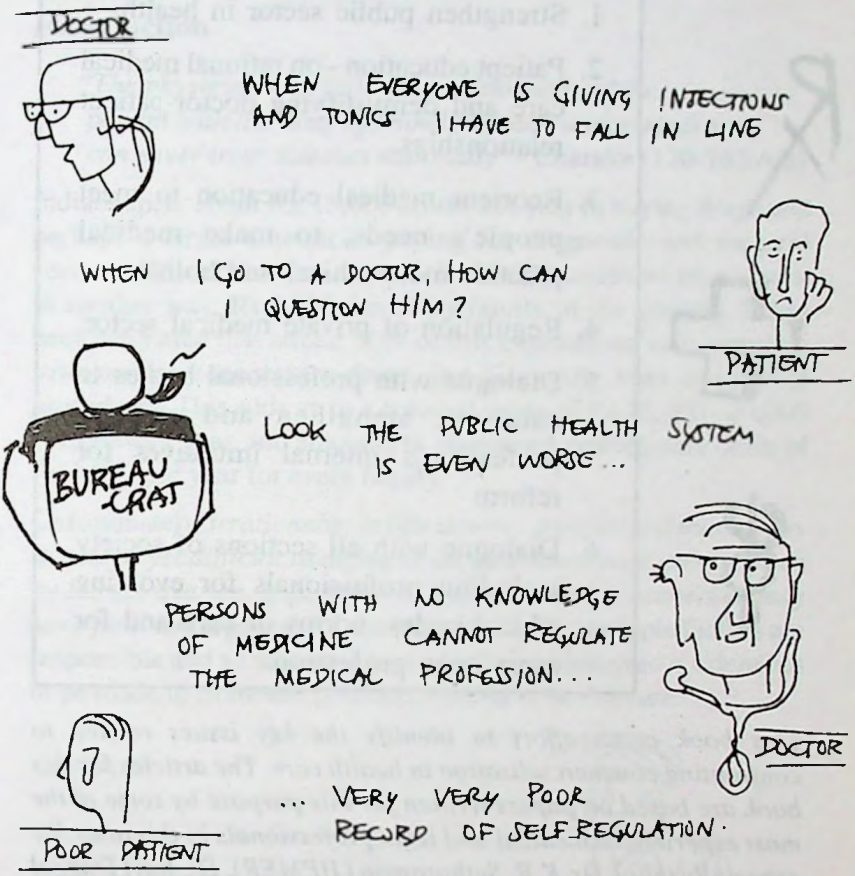


(Tomorrow when the husband dies, the family is on the street)



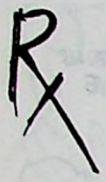
"A disproportionate share in decision making and public opinion is contributed by the elite from these hospitals due to the prestige they command - though they have little or no experience of health planning or even working with the poor.

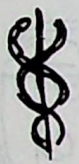
The question is are we individually and collectively helpless?



Or are there ways to confront comercialization of health care?

The six components of checking commercialization:





1. Strengthen public sector in health.
2. Patient education - on rational medical care and demystifying doctor-patient relationships.
3. Reorient medical education to meet people's needs; to make medical practice more ethical and holistic.
4. Regulation of private medical sector.
5. Dialogue with professional bodies to catalyze, stengthen and support profession's internal initiatives for reform
6. Dialogue with all sections of society including professionals for evolving ethical codes, norms of care and for more open profession.

This book is an effort to identify the key issues related to confronting commercialisation in health care. The articles for this book are based on papers written for this purpose by some of the most experienced medical and legal professionals in this area. We especially thank Dr. K.R. Sethuraman (JIPMER), Dr. Ravi Duggal (CEHAT), Dr. Ravi Narayan (CHC), Dr. N.R. Madhava Menon and Dr. Frances - for their contributions. This book must be seen as part of the process of initiating a dialogue rather than of asserting dogmatic positions.

Chapter - 2

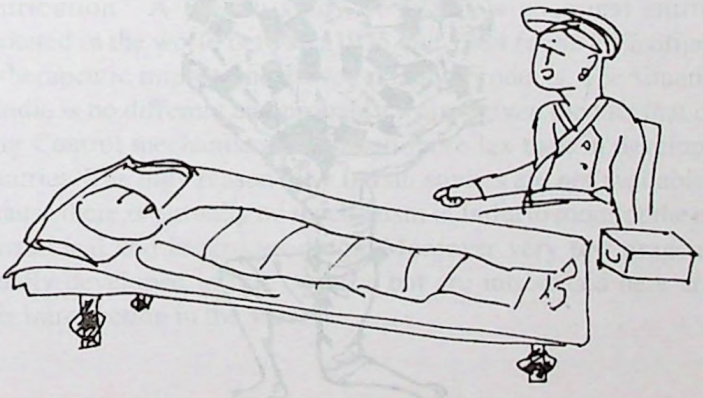
Rational Medical Care

Introduction

"The physician who fails to enter the body of the patient with the lamp of knowledge and understanding can never treat diseases rationally" - Charaka (120-162 AD)

Indians spent about Rs. 15,000 crores last year in buying drugs and perhaps a larger amount in paying for diagnostic and surgical services. This adds up to approx. Rs.35,000 crores — or, to put it in another way, Rs.2,000 for every family in the country. It has been estimated that atleast 50% of this expenditure is incurred on irrational or unnecessary drugs and diagnostic tests or surgical procedures. This adds up to a colossal waste of Rs.15,000 - 20,000 crores every year, and amounts to an average unnecessary drain of Rs.1,000 per year for every family!

Unfortunately, *irrationality is like dowry - a social evil that is easy to detect, yet difficult to define in an individual case, perpetuated by human avarice, impossible to eradicate and if unchecked may have fatal consequences.* Like all social evils, multiple factors are responsible and all the key issues need to be addressed if a dent has to be made in irrational practices related to health care.



The first, and best known, part of irrational practices in health care is related to irrational prescription of drugs. WHO has defined irrational prescribing as use of a therapeutic agent when the expected benefit is negligible or nil or when its usage is not worth the potential harm or the cost.

Irrational drug prescribing can occur when the medication prescribed is incorrect, inappropriate, excessive, unnecessary or inadequate. Accordingly, the types of Irrational Prescribing are:

1. **Incorrect prescribing:** This means the use of wrong medicines to treat a disease or the use of medicines when no medicines are required.
2. **Inappropriate prescribing:** This pertains to use of medicines that are not suitable for the particular patient, viz. use of medicines that may be harmful in pregnancy, in children, in older people, etc.

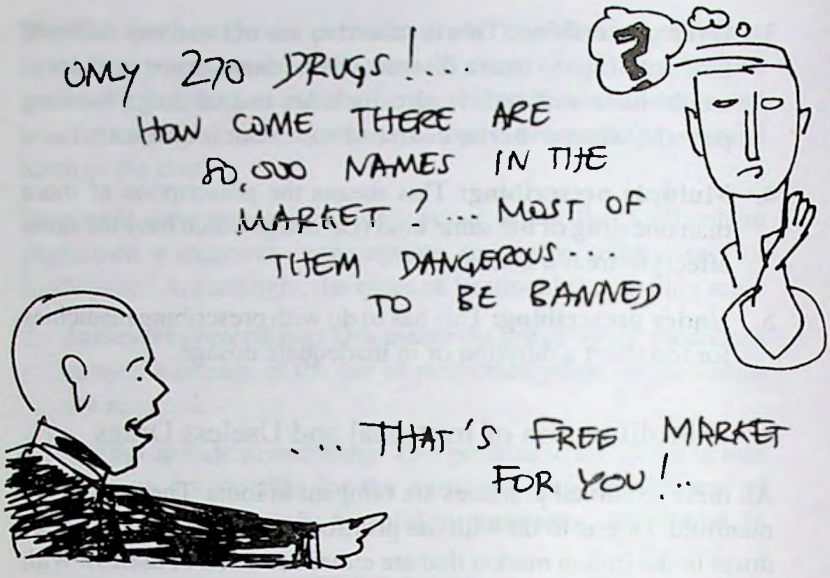
3. **Over prescribing:** This is related to use of too many different kinds of drugs to treat a disease, when fewer (or just one) drugs would have sufficed. It also includes use of drugs for long periods, when a shorter course of treatment is adequate.

4. **Multiple prescribing:** This means the prescription of more than one drug of the same kind (i.e. drugs which have the same effect) to treat a disease

5. **Under prescribing:** This has to do with prescribing medicines for too short a duration or in inadequate dosage.

Proliferation of Irrational and Useless Drugs

All these irrational practices are rampant in India. The reasons are manifold. One is to do with the proliferation of a large number of drugs in the Indian market that are either irrational or useless. With rapid developments in Science and Technology there has been an explosion in the number of drugs which are available in the market. Unfortunately only a small minority of drugs entering the market offer an advantage over existing drugs. A study in the U.S. showed that of the 348 new drugs introduced from the 25 largest US drug companies between 1981 and 1988 only: 3% made an "important potential contribution to existing therapies"; 13% made a "modest potential contribution; and 84% made "little or no potential contribution". A French study of 508 new chemical entities marketed in the world between 1975 and 1984 found 70% offered no therapeutic improvement over existing products. The situation in India is no different and probably worse, given the fact that our Drug Control mechanisms are much more lax than in developed countries. The only reason why Indian studies are not available is because there is virtually no mechanism in India to monitor the use of irrational and hazardous drugs. Moreover very few drugs are actually developed in this country, but are introduced here after their introduction in the West.

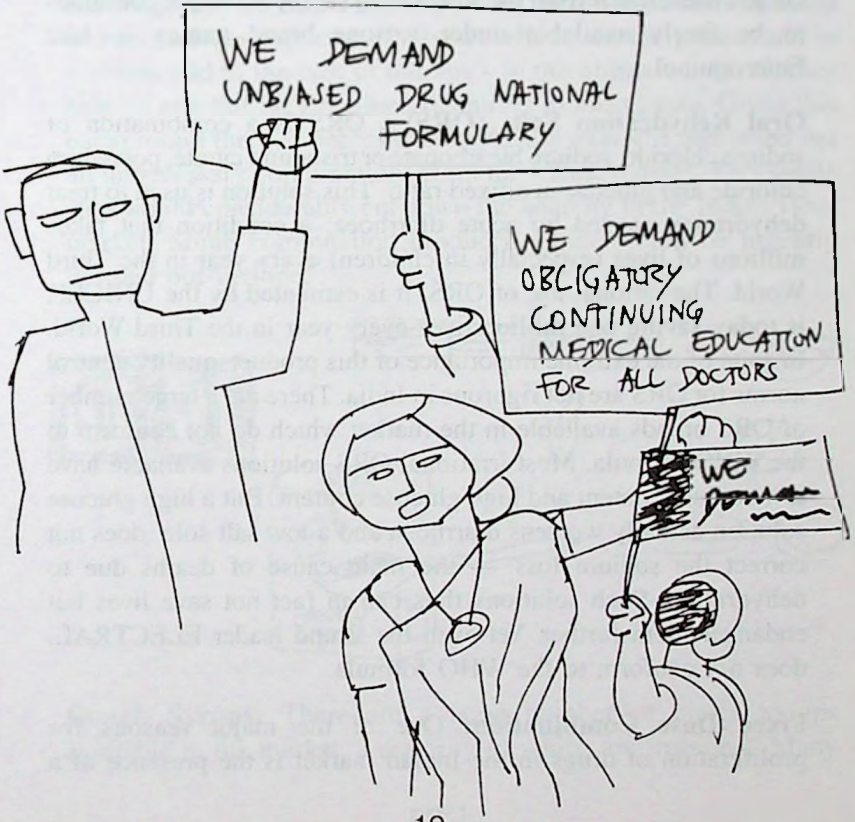


As a consequence there are an estimated 60,000 to 80,000 brands of various drugs available in the Indian market. On the other hand the WHO lists a little over 270 drugs which can take care of an overwhelming majority (over 95%) of the health problems of a country. In this situation of extreme anarchy the task of an already overstretched Drug Control Authority becomes almost impossible to cope with. A majority of the estimated 80,000 products in the market are either hazardous, or irrational or useless.

The pharmaceutical companies and the government regulatory bodies are both to blame for allowing such a situation to develop in this country. But all this would not be possible without the active involvement of the medical profession, who contribute by prescribing such irrational and useless drugs. One reason for this is the fact that there is almost no source of regular unbiased, authentic information on drugs available in the country. Given the rapid changes in treatment procedures and introduction of a large array of new drugs, medical practitioners need to update their knowledge regularly. Such a system of continuing medical education is largely

absent in this country, and most doctors do not find the need to take time out from their busy practice to update their knowledge by reading the most recent books and journals. Thus we have the sad practice of a bulk of medical practitioners depending on promotional material supplied by Pharmaceutical companies. Obviously such promotional material only provides biased information to doctors, with a view to maximising the sale of the products being promoted. It thus makes it possible to sell a large number of useless and irrational drugs.

Some common irrational or useless or hazardous drugs are mentioned below. It may be noted that this is just a short illustrative list, and there are numerous other examples available.



Analgin: The drug can cause agranulocytosis, a fatal blood disease. The drug can also cause rashes and serious life threatening cerebral coma. Large doses can cause renal tubular necrosis, a degenerative disease of the kidneys. In India Analgin is used in trivial cases and can be procured from most chemists without a prescription.

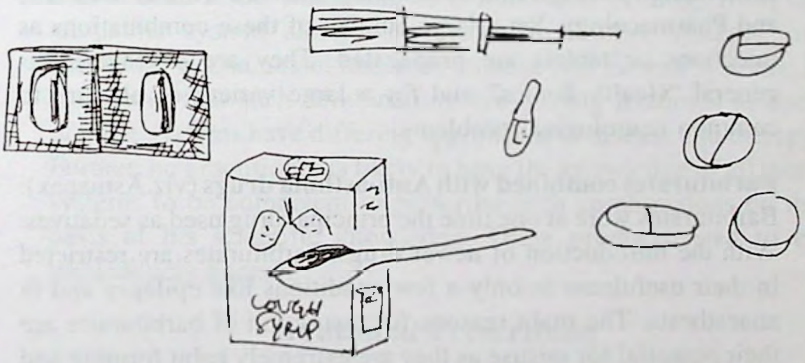
Clioquinol :Clioquinol belongs to a group of drugs called Halogenated Hydroxyquinolines. In the Sixties this drug was found responsible for a massive epidemic of a syndrome called SMON associated with progressive muscular weakness, degeneration of nerves and loss of vision. As a result the drug was banned in many countries and the original manufacturer Ciba Geigy, withdrew it from the world market. Yet in India it continues to be freely available under various brand names — like Enteroquinol.

Oral Rehydration Salts (ORS) : ORS is a combination of sodium chloride, sodium bicarbonate or trisodium citrate, potassium chloride and glucose in a fixed ratio. This solution is used to treat dehydration caused by acute diarrhoea, a condition that takes millions of lives (especially in children) every year in the Third World. The rational use of ORS, it is estimated by the UNICEF, is today saving one million lives every year in the Third World. In spite of the extreme importance of this product, quality control norms for ORS are not rigorous in India. There are a large number of ORS brands available in the market which do not conform to the WHO formula. Most irrational ORS solutions available have low sodium content and high glucose content. But a high glucose solution actually worsens diarrhoea and a low salt soln. does not correct the sodium loss — the main cause of deaths due to dehydration. Such solutions thus can in fact not save lives but endanger them further. Yet even the Brand leader ELECTRAL, does not conform to the WHO formula.

Fixed Dose Combination: One of the major reasons for proliferation of drugs in the Indian market is the presence of a

huge number of Fixed Dose Combinations that is a single Formulation containing 2 or more drugs in a fixed ratio. Most of these combinations are without any rationale except the motive to make profits. The WHO says in this context: *"In the great majority of cases essential drugs should be formulated as a single compound. Fixed-ratio combination products are acceptable only when the dosage of each ingredient meets the requirements of a defined population group and when the combination provides advantage over single compounds administered separately in therapeutic affect, safety and compliance.* (WHO Technical Report Series, 722.) The WHO list of essential drugs includes only 7 drugs in a total of 270 drugs.

All drugs may be called useful poisons. Fixed-dose combinations add an unnecessary load of adverse effects on the patient and in addition add to the cost of therapy - in the ultimate analysis they help no one but the drug manufacturers in most cases. Given this background there is necessity to critically examine and weed out all unnecessary combinations from the Indian market. This single step would considerably cut down the anarchy in the Indian Drug market. Some combination products which should be urgently weeded out include:



Cough Syrups: There are a large number of cough syrups available in the market, a majority of which are irrational. Many

of these combine cough suppressants with expectorants (i.e. an ingredient which facilitates expulsion of sputum.) Moreover cough syrups are seldom effective in treating cough, and only in rare circumstances is their use justified. The British National Formulary says: "*The drawback of prescribing cough suppressant are rarely outweighed by the benefits of treatment and only occasionally are they useful as, for example, if sleep is disturbed by a dry cough. Cough suppressants may cause sputum retention and this may be harmful in patients with chronic bronchitis, etc.* Cough syrups, hence, are usually not only irrational in that they combine ingredients with opposing therapeutic aims, but it is doubtful whether the ingredients are capable of exerting the effect they are supposed to : that is as cough suppressants or as expectorants. Given this background, all cough mixtures need to be critically reviewed.

Vitamin B1, B6, B12 combination (viz. Neurobion): Probably no other combination of drugs is as completely without rationale as combinations of Vitamins B1 (Thiamine), B6 (pyridoxine) and B12 (cyanocobalamine). Both Vit. B1 and Vit. B12 have specific uses in diseases caused by deficiencies of these drugs. Why they should be combined along with Vit. B6 is anybody's guess. This combination does not find mention any standard work of Medicine and Pharmacology. Yet a large number of these combinations as injections or tablets are propagated. They are propagated as general "Health Tonics" and for a large variety of obscure to common neurological problems.

Barbiturates combined with Anti-asthma drugs (viz.Asmapax): Barbiturates were at one time the principal drug used as sedatives. With the introduction of newer drugs, barbiturates are restricted in their usefulness in only a few conditions like epilepsy and in anaesthesia. The main reasons for restriction of barbiturates are their potential for misuse as they are extremely habit forming and their popularity as a "suicidal" drug. Sale of single ingredient formulations of barbiturates are under severe restrictions in this

country. Yet, ironically, barbiturate combinations can be freely purchased even over the counter. They are commonly combined with anti asthma drugs. This is a dangerous practice as barbiturates can depress respiration — which can be life threatening in asthma patients.

Combinations of Antibiotics: A large number of combinations of two different antibiotics are available in the market. Two categories of these are rational - combination of trimethoprim and sulphamethoxazole as co-trimoxazole and combination of anti T.B. drugs. These are the only two combinations mentioned in the WHO list of Essential drugs. Most other combinations carry the risks and disadvantages associated with combination products related earlier. In the case of antibiotics the disadvantages are greater, one because the side effects tend to be more pronounced; two because the increase in cost is greater; and three because of the added risk of developing antibiotic resistance. The commonest irrational combinations available is a combination of Cloxacillin with Amoxycillin or Ampicillin.

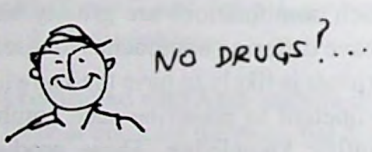
Combination of Drugs from Different Systems: Today there is a new trend in the marketing of combination of drugs from the allopathic system along with drugs from other systems viz. ayurveda, siddha, unani and even chinese and Korean systems. It is obvious that such combinations are grossly irrational as each of these systems have differing approaches to disease and therapy. Further, no practitioner is likely to have the knowledge of all these systems to be competent to prescribe such combinations on the basis of his scientific knowledge. These products need to be immediately banned.

Irrational Prescribing

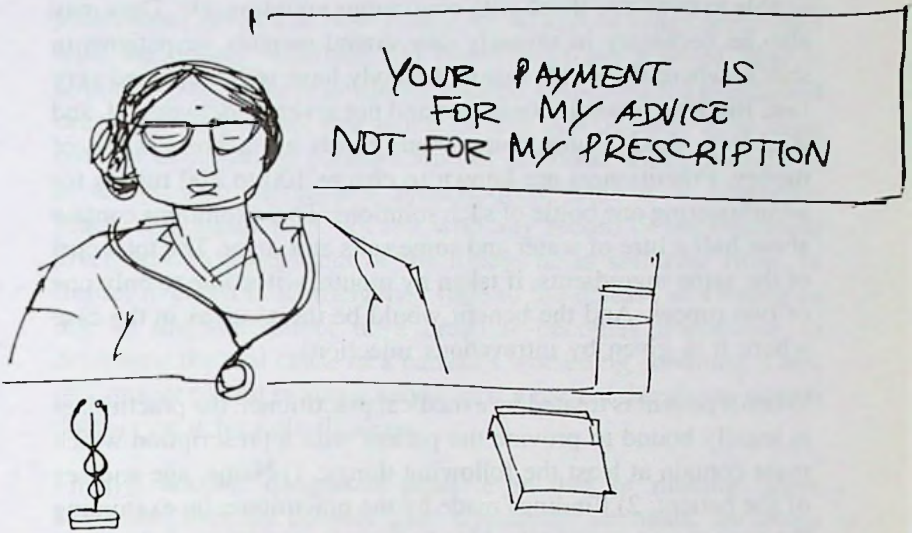
It needs to be understood that the problem is not limited to just a question of irrational or useless or harmful drugs. Rational, or even life saving drugs can be used in an irrational manner. The

commonest problem is the unnecessary use of drugs. Thus, often we see expensive antibiotics being used for trivial infections. Moreover this is often accompanied by wrong dosage schedules. Another problem is the prescription of a large number of drugs for a simple ailment, when one or few drugs would have sufficed. doctors, in many cases, when they are not sure of the diagnosis prescribe a large number of drugs to cover for all the possibilities. Thus a patient coming with fever may be given some antibiotic, a drug to treat malaria, a drug to treat typhoid, etc. It may turn out that the patient was just suffering from a viral fever, which could have been treated with some paracetamol tablets only. Such prescription practices increase the cost to the patient, unnecessarily exposes the patient to potential side effects, and in the case of antibiotics leads to drug resistance, i.e. a situation when these antibiotics become useless when they are really required.

Patients must also realise that if a doctor advises no drugs, he is giving as valuable (or in some cases more) advice as someone who prescribes a large number of drugs. All illnesses do not require drugs — in fact a large number of illnesses are "self limiting", i.e. the body cures itself without the use of drugs. So patients should not be impressed by a doctor who prescribes a large number of expensive drugs: in most cases the doctor is just hiding his inability to reach a correct diagnosis by trying to cover for all eventualities.



Some other common irrational practices that need to be mentioned. One is the preference among patients and doctors alike for injections. Under normal circumstances injections are not required to be given, except in the case of drugs that can be given only by injection, like insulin, some penicillins, streptomycin, etc. Most drugs are available in both forms: that which can be given by

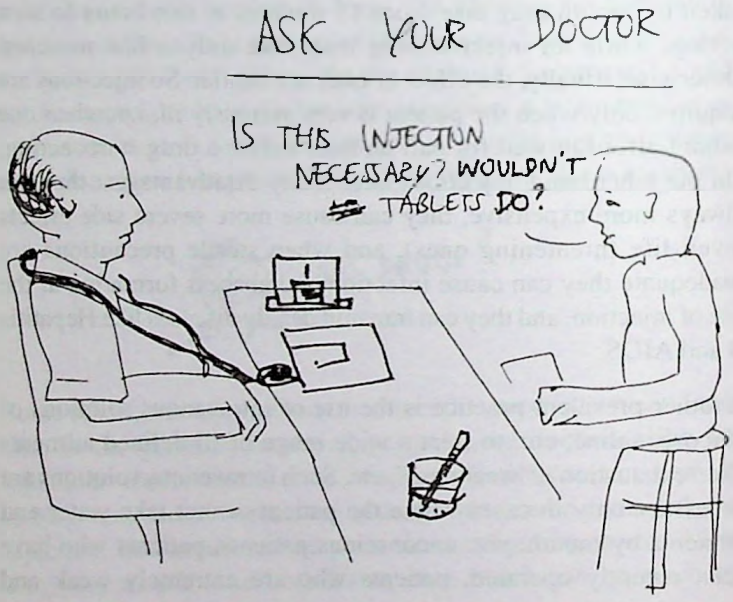


injection, and that which can be taken by mouth. A drug that is taken by mouth may take from 15 minutes to two hours to start acting, while an injected drug may take only a few minutes. Otherwise, usually, the effect of both are similar. So injections are required only when the patient is very seriously ill, i.e. when one cannot afford to wait for half an hour before a drug starts acting. On the other hand, injections have many disadvantages: they are always more expensive, they can cause more severe side effects (even life threatening ones), and when sterile precautions are inadequate they can cause infection and abscess formation at the site of injection, and they can transmit deadly diseases like Hepatitis B and AIDS.

Another prevalent practice is the use of intravenous solutions of glucose, saline, etc. to treat a wide range of ill defined ailments like "exhaustion", "weakness", etc. Such intravenous solutions are necessary only in cases where the patient cannot take water and ailments by mouth, viz. unconscious patients, patients who have been recently operated, patients who are extremely weak and

unable to swallow, those with continuous vomiting, etc. They may also be necessary in severely dehydrated patients, or patients in shock, where the fluids inside the body have to be replaced very fast. But if a person is conscious and not severely dehydrated, and is able to drink fluids, intravenous fluids are a gross waste of money. Practitioners are known to charge 100 to 200 rupees for administering one bottle of such solutions. These solutions contain about half a litre of water and some salts and sugar. The total cost of the same ingredients, if taken by mouth, will come to only one or two rupees. And the benefit would be the same as in the case where it is given by intravenous injection!

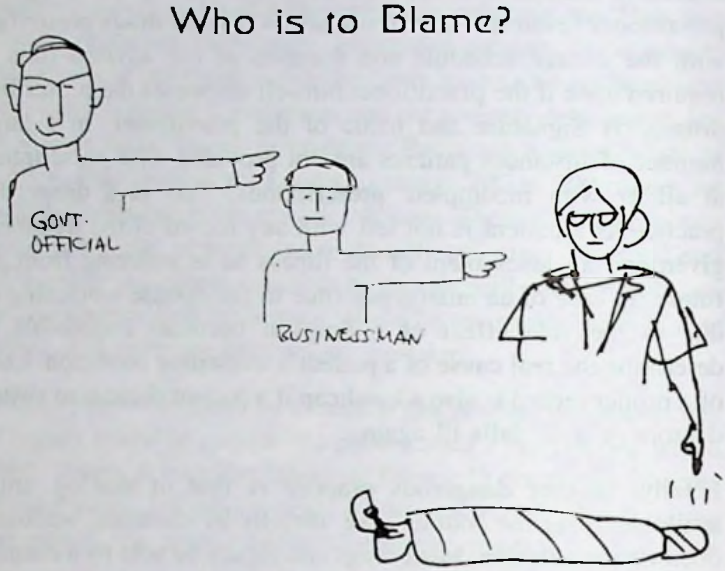
When a patient is treated by a medical practitioner, the practitioner is legally bound to provide the patient with a prescription which must contain at least the following things: 1) Name, age and sex of the patient; 2) Findings made by the practitioner on examining the patient, viz. pulse rate, blood pressure, condition of the chest



abdomen, cardiac system, etc.; 3) Diagnosis arrived at by the practitioner (even if it is provisional); 4) List of drugs prescribed with the dosage schedule and duration of use advised (this is required even if the practitioner himself dispenses the prescribed drugs); 5) Signature and name of the practitioner. In a large number of instances patients are not provided with prescription at all or with incomplete prescriptions. This is a dangerous practice as a patient is not left with any record of the treatment given and an assessment of the illness he is suffering from. In future, in case of an emergency (due to the disease worsening or due to the side effect of a drug) it becomes impossible to determine the real cause of a patient's worsening condition. Lack of a proper record is also a handicap if a patient decides to switch doctors or if he falls ill again.

Finally, another dangerous practice is that of making drugs available "over the counter", i.e. directly by chemists, without a doctor's prescription. Most drugs can legally be sold by a chemist only if the buyer produces a prescription. There are only a few simple drugs which can be sold without a prescription, viz. paracetamol, aspirin, etc. All other drugs are marked: "To be sold on the prescription of a Registered Medical Practitioner only". It is dangerous to buy drugs without a prescription as all drugs can have side effects, and have very specific do's and dont's.

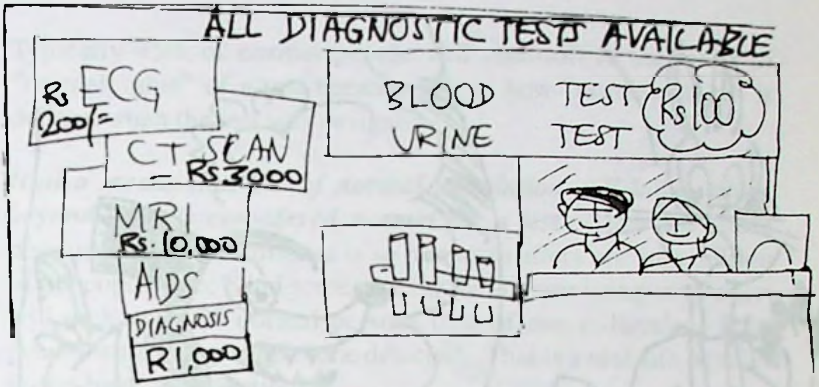
All these irrational practices continue to flourish because the five actors in this drama: the government as a regulatory authority, the drug companies as producers of drugs, the doctors as prescribers of drugs, the chemists as sellers of drugs, and the consumers as users of drugs, at some level or the other do not fulfil the required obligations and are unmindful of the potential harm that inappropriate use of drugs can cause. Drugs can save lives, but their inappropriate use can also take lives. It is estimated that 20-30% of illnesses — especially in the aged and in children are caused by use of drugs.



Rational Use Of Diagnostics

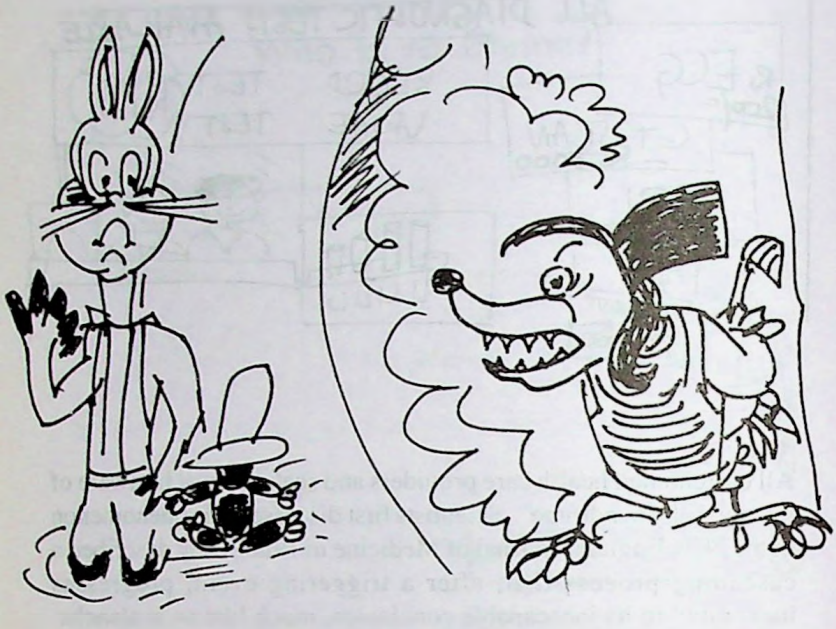
Using WHO definition of irrational drug therapy as the basis, irrational use of diagnostics (including laboratory tests of blood, urine, sputum, etc.; X-Rays; scans; etc.) may be defined as: "a diagnostic test is irrationally used when the expected benefit is negligible or nil or when it is not worth the potential harm or the cost."

While there is some awareness about irrational drug usage, almost no enough attention has been focused on irrational use of diagnostics. If one realises that an irrational CT-Scan is equivalent in wastage to about 100 bottles of an irrational 'tonic', then the importance of rational use of diagnostics will be apparent. One reason for this neglect may be that most medical professionals are not aware of the need to selectively and critically use the diagnostic tests and avoid the "tar baby syndrome"



All enlightened health care providers and seekers must be aware of the 'tar-baby syndrome'. Scientists first discussed this phenomenon in the New England Journal of Medicine in 1986. They described a cascading process that, after a triggering event, progresses inexorably to its inescapable conclusion, much like an avalanche. They called it the "Tar Baby syndrome" based on an old children's folk tale called "*Brer Rabbit and the Tar Baby*".

> *<u>The Story :</u> One day Brer Fox got hold of some tar and made a Tar Baby. He put a hat on it and set it in the middle of the road. Then he hid behind a bush to see what would happen. Presently, along came Brer Rabbit. He politely wished the Tar Baby good morning. When it did not respond, he wished it again and then yet again. Finally, thinking the tar baby was being deliberately rude, he punched it in the face and of course, his hand got stuck in the tar. He punched it with the other hand and that hand too got stuck. When he tried kicking it, his legs got stuck. He could not free himself.*



How does a clinical cascade begin? A physician or at times, a patient, may be goaded by anxiety and frustration, the same stimuli that provoked Brer Rabbit to kick the tar baby. Desire to allay anxiety, to feel in control and to overcome uncertainty prompt the order of some tests -- a seemingly benign and safe action. However it may turn out to be a misstep that sets in motion a cascade of chain reactions that get progressively more risky and more expensive.

The myth of "laboratory proof" has to be realised by all, especially the professionals. Most doctors unfortunately use laboratory tests for support rather than illumination.

Very few tests can make or break a diagnosis by giving absolute proof that a disease is present or absent. Most tests only affect the probability of a disease being present or absent (the likelihood ratio).

Typically 95% of normal people will conform to the range of "normal value" of a test because that is how "normal range" is defined when the test was designed.

It also means that 5% of normal population will have values beyond what is considered normal for a test. They are "false positive" cases. If a disease is so rare as to affect one in a million of the population, blind screening for the disease using such a test will pick up 5000 normal persons (5% of one million) as false positives for every single case detected! That is a real-life needle-in-the-haystack situation!

Mindless screening tests thus initiate clinical cascades. It has been estimated that a battery of 12 biochemical tests done by auto-analyser will produce at least one false positive "abnormal" result in 46% of healthy persons. ***A 20-test battery will produce abnormal (false positive) results in about 64% of healthy persons***; this will lead to further tests to clarify the issue. It is good for health care industry but may be risky or ruinous for the patients.
The plain truth is that clinical practice is a treacherous pathway lined with potential tar babies. It is indeed quite easy to "kick the tar baby" and initiate a clinical cascade of further tests. Beware of "tar baby syndrome" whenever you go for a battery of diagnostic tests. *With clinical testing, more is not necessarily better.*

Prudent Use of Diagnostic Tests

Before requesting an investigation, the clinician should ask himself/herself the following queries:

1. Will the test result help me to -
    a) Confirm/establish diagnosis,
    b) Rule out a diagnosis,
    c) Monitor therapy,
    d) Estimate prognosis, or
    e) Screen for and detect a disease?

2. Can the abnormality I seek in this case -

   a) Exist without any clinical evidence of it?
   b) Even if present, be in any way harmful to the patient?
   c) Be treated or controlled? and
   d) Be worth the cost and the risk for this patient?

3. Is there no safer and more economical alternative?

If, after careful thought, the answer to all these questions is a clear 'No', then there is no need to do the test. If the answer to any one of them is 'Yes', the test may need to be performed depending on its availability, predictive values and affordability.

Rationality and Cost-Risk-Benefit Analysis

Any health care option can be analyzed in terms of benefits, risks and cost. Benefits have to be weighed against risks and against cost. An enlightened health care seeker can cope with difficult decision making process through analysis. Doctors should encourage such patients to take decisions instead of being paternalistic and talking down to them.

Cost-benefit and risk-benefit can be simplified into four categories:

Category 1:

a) Low risk - Low benefit
b) Low cost - Low benefit

These are mostly rituals in health care that are routinely done. "Why not try it? After all there is no harm" or "It does not cost much" are some arguments put forth to promote these options.

Category 2:

a) Low risk - High benefit
b) Low cost - High benefit

These are ideal options to be avidly accepted. "It is safe and dramatically improves outcome" or "It is a steal" are some arguments put forth to promote these options.

Category 3:

a) High risk - High benefit
b) High cost - High benefit

Many modern miracles of health care belong to this category. Some examples are transplantation, assisted reproduction, foetal surgery and cancer chemotherapy. Quite often, the benefits are highlighted and the risks and costs are understated in the media and by health care providers. Care seekers may mistake these options to be of low risk or low cost. If they burn their fingers due to unaffordable cost or adverse outcome, they may react badly and seek redress.

Much health care litigation in court arises from mistaking a category 3 option as a category 2 option. Proper pre-treatment counselling is the only effective solution.

Category 4:

a) High risk - Low benefit
b) High cost - Low benefit

These options should be weeded out from rational health care.

Some researchers wanting to be the first to prove a point pursue high risk-Low benefit options. High cost-low benefit options are pursued by 'health industry' that looks for new ways of making profits.

T.S. Eliot has warned us against action taken 'not for the good it will do but that nothing be left undone'. "What other chance do you have" is the question put to the care seeker to justify category 4 options. This pursuit of the margin of the impossible has become "technological brinkmanship" in health care (W.A. Silverman: Perspectives in Medicine and Biology, 1995; 38: 480-95). This leads to the offensive practice of the so-called 'defensive medicine'. In the name of ruling out possibilities, a large number of tests are performed. Tests should be critically selected to 'rule in' a disease rather than 'rule out' all other possibilities.

FACTORS THAT PROMOTE IRRATIONAL MEDICAL CARE:

Why is it that despite so much training, irrational medical care is so widespread? And what can be done to restore the rational practise of medicine? Below we discuss six factors that favour irrational medicine and then go on to discuss factors that could promote rational medical care.

1. Medical Fashions Erode Rationality

Health care providers, episodically push certain disease labels and treatments because everyone else is doing the same, and it would be unfashionable not to do so. Dr. Buram listed some examples of 1987 in the New England Journal of Medicine (317: 1220, 1987).

1. Treatments of fashion: The use of third generation cephalosporin for community acquired pneumonia (unwarranted and irrational).

2. Disease of Fashion: Chronic fatigue syndrome which was known by many other names earlier.

3. Fashions in Surgery: Historically, tonsillectomy, stomach-freeze for peptic ulcer, gastric balloon inflation for obesity are some humbling examples of fashion. The current craze for - and uncritical acceptance of - all complementary and alternate medical practices

is an example of a fashion born of collective gullibility of the post-modern society. This too shall pass.

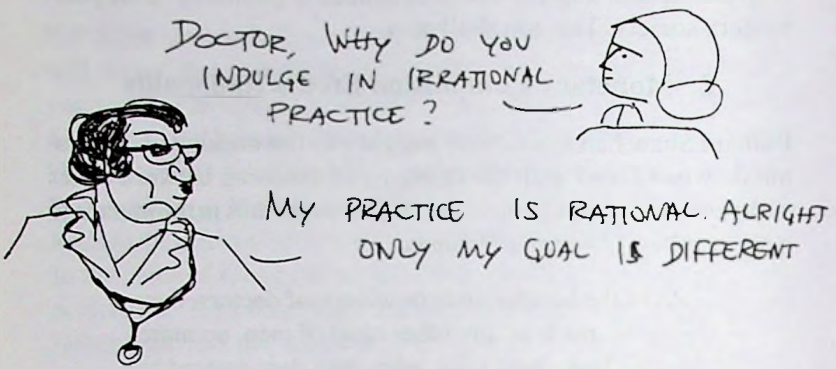
2. Monetary Compulsion Erodes Rationality

Bernard Shaw had an uncanny insight into the working of doctors' minds when faced with the dilemma of choosing between ethics and monetary compulsions. In 1906 he wrote thus in the preface to a piece called *"Doctor's Dilemma"*:

> "As to the honour and conscience of doctors, they have as much as any other class of men, no more and no less. And what other men dare pretend to be impartial when they have a strong pecuniary interest on one side?"
>
> "It is simply unscientific to allege or believe that doctors do not under existing circumstances perform unnecessary operations and manufacture and prolong lucrative illnesses."

The pressure to bring in income by unethical means is much higher in hospitals run for profit by non-technical financiers. Dr.Sethuraman, Professor of Medicine in JIPMER, Pondicherry, reports a story related by a junior doctor, who was his former student, and who worked in such a place later. He said this about his hospital: "No mother had a chance of normal delivery during the second half of every month because money had to be generated to pay back the next monthly installment to the bank. Similarly, any one with a chest symptom will be put into the intensive care and kept for five days unless they run out of money and ask for discharge." When he raised ethical queries, he was simply told to 'join in or get out'. He chose to get out.

Doctors in the private sector argue, "The patient is happy getting the maximum attention, we are happy collecting our fees and the health care industry is happy generating income and wealth for the



shareholders. *It is an all-win situation*." This is a vicious argument and can attract the reply, "A drug dealer or a pimp will also use the same logic and say it is an all-win situation. Can you or society accept it then?"

The harsh reality is that two-thirds of our rural families are in debt because of health care expenditure. If the chain of rural indebtedness has to be broken, planners and health activists have to squarely address this issue and find some lasting solutions. For the conscientious doctor, there is an ethical self test that can be used as a guide: "Would I like myself or my near and dear to be treated thus?"

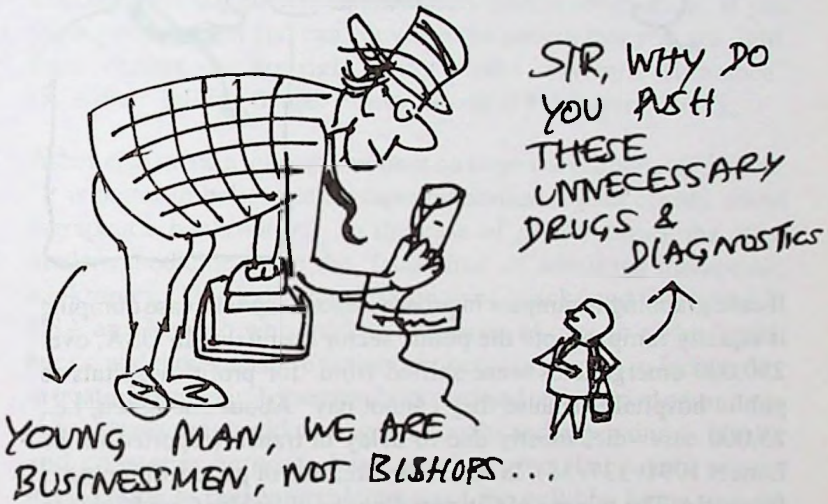
3. Advertising and Corruption Erode Rationality

Irrational practices are often initiated and maintained by marketing techniques of the advertising industry. The drug industry spends 20% of its annual sale or about Rs. 3,000 crores in advertising; this works out to about Rs. 50,000 per doctor per annum and each doctor prescribes drugs worth Rs. 250,000 per annum. Fashions in diagnostics are maintained by a well established kick-back scheme all over India. It is of great concern that what started in Mumbai in the 70's has spread through out the country and is the most important

cause for unnecessary health care interventions. PHA 2000 must address these growing and cancerous developments in health care industry.

What are commissions :

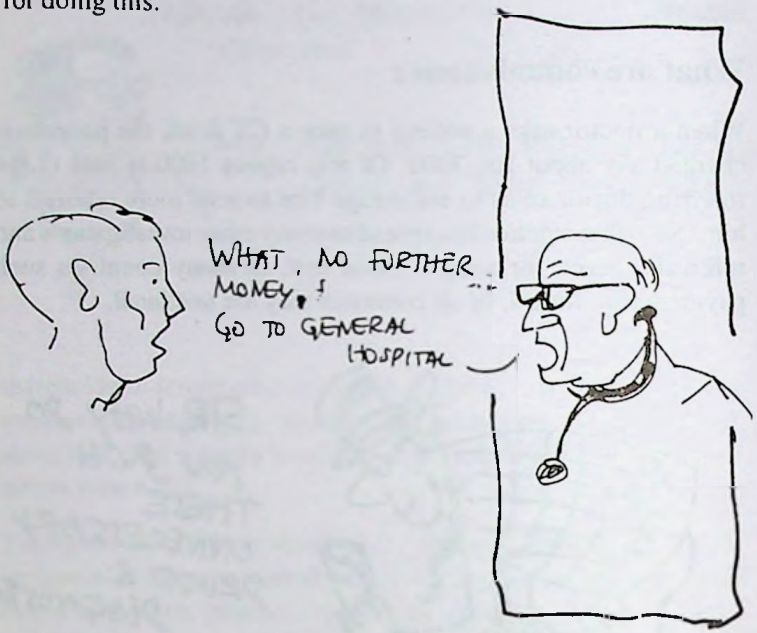
When a doctor asks a patient to take a CT Scan, the patients is charged say about Rs. 3000. Of this rupees 1000 is paid to the referring doctor so as to encourage him to send more referrels to him. Now this practice has spread to many other investigations and referrels - even for simple blood test. In many countries such payments are illegal. In all countries they are unethical.



4. Case Dumping and Case Grabbing Erode Rationality

Some for-profit hospitals engage health care workers, transport workers and others as touts to fetch cases for surgery and other procedures. These touts can be spotted in and around other hospitals offering unsolicited "helpful advice" to prospective clients. Doctors in the know, working in the private sector say, "Cases admitted for

surgery are discharged against medical advice and transferred to another hospital. Insiders are involved and get a good commission for doing this."



If case grabbing is rampant in private sector hospitals, case dumping is equally rampant into the public sector hospitals. In USA, over 250,000 emergencies were shifted from 'for profit' hospitals to public hospitals because they cannot pay. About one in ten, i.e., 25,000 cases die, mostly due to delay in transit (reported in the Lancet 1991; 337: 38). In India, the situation of patient dumping is far worse. The release of Citizens Charter of Health Care Rights in Government hospitals (see annexure 3 & 4) is a step in the right direction; but who will implement it? When?

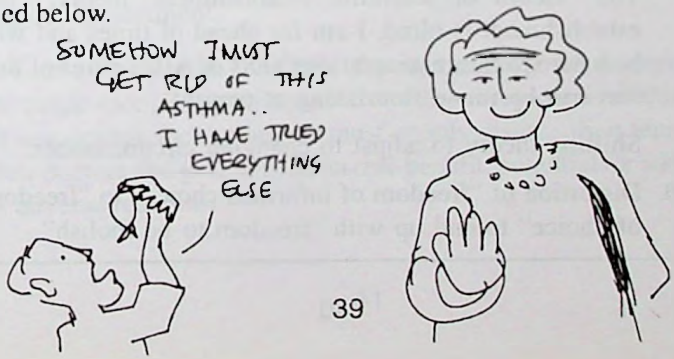
5. Gullibility Promotes Quackery and Fraud

There area a number of gullible persons who fall prey to doubts and fears raised by proverbs, house-lizards, black cats, astrologers, palmists and numerologists. They abuse modern medical science

to pander to their fears and phobias; many medical practitioners are only too happy to oblige them as 'it is good for the business'. The dividing line between trust and gullibility is a fine one. When some one is ill, there is pressure to "do something" and it may be tempting to try unproven remedies. Health care quackery is big business even in the developed countries. Unethical advertising, uncritical media hype and human gullibility help propagate it. When the truth about "the miraculous cure" becomes apparent, the stakeholder shifts the focus to protect the health care business interests.

"The capacity of human beings for self-delusion should never be underestimated; conviction profoundly affects observation. If you think you are right and can convince the patient that you are right, then whether you are right or not makes very little difference" (R. Asher: Talking Sense. Pitman Medical Publishers, 1972).

Asher also made a telling comment on hope prevailing over reason. "It is better to believe in therapeutic nonsense than openly admit therapeutic bankruptcy." In the case of AIDS, during the 80's, modern medicine made the 'fatal error' of admitting therapeutic bankruptcy. This led to mushrooming of quacks and charlatans in USA and Mexico who made wild claims of cure to make 'quick bucks' and then vanish. Similar quackery is going on in India today in treating many viral diseases. Informed and enlightened consumers should break the shackles of age-old myths and superstitions. Health and consumer activists have another area that needs urgent intervention to prevent exploitation of the gullible. Some tips are listed below.



Ten Tips to Detect possible Quackery or Fraud in health care

Like politics, health care has also become the last refuge for many scoundrels.

J.H. Young, a professor of history has compiled the following guidelines:

1. Exploitation of fear and phobias or of hope for a miracle.
2. Claims of miraculous scientific breakthrough
3. Promise of painless safe treatment with excellent chances of "cure".(in a condition that has resisted treatment by one or more other health care providers.)
4. Reliance on anecdotes and testimonials.—They don't separate facts from opinions or cause and effect from a mere coincidence.(for example-"I can tell you of a person who took this drug and right away was cured")
5. Heavy promotion by advertising.
6. Large sums of money payable by clients for achieving cure.
7. The use of Simpleton science (one-size-fits-all type of dogma): diseases have one basic cause and one way of treatment takes care of all diseases. For example, water is the basis of all diseases and hydrotherapy cures them.
8. The 'victim of scientific establishment' theory: "the establishment is blind, I am far ahead of times and will be a hero to future generations"(lots of AIDS cures of this sort can be found flourishing at present).
9. Shifting theory to adjust to changing circumstances.
10. Distortion of "freedom of informed choice" to "freedom of choice" to end up with "freedom to be foolish".

6. Non-compliance Eclipses Rationality

Doctors tend to overestimate compliance of their patients (Norrel SE: Soc Sci Med 1981; 15E: 57-61). They often presume that all the patients diligently follow all their advice and do not even check. But patients may feel burdened by treatment advice especially the life style changes and unpleasant procedures or medications.

"You must take it. It is for your own good", is all that most doctors can say to coax their patients to comply with the treatment.

Some common reasons for non-compliance include:

1. Misunderstanding of the nature of the disease: Patients with diabetes or high blood pressure may assume that one course of treatment will cure the disease. Many chronic health problems need life-long monitoring and follow up. Effective counselling on the nature of illness may reduce this form of non-compliance.

2. Wrong assumption that "control is cure". This is an extension of the previous fallacy. The patients take medicines till the blood pressure, blood sugar, etc., normalise. Then they stop all treatment thinking that the disease is cured. Proactive advice - "when values reach normalcy, you have to go on to maintenance therapy" - may help avoid such non-compliance.

3. Misunderstanding of name of drug or its dosage or duration of treatment: Effective communication, especially when written in a language that the patient can read, reduces this form of non-compliance. Patients should not feel hesitant to clarify all doubts regarding treatment.

4. Fear of "addiction" and fear of powerful drug: Media reports of the panic-mongering type are followed by an epidemic of this form of non-compliance! Patients must openly discuss their fears with their doctors and get clarified on risk-benefit, potential for addiction or adverse reactions.

5. Mistaking "illness" for "disease": Though the terms disease and illness are interchangeably used in the health profession, medical anthropologists make a clear distinction. Disease is what is diagnosed by the health professional. It is the abnormality of the body or mind. Usually, though not always, there is a lesion (alteration) of organs or tissues, that can be detected. Illness is what the person with or without a disease perceives. It is subjective. In many diseases like high blood pressure, diabetes and early cancers, a patient may not feel ill at all. On the other hand, in benign conditions like tension headache and irritable bowel syndrome, the patients may perceive severe illness but their doctors may say, "You do not have any disease; all the tests are normal".

It is important that health care seekers and providers understand the concept of "illness-disease" and the possible paradoxical relationship between them. It is the only way to reduce non-compliance among those with a "chronic disease without illness". It is also the only way to reduce 'doctor shopping' by those with a "chronic illness without disease". ***This is an area for health activists to run a major campaign.***

6. Social-cultural-religious barriers: Social events disrupt the schedule of an otherwise compliant person. Happy events like a wedding as well as sad events like death of a near and dear result in temporary non-compliance because "taking treatment did not seem terribly important then".

Dr.Sethuraman reports the case of a Muslim diabetic who thought all insulin is extracted from pigs. He never verified this suspicion with any one else. After nearly two years of non-compliance, he finally confided in Dr.Sethuraman. There are many such deep-rooted social, economic, cultural and religious barriers to compliance.

7. Non-compliance by denial: Denial is one of the coping mechanisms that results in non-compliance. Denial refers to a patient refusing to accept a diagnosis, usually one with a poor outcome. This is the most difficult to manage. Unless the provider-client relationship is strong, mutually respectful, and is able to address deep most concerns of the client, the barrier of denial cannot be breached.

FACTORS THAT PROMOTE RATIONAL MEDICAL CARE

Holistic Care Promotes Rationality

"Holistic is a buzz-word today - different persons interpret it in different ways. It is not a mix and match of various systems of medicine as being interpreted now. Ancient physicians like Hippocrates and Charaka have advocated truly holistic perspective in medicine.

Hippocrates said "*I would like to know what kind of person has a disease rather than what disease that person has.* Just think about it! Even today, it is difficult to improve upon this simple and yet accurate view of holistic perspective. Consider the diseased person as a whole - his/her personality, attitude to life, knowledge, and socio-economic and cultural standing etc.- in order to understand the illness from a holistic viewpoint.

If Medicine had such a 'holistic' view, then when and how did it degenerate to be a dehumanised profession? As medical sciences

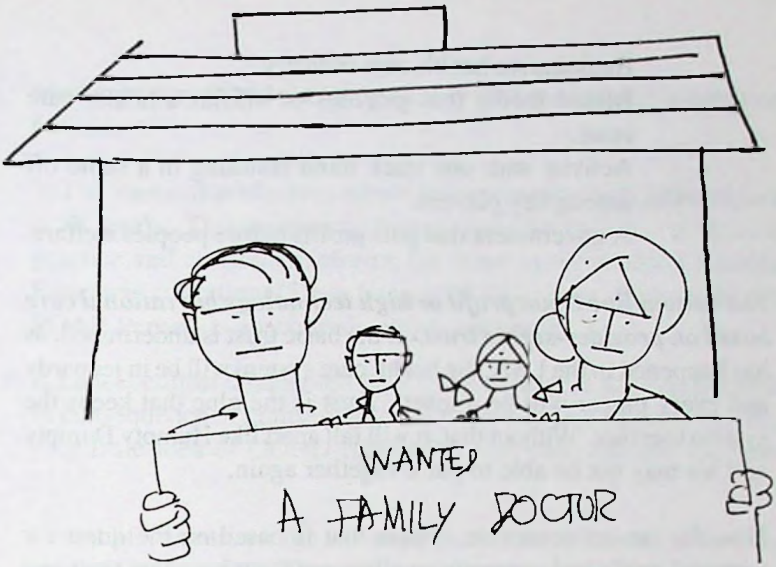
advanced, we could understand more and more about the causation of diseases - revolutionary discoveries and progress were made in the field of medicine and therapy.

Our attention shifted more and more to the biological sciences at the expense of behavioural sciences. In order to cope up with the advances, specialisation became order of the day. As a cynic had said it, "Specialist doctors learn more and more about less and less until they know *everything about nothing*". Dr. K. White has coined the term *Ignorant Savant* for this breed of specialist doctors who are well informed in their own limited fields but are ignorant of patients life-world. T.S. Eliot lamented thus: "Where is the knowledge we have lost in information? Where is the wisdom we have lost in knowledge?"

Primary Care Can Promote Holism

Just as stomach and bowels have a primary non-glamorous job of breaking down complex food, primary care provider has to have a holistic view of a patient's illness and sort out his/her various problems. Sorted out health problems have to be specifically referred for specialised treatment.

During the 70's and 80's, USA went for specialist treatment in a big way. It was a disease oriented, procedural, piece-meal approach that was ruinously expensive and soon controlled by insurance industry. Now advanced societies have realised this folly and are trying to revert back to a primary care approach that is patient-oriented, holistic, continuous and comprehensive. Unfortunately, the third world countries are caught in this quick sand now. ***Empowering "just an MBBS doctor" to shed his/her diffidence and practice rational primary care will go a long way to rectify the depressing scenario.***



Primary care physicians need to develop into "health care advocates" for their patients. They must reverse the current trend and help patients to avoid inappropriate entry to specialist care; not merely because it is costly, but because it wastes everybody's time, incurs unnecessary risks and diverts attention from rational, more appropriate and effective solution (Hart JT: Lancet 1992; 340: 772-775).

Synergy Fosters Rational Health Care

Health care providers, care seeking public, industry (diagnostic, therapeutic and insurance) media, activists and governmental machinery are all key players and stakeholders in health care delivery system. If they cooperate and stand together to achieve the goal of "ethical and effective health care for all", then the system will be strong and functional. But if each player sets his own agenda forgetting the common goal, then the system will be weak and dysfunctional. Some examples are:

- Ignorant, unethical or corrupt health-care provider.
- Foolish, non-compliant or deviant behaviour by the care seeker.

- Exploitative health-care industry.
- Biased media that glorifies or vilifies a health care issue.
- Activist with one track mind resulting in a stand off among key players.
- A government that puts profits before peoples welfare.

The bottom line is not profit or high technology but rational care based on provider-seeker trust. If the basic trust is undermined, as has happened in the USA, the health care system will be in jeopardy and every player will be a loser. Trust is the glue that keeps the system together. Without that, it will fall apart like Humpty Dumpty and we may not be able to put it together again.

How far can an economic system that is based on the quest for personal profit and competition allow a system based on trust and altruism to grow? Can a medical profession shaped only by market forces ever be a noble profession? These are some basic questions we need to think about.

Other Strategies to promote Rational Care

Many target groups need to be addressed and multi-pronged action is required. *All bad practices and drugs need weeding out by the government while rational management practices are to be promoted by the health care providers, seekers and other interested groups.*

1. Governmental regulation could remove all irrational formulations and help curb exploitative health care. We need a strong drug-control authority with enough teeth to implement whatever policy they announce from time to time.

2. The health care and drug industry could be coaxed by pressure of the consumer groups and by the medical lobby. But the medical fraternity treads gently in this regard as "*You do not bite the hand that feeds you*". It therefore becomes largely a task of

consumer groups and public opinion to curb the industry's unethical policies.

3. The medical profession needs to reorient towards rational care at all levels. This means two things: periodic updates for those in practice and curricular reforms for those in the medical schools. Educators of Rational Drug Usage (ERDU-group) initiated by CI-ROAP, Penang is an example of this approach:

A Lancet editorial lamented thus: "The treatment has deteriorated. In consequence of cramming science down men's throats, they had very little idea of GOOD practice". The year was not 1985 but 1885!

In real life situations, life is complex and rational decision making much more exacting. The doctor ought to know the social, cultural and anthropological reasons of the health seeking behaviour of the person sitting in his/her consultation room.

Medical curricula have shown benign neglect of these "soft sciences", resulting in the training of 'hard boiled' medicos bristling with scientific information but unable to apply it well. Later in their practice, things only get worse because, "One of the things the average doctor does not have time to do is catch up with the things he did not learn in school. If medicine is a mystery to the average man, nearly everything else is a mystery to the average doctor" (Milton Mayer).

Behavioural sciences module needs to be introduced in medical education, not as a transplant from the West, but evolved in the context of the realities of the third world.

4. Finally, consumer education and people mobilisation *to insist on and get quality and rational health service as a matter of right.* This will not only be the most effective socio-political strategy but the most difficult and daunting one too. ***PHA-2000 is an ambitious attempt in this direction.*** There are two types of intervention to

achieve this. One type like "the 12 questions to a doctor" are measures to help the patient to cope better with the doctor-patient relationship. The others are institutional and organizational measures - like making information easily available in books or on the Net, or by creating a statutory medical board that would give a second opinion when needed. Now is the time for all those concerned with the current crisis in health care to actively support its mission. Come on, let us all act!

Eight hints to Detect an Uncaring (irrational) Doctor

The following are some warning signs that indicate that your doctor may not be doing his/her best to help you.

He/She:

1. Does not listen to what you are saying.
2. Does not probe into your symptoms and complaints. (usually it is essential for a doctor to ask more questions regarding your complaint before he can reach a conclusion).
3. Does not examine you completely or forgets to examine the organ or body system about which you have raised some doubts.
4. Seems to be forgetful and peculiar in behaviour, either smiles inappropriately or is short-tempered.
5. Acts in a paternalistic (fatherly) manner; is all-knowing and tells you "the only way" to manage your problem.
6. Does not educate you on the nature of illness and the rationale of tests ordered and treatment advised.
7. Does not discuss risks and benefits of the tests, procedures and medicines advised.
8. Gets upset or reacts defensively when you suggest seeking a second opinion.

What every intelligent patient should ask his/her doctor?

If you want to be an informed seeker of health care, discuss with the doctor the following points before agreeing to undergo any procedure.

1. What is actually wrong with me?(you can ask for the name of the disease -if any, that you have)
2. How serious is this disease/condition?
3. What may happen to me if I leave it untreated?
4. What kind of procedure are you planning to do?
5. Is the procedure done for diagnosis, for treatment or for both?
6. What are the risks of this procedure?
7. What are the chances that the proposed procedure will be successful in my case?
8. Will the success be a long term or short-term benefit?
9. What alternative procedures/treatments are available?
10. Of these, which do you think would be the best for me? Why?
11. Could you suggest any source of information on this disease that I could read or watch?

PEOPLES INITIATIVES FOR RATIONAL MEDICAL CARE:

- The Kerala Shastra Sahitya parishad has conducted widespread public awareness programmes against irrational and hazardous drugs. Some of the major hazardous drugs on the Kerala market experienced a sharp drop in sales as a result of the campaign.
- CEHAT, Maharashtra has initiated, with district NGOs, public campaigns against misuse of intravenous saline infusion by putting up posters in all private nursing homes and clinics

decrying the practice. This has provoked a response from the local medical association, which however conceded that the issue raised was correct even if such postering was not the desired approach!

- Member organisations of the ALL-INDIA-DRUG-ACTION-NETWORK have been active in researching and working up lists of banned and bannable drugs on the Indian market which have been published and widely circulated. The failure to ban many of these drugs have also been addressed by a number of public interest litigations in the Supreme Court which has forced the drug controller to take some action on many of these drugs. Neither policy makers nor health professionals and their associations have seldom addressed rational health care issues. One can rightly claim that going by past experience it is only alert coalitions of non-governmental organisations that have addressed these issues. This essential watchdog role of the non-governmental organisation needs to be emphasised.

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Chapter - 3

Private Health Sector in India: A Critical Review

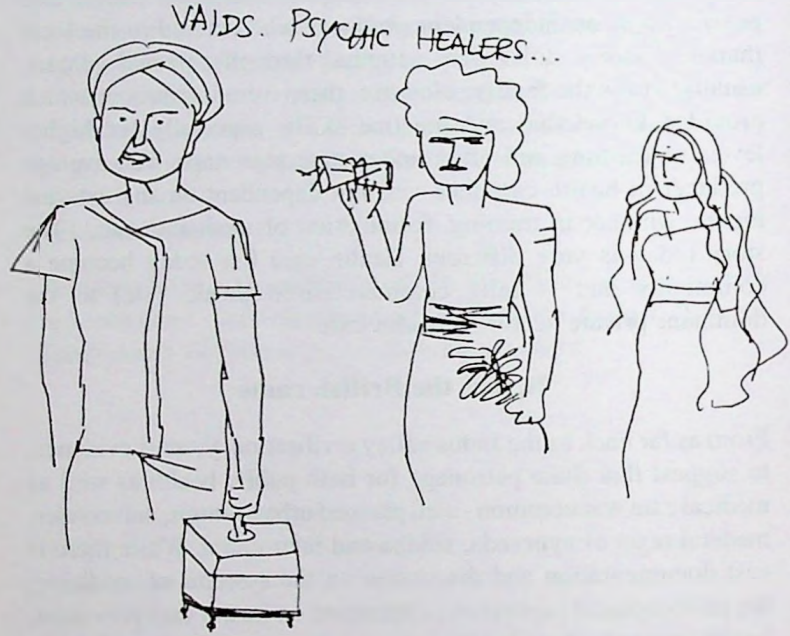
A Historical Introduction

The way we perceive and understand the health sector today is shaped largely by the social and economic setting of the day and its critique and contradictions. Health care, as we know it today, evolved as an institutional system under capitalism, like any other sector of the economy. In pre-capitalist times the health care provider was an independent producer who catered to the local market. His/her skills were acquired through personal contact, usually within the family; ofcourse, there were institutions which provided knowledge and practice skills, especially for higher levels of learning and often under state patronage. The average producer of health care then was not dependant on any external inputs, whether in training, formulation of medicines etc.. The story today is very different. Health care has today become a commodity and is fully commercialised thanks (sic) to the dominant private sector in health care.

Before the British came

From as far back as the Indus valley civilisation, there is evidence, to suggest that State patronage for both public health as well as medical care was common - well planned urban centres, universities, medical texts of ayurveda, siddha and later unani. While there is vast documentation and discussion on the systems of medicine, the philosophical context etc.., literature on health care provision, health care providers, health care spending, organisation of health care services etc.. is conspicuous by its absence. Oral history and

folk traditions, however, do indicate that a large variety of individual practitioners existed - vaids, herbal healers, snake-bite specialists, birth attendants, abortionists, psychic healers, faith healers etc.. During this period, which coincides with the pre-colonial period, structured health care delivery had clearly established three characteristics. Firstly it was considered a social responsibility and thus State and philanthropic intervention were important. Secondly the services provided were free of cost to all who could avail them or had access to - ofcourse, caste, class and other such biases were there. And thirdly most of these facilities were in towns thus showing a neglect of the countryside.



Under British rule....

Under colonialism Indian medical science declined rapidly. Ayurveda, both due to its unwillingness to become open and adapt to changing times, and due to reduced patronage with Unnani-Tibb becoming dominant in the medieval period, had already suffered a set back. With the coming of the Europeans even Unnani medicine got reduced patronage. The impact of colonialism was far reaching. The gradual destruction of the local economy also destroyed local medical practices. However, the diffusion of modern medicine which was emerging was poor, especially in the rural areas. Hence, people living in these areas had to resort to whatever remained of what was now called folk and/or traditional medicine.

The Indian Medical Service (IMS) set up in 1864 catered mostly to the needs of the armed forces. However, by early 20th century hospitals for the general population were established in chief moffusil towns, besides the Presidency headquarters. The expansion of the medical facilities followed the devolution of the imperial government, especially after 1880 with the setting up of municipalities and district boards.

However, these medical facilities had a distinct racial and urban bias. Separate provisions were made on employment and racial grounds, though in some places non-official Europeans might be allowed access to hospitals designed for civil servants. In General Hospitals, wards for Europeans and Eurasians were separated from those for the rest of the population. The rural areas had to wait till the Government of India Act 1919 whereby health was transferred to the provincial governments and the latter began to take some interest in rural health care. However, this interest was confined to developing for the rural areas a structure of only preventive health care and not hospitals and medical clinics, that is the rural areas were to be given "public health" and not medical care. There was a romance attached to leaving the rural areas to their folk traditions and practices for their medical care but intervention was needed to

maintain public health so that epidemics could be controlled ! The result of this was that medical care activities of the State were developed mainly in the urban areas, and rural areas were deprived the devolution of medical care within their reach. This is an important historical fact to note because this same differential treatment for urban and rural areas has continued even in the post-colonial period, and the international actors, now many more in number and more aggressive at that, provide for its continuity both financially and ideologically.

Before Independence

It had been terrible years. Famine and epidemics swept the land. Between 1890 and 1920 it is estimated that over 20 million died of plague, small-pox, cholera and malaria alone - not to speak of other fevers and tuberculosis.

The worst Famine in Indian history.
The Great Bengal Famine :
over
4 million dead!

This dualism underlies the history of development and underdevelopment and without keeping this in context the analysis of the health sector will have little meaning. Further, the imperial government in India adopted measures that were totally inadequate to deal with the problems at hand. Apart from the racial and urban bias in developing public health infrastructure they also ignored the way the private health sector was developing. No concern whatsoever was shown at regulating the private health sector. As a consequence the number of unqualified practitioners kept increasing. While those concerned with colonial administration and

living in the enclaves had access to the modern health care services which were evolving, the remaining ("natives") were left to the mercy of these private practitioners most of whom were either "traditional" practitioners trying to integrate with modern medicine or outright quacks. By Independence the qualified allopaths had reached 50,000 and others 150,000. (See Annexure 1)

> The health sector world-wide is perhaps the largest subsector of the economy. No other sector of the larger economy has a reach as much as the health sector, its market being assured, whatever the odds. Given this basic feature, modern medicine under capitalism has exploited fully the opportunities for making a profit through provision of health care. Historically, provision of health care services has moved away from the traditional, non-institutional trained and home-based petty-commodity producer, to the sophisticated, institutionally qualified, market and commodity dependent service provider on one hand and the completely corporate, institution-based service on the other hand.

Changes with Independence

Independent India has not as yet seen a radical transformation in provision of health care services for its majority population, especially the masses in the rural areas. This despite a National Health Plan available on the eve of Independence. The detailed plan set out by the Bhore Committee was both well studied and comprehensive and designed to suit Indian conditions. It sought to construct a health infrastructure which would require an increase in resource allocation by the state of about three times that existing then. These state health services would be available universally to all free of cost and would be run by a whole time salaried staff. The

Bhore Committee plan was biased in favour of rural areas with the intention of correcting the wide rural-urban disparities in the shortest possible time. When implemented fully in 25-30 years the level of health services would improve ten-fold(of that existing in the early forties) to 567 hospital beds per 100,000 population, 62.3 doctors per 100,000 population and 150.8 nurses per 100,000 population spread proportionately all over the country. This development would make the private health sector dispensable. This level of health services would have been about three-fifths that of World War II Britain.

On Independence Year : 1947.

Population : 344 Million
Life expectancy : 33 years.
Infant Mortality : 149 per 1000 -
Under 5 mortality : 246
Malaria : 70 Million cases and 2 Million deaths per year.
TB : 2.5 million cases : 5 lakh deaths per year.
Smallpox : 70,000 deaths per year : 15% of all infant deaths
Cholera 1,17,000 deaths in Madras province alone!
Leprosy 1 million cases.

India Today : 50 years later

Population : 900 million
Life expectancy : 61 years
Infant Mortality : 74 per 1000
Under 5 mortality : 115
Malaria : 9 Million cases
deaths : over 10,000
TB : 12.7 million cases
5 lakh deaths/year
Smallpox : Nil - Completely eliminated.
Cholera : Almost eliminated but now rising again.Gastroenteritis rampant.
Leprosy Decreasing.

But this is nothing to be happy about.

Viewed historically the post-Independence state health financing and health services development was not very different from the colonial period. The same pattern of a focus on elite groups continued. What changed was the proportion of medical institutions and facilities in the private sector. Especially, the last two decades have witnessed a very high growth rate of private hospitals and dispensaries. (See Annexure 2)

Today health care has become fully commodified and the private sector is the dominant provider of health care globally, as well as in India (though not necessarily in financing, and especially in the developed countries where public financing is the dominant mode). New medical technology has aided such a development and the character of health care as a service is being eroded rapidly.

Provision of routine medical care for a wide range of diseases and symptoms is mostly in the private sector. While government health centres exist across the length and breadth of the country they have failed to provide the masses with the basic health care which the latter expect. It will suffice to say that a fairly large investment by the public sector in health care is being wasted due to improper planning, financing and organisation of the health care delivery system - the national public sector health expenditure today is Rs.20,000 crores (1999-2000), being spent on 5000 hospitals and 550,000 beds, 11,100 dispensaries, 23,000 PHCs, 140,000 subcentres and various preventive and promotive programs, including family planning.The State employs 140,000 doctors and also runs 103 medical colleges. But the services provided by the state do not meet the expectations of people and as a consequence the latter are forced to use private health care whatever be its quality and / or effectiveness.

FEATURES OF THE PRIVATE HEALTH SECTOR

Private general practice is the most commonly used health care service by patients in both rural and urban areas. While this has been known all these years, data in the eighties from small micro studies as well as national level studies by the National Sample Survey and the NCAER, provided the necessary evidence to show the overwhelming dominance of the private health sector in India. These studies show that 60-80% of health care is sought in the private sector for which households contribute out-of-pocket 4% to 6% of their incomes. This means a whopping Rs.60,000 to 80,000 crores private health care market in the country at today's market

prices. This includes the hospital sector where the private sector has about 50% of the market share.

There is a close relationship between the failure of the public sector and the growth of a private sector. First, the former justifies the latter. Second, there exists, perhaps the only place in the world, a private sector that lies well-entrenched within the public sector, a sector that has fully utilized the public sector for its growth, and has never been called upon to repay it. This trend continues to this day.

How big is it?

Our estimate is based on indirect extrapolation using the assumption that all doctors (compiled from lists of the various medical councils) minus government doctors is equal to the private sector. Today there are about 12,00,000 practitioners registered with various system medical councils in the country and of these 140,000 are in government service (including those in administration, central health services, defence, railways, state insurance etc..). This leaves 10,60,000 doctors of various systems of medicine floating in the private sector and one can safely assume that atleast 80% of them (850,000) are economically active and about 80% (680,000) of the latter are working as individual practitioners. Apart from this there are as many unqualified practitioners according to an estimate based on a study done by UNICEF/ SRI-IMRB in Uttar Pradesh, and if we accept this estimate then the total medical practitioners active becomes about 14,00,000, that is one such practitioner per 700 population! Even if we count only qualified, active practitioners, the ratio is one for about 1160 population - not bad at all.

Where is it?

Urban concentration of health care providers is a well known fact - 59% of the country's practitioners as per 1981 census (73% allopathic) are located in cities, and especially metropolitan ones. For instance, of all allopathic medical graduates in Maharashtra 55% are located in Bombay city alone which has only 12% of the

state's population! This selective concentration of health care providers then becomes a major concern to be addressed, especially since the health care market is supply induced and when people fall ill they are wholly vulnerable and forced to succumb to the dictates of such a market. The consequence of this is that access to health care providers gets restricted to those living in urban and developed pockets and the vast majority of the rural populace have to make do with quacks or travel to the urban areas for satisfying their health care needs. Infact, studies have shown that those living in rural areas spend about as much on health care as those in towns and hence relocation can become economically viable for qualified private practitioners.

What systems constitute it?

Medical practice in India is a multi-system discipline. Some of the major recognised systems are allopathy or modern medicine, homoeopathy, ayurveda, unani, and siddha. Apart from these there are others like naturopathy, yoga, chiropractic etc.. as also a very large number of practitioners who do not have any qualification from any recognised system. All this creates a complexity which makes information management, recording, monitoring etc.. a daunting task and it is this very diversity and complexity which is in part responsible for the chaos and lack of regulation and quality control. Thus, a major question which needs to be addressed is how do we view practitioners of different systems of medicine, how should they be distributed in the population and what type of care should each group be allowed to administer. We strongly feel that this is an important issue of concern for policy makers. If some steps in the direction suggested are not undertaken with due seriousness then the existing system hierarchies (with allopathy as dominant and homoeopathy and ayurveda qualifications serving as a legitimacy to practice modern medicine or as alternate to allopathy for the patient when the latter fails to cure) will continue and quality care or care with basic minimum standards will never be achieved.

How are they licensed to practise?

Legally speaking registration gives the qualified practitioner the right to practice medicine and it is the duty of the concerned authority to assure the consumers of such health care that no practitioner without appropriate registration is treating patients. It is well known that the various medical councils have been lax and negligent and have not been performing their statutory duties. As a consequence of the latter the medical practitioners have also become lax and a large number of them are practicing today not only without proper registration but also without the requisite qualifications. All this then becomes a threat to the patient who is thrown at the mercy of doctors who may not have the necessary skill and who practice with half-baked knowledge. Thus, even something for which there is a law and an authority to administer it, it is being neglected.

What types of care does it give?

When people fall ill the first line of contact is usually the neighbourhood general practitioner (GP) or some government facility like a dispensary or primary health centre or a hospital. That the GP is the most sought after health care provider has been confirmed now by a number of studies, and this ranges from 60% to 85% of all non-hospital care which patients seek. In a small proportion of patients, about one in ten, the GP may need to refer the patient to a specialist. While modern medicine has simplified treatment of most illnesses and symptoms to afew drugs (even making many of us self-prescribers) its commercialisation has brought in more problems than the benefits it has created. The pharmaceutical industry and the medical equipment industry have both caused much harm to the character of the medical profession. Their marketing practices have lured a large majority of medical professionals (and not the unqualified quacks alone) to increasingly resort to unnecessary and irrational prescriptions of drugs, the overuse of diagnostic tests, especially the modern ones like CAT

Scan, ultrasound, ECG etc... and uncalled for references to specialists and superspecialists (for all of which a well organised kickback system operates - the givers and beneficiaries calling it commission!).

PATTERNS OF GROWTH-FROM PRIVATE TO CORPORATE

The Ministries of Health have shown little concern for planned development of the health sector in India. The Planning Commission's concern was with only the public sector inspite of knowing that the private health sector is the dominant one and such planning has no meaning if the private sector is left out of the ambit. As a consequence of this the availability of data on the private health sector is a major problem. The only definitive set of private sector data is on the number of hospitals and beds and that too is an underestimate as various micro studies have revealed. Another set of data on the private health sector which is somewhat definitive is pharmaceutical production where 90-95% of formulations are manufactured in the private sector.

In India the limited data we have shows that this process of rapid increase in the number of private hospitals and their capacity began in the mid-seventies and has advanced progressively, increasing from a mere 14% of hospitals in 1974 to 68% in 1995. This period of rapid private sector expansion in the hospital segment also coincides with newer medical technologies being made available as well as large scale increases in the number of specialists being churned out from medical schools.

The private hospital sector is presently in the process of making another transition in its rapid growth. This is the increased participation of the organised corporate sector. The new medical technologies have made the concentration of capital possible in the medical sector. These new technologies are increasingly reducing the importance of the health care professional. S/he is no

longer the central core of health care decision making and corporate managers are increasingly gaining control of the health care sector. New medical technologies have opened new avenues of corporate investment that is going to bring about far reaching changes in the structure of health care delivery. With private insurance also on the anvil health care too will soon make its way into the big league of monopoly capital.

Production and Growth of Medical Human Power : The training and education of doctors of the modern system is predominantly in the public sector. Until the last decade the private sector showed little interest in medical education and the entire burden of producing doctors and nurses was on the state. But in recent years private medical colleges are increasing in numbers rapidly, many without getting the necessary permission of the Medical Council of India because they lack the necessary facilities essential for imparting such education and training. This trend has been largely due to lack of any regulation on the growth of the private sector, the states unwillingness, and rightly so, to increase the number of medical seats in the public sphere and the large demand of doctors in mid-east and western countries. It must be noted that inspite of various restrictions outmigration of allopathic doctors remains very high with about 4000 to 5000 doctors leaving the country every year which at today's prices means a loss of Rs.400 - 500 crores, assuming Rs.10 lakhs as the cost of production of a doctor.

In contrast, production of doctors under ayurved, homoeopathy, unani, siddha etc.. is largely in the private sector with very limited subsidies from the state. Even these doctors are largely produced for the private market. And with lack of any regulation of medical practice most of them indulge in whole-scale crosspractice, especially allopathy. Infact it is an open secret that the non-allopathic qualification is a via media for setting up the more profitable practice of modern medicine.

The story about nurses is a little different from that of doctors. Firstly, we do not produce enough nurses and what is produced is either absorbed by the state or more often by outmigration. It is funny, but we produce more doctors than nurses in India! Secondly, the demand for qualified nurses in the private sector in India is very small because the private hospitals and nursing homes do not follow any standard practices and prefer to employ nursing personnel who are trained only as auxiliaries or worse still are trained on the job. Neither the Nursing Council or Medical Council or the State have shown any interest in regulating this aspect of private care.

Today with an estimated 700,000 qualified practitioners of various systems and an equal number of unqualified practitioners in individual private practice we have the largest private health sector in the world and one which is completely unregulated. This segment of the private health sector is providing only curative services on a fee-for-service basis.

Production of Drugs and Medical Equipment : With a turnover of over Rs.16,000 crores and more than 90% of this being in the private sector the private pharmaceutical industry is the engine of the private health sector in India. It has penetrated the remotest of rural areas and has not deterred from using even the large unqualified segment of practitioners to expand its market. If someone has any information on private medical practice it is the pharmaceutical industry. Its well organised network of medical representatives know the private medical sector in and out. The nonallopathic drug industry, mainly ayurveda and homoeopathy, is also fairly large but organised information on it is not available. Also there are no known complete estimates of turnover or drug production. However, there are a number of ayurvedic drug manufacturers whose turnover is in hundreds of crores, and again mostly in the private sector.

For the consumer the major concern is the rapid increase in drug prices. During the last two to three years prices of many essential

drugs have doubled and this makes seeking of health care more expensive not only in the private health sector but also in the public health sector because the latter's drug budgets have not increased with the increase in drug prices.

The medical equipment industry in India is much smaller than the pharmaceutical industry and India still has to rely heavily on imports, especially of hitech equipment. But there is every indication that it is on the verge of growing very rapidly.

THE PUBLIC AND THE PRIVATE

One of the myths that we need to question is that the private sector grows by its merit and its industriousness, while the public sector collapses due to lack of motivation and public support. In reality, it is state policy that undermines the public sector and builds the private sector. Direct and indirect support to the private health sector by the state is the main form which privatisation takes in India. Some instances are as under :

- medical education as indicated above is overwhelmingly state financed and its major beneficiary is the doctor who sets up private practice after his/her training -the government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals. It provides incentives, tax holidays, subsidies to private pharmaceutical and medical equipment industry. It manufactures and supplies raw materials (bulk drugs) to private formulation units at subsidised rate/low cost. It allows exemptions in taxes and duties in importing medical equipment and drugs, especially the highly expensive new medical technology.

- the government has allowed the highly profitable private hospital sector to function as trusts which are exempt from taxes. Hence they don't contribute to the state exchequer even when they charge patients exorbitantly.

- the government has been contracting out its programs and health services selectively to NGOs in rural areas where its own services are ineffective. This will further discredit public health services and pave the way for further privatisation.

- the government has pioneered the introduction of modern health care services in remote areas by setting up PHCs. While the latter introduces the local population to modern health care, but by being inefficient it also provides the private sector an entry point to set themselves up. Often it is the same doctor employed in the PHC who opens up practise in private.

- construction of public hospitals and health centres are generally contracted out to the private sector. The latter makes a lot of money but a large part of the infrastructure thus created, especially in rural areas, is inadequately provided and hence cannot meet the health care demands of the people.

- The government also acquires land for corporate hospitals under land acquisition acts which are meant for the public good, and gives it to the corporate sector at well below market rates but in return the corporate hospital has no commitments. The government also allows large corporate hospitals to import over crores worth of equipment, free of all import duties, on the grounds that they are providing free care for over 40% of their patient. But then coveniently forgets to implement the later. The governments loss is estimated at over 500 crores on this alone.

- medical and pharmaceutical research and development is largely carried out in public institutions but the major beneficiary is the private sector. Development of drugs, medical and surgical techniques etc.. are pioneered in public institutions but commercialisation, marketing and profit appropriation is left with the private sector. Many private practitioners are also given honorary positions in public hospitals which they use openly to promote their personal interests.

- in recent years the government health services have introduced selectively fee-for-services at its health facilities. This amounts to privatisation of public services because now utilisation of these services would depend on availability of purchasing power. Increasing private sources of income of public services would convert them into elitist institutions, as is evident from the functioning of certain speciality departments of public hospitals.

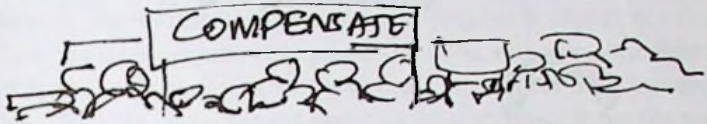
- the government has allowed the private health sector to proliferate uncontrolled. Neither the government nor the Medical Council of India have any control over medical practice, its ethics, its rationality, its profiteering etc..

The above are a few illustrations of how the state has helped strengthen the private health sector in India. In today's liberalised scenario, and with World Banks advice of state's role being restricted to selective health care for a selective population, the private health sector is ready for another leap in its growth. And this will mean further appropriation of people's health and a worsening health care scenario for the majority population.

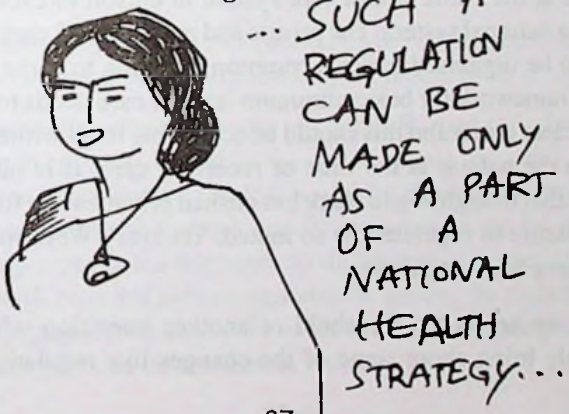
REGULATING THE PRIVATE HEALTH SECTOR

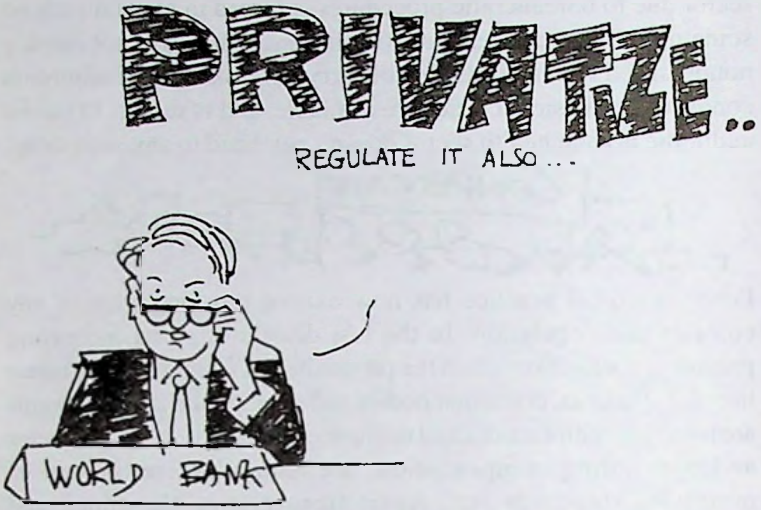
The private health sector is responsible for nearly three-fourths of all health care in the country and yet it is not regulated in any significant manner by any authority even when there are Acts established for that purpose. For instance the Councils of the various systems of medicine are supposed to assure that only those having the appropriate qualifications and those registered with them may practice the particular form of medicine. But evidence shows that this does not happen in practice and hence unqualified persons set up practice, there is rampant crosspractice, irrational and other malpractices are common, there are no fixed schedules of charges for various services being rendered, hospitals and nursing homes do not follow any minimum standards in provision of services, practice may be set up in any place etc. Whereas the public health

sector due to bureaucratic procedures is forced to maintain atleast some minimum requirements, (for instance, they will not employ nonqualified technical staff) will carry out tasks only if minimum conditions or basic facilities are available, and is subject to public audit, the private health sector doesn't pay heed to any such thing.



Private medical practice has now existed too long without any controls and regulation. In the last decade or so an increasing pressure is being exerted on the private health sector to put its house in order. Patients, consumer bodies and other public interest groups are targeting malpractices and negligence in the private health sector and demanding compensation, accountability, setting up of minimum standards etc.. Apart from getting the concerned authorities to implement existing Acts, laws etc... there is a need to bring in an entirely new range of comprehensive regulations as existing in countries which have near universal health care provision with predominantly privately managed care. This means drastic changes in health policy and reorganisation of the entire health care system. We recognise that privately provided health care has come to stay but we also believe that it needs to be organised in an appropriate manner to evolve a public-private mix which provides universal health care coverage.





The new strategy should focus both on strengthening the state-sector and at the same time also plan for a regulated growth and involvement of the private health sector. There is a need to recognise that the private health sector is huge and has cast its nets, irrespective of quality, far wider than the state-sector health services. Through regulation and involvement of the private health sector an organised public-private mix could be set up which can be used to provide universal and comprehensive care to all. The need of the hour is to look at the entire health care system in unison to evolve some sort of a national system. The private and public health care services need to be organised under a common umbrella to serve one and all. A framework for basic minimum level of care needs to be spelt out in clear terms and this should be accessible to all without direct cost to the patient at the time of receiving care. It is interesting to note that though World Bank has pushed privatization forcefully, the pressure to regulate it is so muted. Yet every Western country does have such regulation.

Today we are at the threshold of another transition which will probably bring about some of the changes like regulation, price

control, quality assurance, rationality in practice etc.. This is the coming of private health insurance that will lay rules of the game for providers to suit its own for-profit motives. While this may improve quality and accountability to some extent it will be of very little help to the poor and the underserved who will anyway not have access to this kind of a system. Worldwide experience shows that private insurance only pushes up costs and serves the interests of the have. If equity in access to basic health care must remain the goal then the State cannot abdicate its responsibility in the social sectors. The state need not become the primary provider of health care services but this does not mean that it has no stake in the health sector. As long as there are poor the state will have to remain a significant player, and interestingly enough, as the experience of most developed countries show, the state becomes an even stronger player when the number of poor becomes very small!

Immediate Policy measures needed

While reorganisation of the health sector will take its own time, certain positive changes are possible within the existing setup through macro policy initiatives.

These are

a) the medical councils should be directed at putting their house in order by being strict and vigilant about assuring that only those qualified and registered should practice medicine

b) continuing medical education (CME) should be compulsory and renewal of registration may be linked to it

c) medical graduates passing out of public medical schools must put in compulsory public service of atleast five years of which three years must be at PHCs and rural hospitals (this should be assured not through bonds or payments but by providing only a provisional license to do supervised practice in state health care institutions and also by giving the right to pursue postgraduate studies only to those who have completed their three years of rural medical service)

d) regulating the spread of private clinics and hospitals through a strict locational policy whereby the local authority should be given the right to determine how many doctors or how many hospital beds they need in their area (norms for family practice, practitioner : population and bed : population ratios, fiscal incentives for remote and underserved areas and strong disincentives and higher taxes for urban and overserved areas etc.. can be used)

e) regulating the quality of care provided by hospitals and practitioners by setting up minimum standards to be followed

f) putting in place compulsory health insurance for the organised sector employees (restructuring the existing ESIS and merging it with the common national health care system where each employee has equal rights and cover but contributes as per earning capacity, for example if each employee contributes 2% of their earnings and the employer adds another 3% then nearly Rs.100 billion could be raised through this alone), special taxes and cesses for health can be charged to generate additional resources (alcohol, cigarettes, property owners, vehicle owners etc.. are well known targets and something like one percent of sales turnover for the products and a value tax on the asset could bring in substantial resources)

g) allocation of existing resources in public sector can be rationalised better through preserving acceptable ratios of salary : nonsalary spending and setting up a referral system for secondary and tertiary care. For specialist, diagnostic services and hospital care a referral system must be put in place and such care must be available only on reference from a general practitioner, except in an emergency.

These are only some examples of what can be done through macro policy initiatives.

What should a Comprehensive Legislation seeking Regulation include?

The following suggestions on regulation encompass the entire health sector. However, they are not an exhaustive list but only some major important areas needing regulation.

1. Nursing Homes and Hospitals :

- ❑ Setting up minimum decent standards and requirements for each type of unit; general specifications for general hospitals and nursing homes and special requirements for specialist care, example maternity homes, cardiac units, intensive care units etc.. This should include physical standards of space requirements and hygiene, equipment requirements, humanpower requirements (adequate nurse:doctor and doctor:beds ratios) and their proper qualifications etc...
- ❑ Maintenance of proper medical and other records which should be made available statutorily to patients and on demand to inspecting authorities.
- ❑ Setting up of a strict referral system for hospitalisation and secondary and tertiary care
- ❑ Fixing reasonable and standard hospital, professional and service charges.
- ❑ Filing of minimum data returns to the appropriate authorities for example data on notifiable diseases, detailed death and birth records, patient and treatment data, financial returns etc..
- ❑ Regular medical and prescription audits which must be reported to the appropriate authority
- ❑ Regular inspection of the facility by the appropriate authority with stringent provisions for flouting norms and requirements
- ❑ Periodical renewal of registration after a thorough audit of the facility

2. Private Practitioners :

- ❑ Ensuring that only properly qualified persons set up practice
- ❑ Compulsory maintenance of patient records, including prescriptions, with regular audit by concerned authorities
- ❑ Fixing of standard reasonable charges for fees and services
- ❑ Regulating a proper geographical distribution
- ❑ Filing appropriate data returns about patients and their treatment
- ❑ Provision for continuing medical education on a periodic basis with licence renewal dependent on its completion

3. Diagnostic Facilities :

- ❑ Ensuring quality standards and qualified personnel
- ❑ Standard reasonable charges for various diagnostic tests and procedures
- ❑ Audit of tests and procedures to check their unnecessary use
- ❑ Proper geographical distribution to prevent over concentration in certain areas

4. Pharmaceutical industry and pharmacies :

- ❑ Allowing manufacture of only essential and rational drugs
- ❑ Regulation of this industry must be switched to the Health Ministry from the Chemicals Ministry
- ❑ Formulation of a National Formulary of generic drugs which must be used for prescribing by doctors and hospitals
- ❑ Ensuring that pharmacies are run by pharmacists through regular inspection by the authorities
- ❑ Pharmacies should accept only generic drug prescriptions and must retain a copy of the prescription for audit purposes

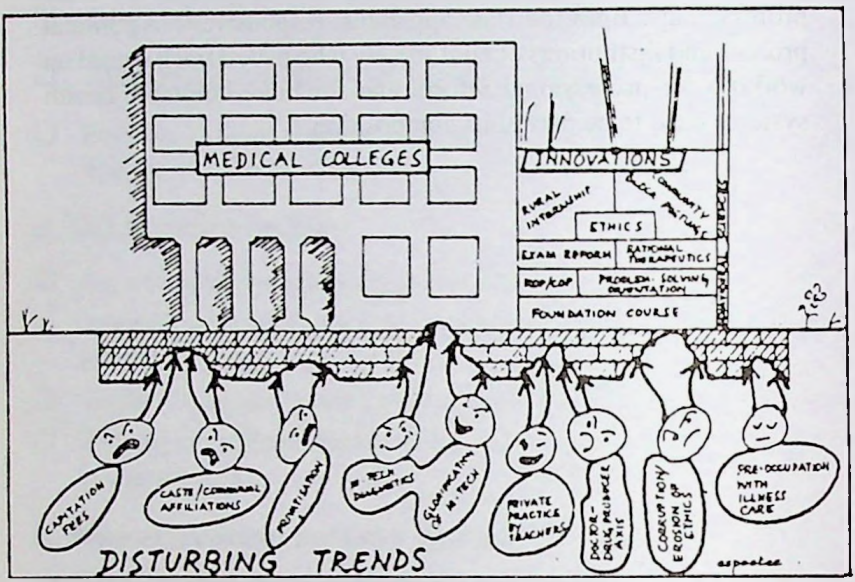
Who should regulate professional practise?

A regulatory authority will have to be set up at national and state levels to monitor, audit and assure that the health sector functions in a reasonable manner and as per agreed and accepted norms. Such a body will necessarily have qualified and reputed health professionals, but neither will it be exclusively health professionals, nor will the professionals on the body be chosen only by other professionals. Both the state apparatus, responsive to a political process and institutions of civil society who have a track record on working for professional reform and for more equitable health systems need to be part of its composition.

Chapter - 4

Medical Ethics, Medical Education and Health Care

Concerns and Challenges from a Peoples Health point of view



1. What are the popular causes for dissatisfaction against doctors and the delivery of health care in India today?

- There are complaints of inadequate care and demand of excessive fees for giving attention.
- Doctors are charged with recommending unnecessary investigations and prescribing avoidable treatments.
- There are reports of exploitation of the ignorance of patients and of acting in violation of the autonomy of patients.

- There are reports of overwhelming emphasis on therapeutic medicine to the total exclusion of preventive and social medicine.
- There is concentration of health care services and doctors in the urban area and near total neglect of village and rural tribal areas.
- There are frequent reports of neglect of patients by doctors and hospital staff and sometimes even maltreatment and unethical and sometimes even criminal behaviour.

While many doctors are sincere and committed to the ethical and scientific framework of their profession and vocation, in today's increasingly corruption influenced socio-economic-cultural political milieu, many are not and this is an increasing area of concern.

One approach to tackling this is legal and administrative. We have discussed this in the earlier chapter. But bringing them under consumer protections act and other such laws is no end in itself. It brings its own problems (defensive medicine, burgeoning legal costs etc.) and though acceptable as an immediate measure is no solution to the basic problems.

The question that needs to be asked is - what is wrong with medical education that all this is happening. Are not doctors trained to serve the rural areas and the poor-at least to practice ethically.

And other than education what are the professional bodies doing about it.

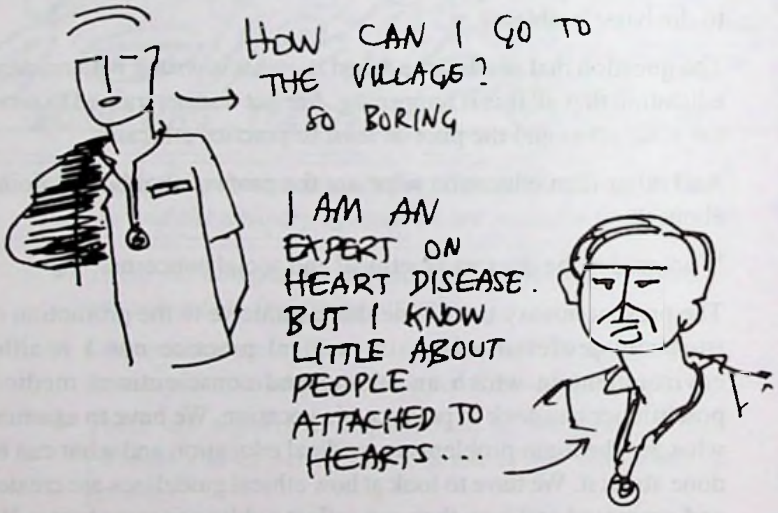
Who guides the doctors on ethical and social concerns?

The present uneasy truce is neither conducive to the promotion of trust and professionalism in medical practice nor a healthy environment in which an ethical and conscientious medical practitioner can seek to practice his vocation. We have to examine what are the main problems in medical education and what can be done about it. We have to look at how ethical guidelines are created and promoted and how they can reflect public concerns better. We

also have to note recent trends that are worsening the situation rather than improving it.

2. *What are the disturbing trends in the institutions that train and produce doctors and nurses and other health professionals for the health care delivery system in India?*

- The major problem of medical institutions have been that they largely draw students from the more urban and affluent sections of society who culturally are not attuned to serving the needs of the poor or serving in rural areas. The other major problem with these institutions are the preoccupation of medical educators with disease care in tertiary care centres and low priority for primary health and community health care. These two factors by them selves are adequate to lead to the production of doctors who are inappropriate for our needs.



- It may also be stated that aspects like behavioral sciences, ethical concerns, an understanding of economic pressures that distort medical science; cultural gaps that impeded doctor -patient communication are all almost completely missing from the syllabus. The doctor emerges with a fragmented and technocratic vision of disease and health, rather than a holistic perspective.

In the last two decades the above problems have got seriously exacerbated by a number of factors. The most important of these are:

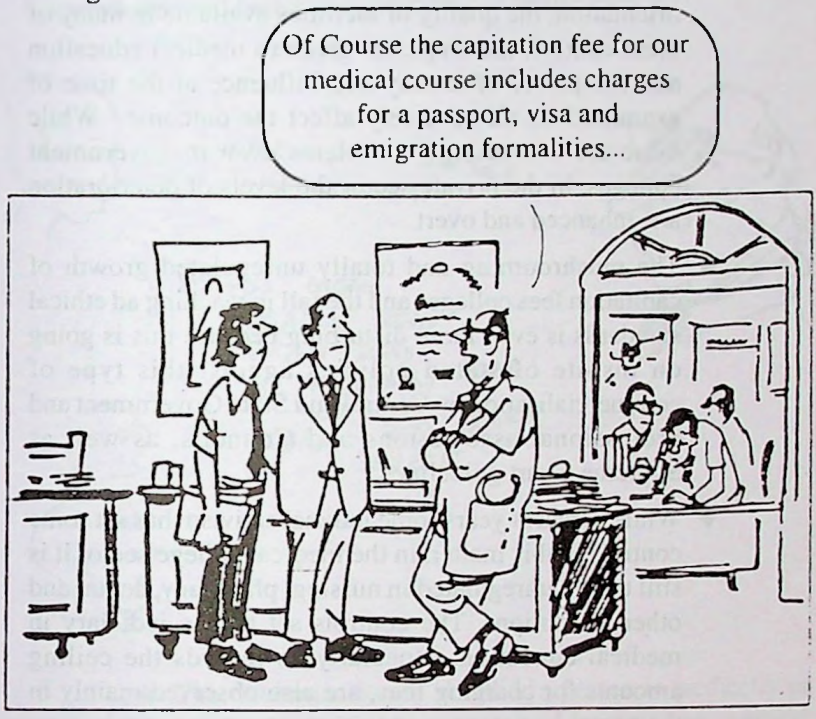
- The growth of private capitation fee colleges, which are increasingly commercialising all aspects of medical education.
- The mushrooming of institutions based on caste and communal affiliations & the mushrooming of private high technology diagnostic centres and the concurrent glorification of high technology, through high-pressure advertising in the media and in medical education.
- The unresolved and probably increasing problem of private practice among full time teachers of medical colleges;
- The increasing 'doctor-drug producer axis' with 'vested interest' in 'abundance of ill health' which includes all sorts of gifts and perks from pharmaceutical companies for doctors - a process that starts from the medical college hospital onwards.
- The rampant corruption that seems to be accepted as routine practice and the increasing erosion of norms of medical ethics, with resulting increase in medical malpractice even among faculty of medical colleges.
- The increasing trend to flout norms for admission/ selection procedures and sanctioned numbers by State Governments and universities that have to be regularly challenged by judicial activism.

Taken together, they are beginning to have 'an insidious but definitive eroding effect on the focus and orientation of health service development in the country as well as the nature of the human power education investment of the State'. Even more disturbing is the fact that young doctors in formation are exposed to unethical practices during the formative years, which influence their knowledge, attitude and practice of medicine in the future. While all the above trends are increasingly widespread in medical colleges - the canker is spreading to nursing, pharmacy, dental and all other institutions training health human power development in the country.

3. What's wrong with 'Capitation Fees Medical colleges for health professionals?

Among all the above trends, the one that is most insiduous is the growth of capitation fee medical colleges and various other related trends including NRI quotas which are commercialising the whole medical education scene.

Many people ask what's wrong with private medical colleges allowing admissions by students whose parents are willing to pay large amounts of capitation fees to ensure admissions? Is this not a good example of self-financing colleges? Is there not a need for increasing involvement of private sector in higher education? If people are willing to pay more for special food, clothes, shoes, consumer good what's wrong with buying seats in a medical college?



- First its important to note that the Supreme Court judgement in a special writ petition from Andhra has established that capitation fees are:

  Wholly arbitrary,

  Unconstitutional according to article 14-equality before law and are evil, unreasonable, unfair and unfit,

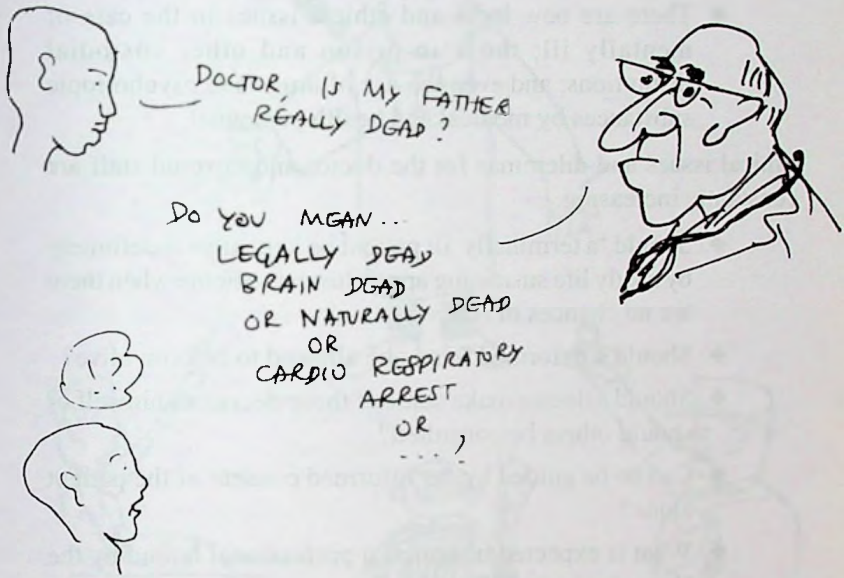
Enables the rich to take admissions where as the poor have to withdraw due to financial inability and

Therefore are not permissible in any form.

- From reports in the media and anecdotally in Medical professional circles there is increasing evidence that the capitation fees ethos is contributing to a fall in qualitative standards. The selection of students and their initial orientation, the quality of facilities available in many of these centers, the emphasis given to medical education and the power of money and influence at the time of examinations all adversely affect the outcome. While these are increasingly problems even in government colleges, in the private sector the levels of deterioration are enhanced and overt.
- The mushrooming and totally unregulated growth of capitation fees colleges and the fall in teaching ad ethical standards is even more disturbing because this is going on inspite of stated policies against this type of commercialisation by Central and State Government and professional associations and Councils, as well as Supreme Court guidelines.
- While in recent years some judicial activism has set some controls in this matter, in the medical college sector it is still totally unregulated in nursing, pharmacy, dental and other institutions. The controls set by the judiciary in medical education, especially as regards the ceiling amounts for charging fees, are also observed mainly in the breach.
- The problem is further worsened by the active involvement of medical College and professional leadership - seniors in the medical profession - many of whom by virtue of being compromised personally are unable to take a public stand against the issue. Even if they do so, it is often a blatant double standard.

4. *Are there Human Rights issues in health care?*

The enormous strides in modern medicine, diagnostic techniques, surgery and health care systems have raised problems in respect of standards of care, extent of human rights protection and adequacies of systems of accountability. Time tested standards, ethical norms, conventions and practices are being questioned in the light of new knowledge and better understanding of health care.



- The determination of whether a person is medically or legally dead is full of intricate problems relating to ethics, morality and law.
- Keeping a body functioning with a respirator, pacemaker, intravenous feeding, renal dialysis etc now invites a variety of legal issues concerning homicide, negligence claims, insurance claims, transplantation of organs, probate law and so on.

- The development of artificial insemination and surrogate parenthood raises problems to the established laws of rape, adultery, legitimacy of offspring apart from issues of ethics and morality.
- Amniocentesis and abortion are medical practices, which have led to lot of concern around basic human rights issues. Sex selective abortion is a specific example of an immoral practice, clearly made illegal by legislative action, that nevertheless continues to flourish and spread.
- There are new legal and ethical issues in the care of mentally ill; those in prison and other custodial institutions; and even the use of drugs and psychotropic substances by medical and health personnel.

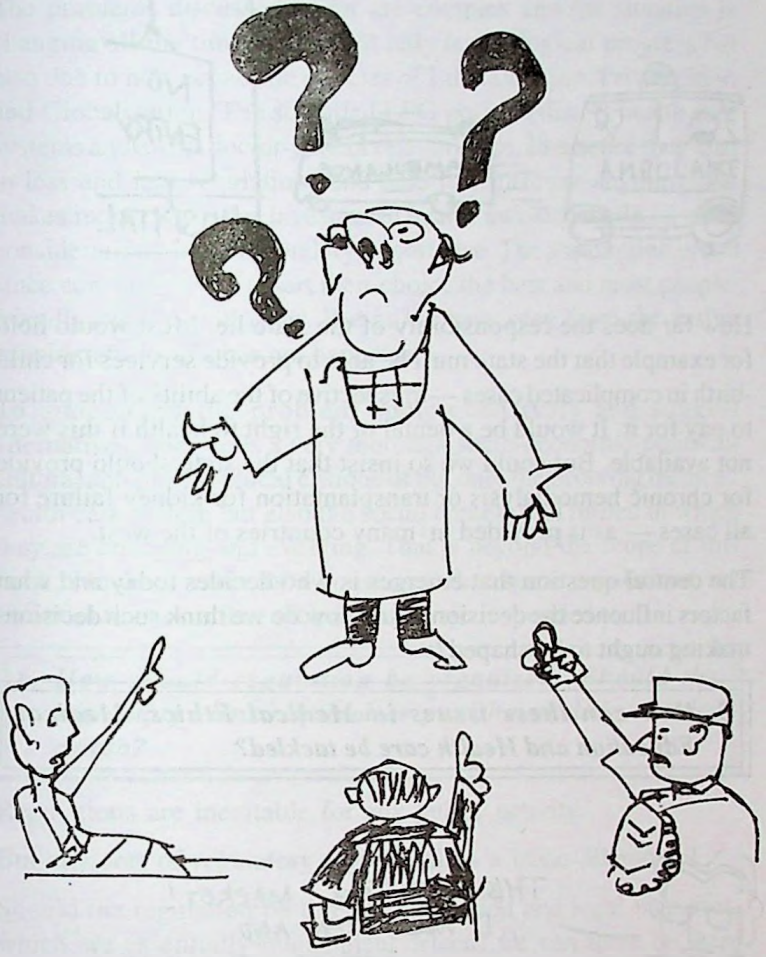
Ethical issues and dilemmas for the doctor and hospital staff are constantly increasing.

- Should 'a terminally ill patient be kept alive indefinitely by costly life sustaining apparatus or medicine when there are no chances of recovery '
- Should a deformed foetus be allowed to be born alive?
- Should a doctor make some of those decisions himself or should others be consulted?
- Can he be guided by the informed consent of the patient alone?
- What is expected of him as a professional bound by the Hippocratic oath?

As science progresses more and more human rights issues and ethical dilemmas will emerge.

There is another set of issues of ethics that relate directly to privatization of health care;

If an emergency case is brought to a private hospital can the patient be turned away for lack of inability to pay. Even if immediately attended to who decides when to send them off. The Supreme Court

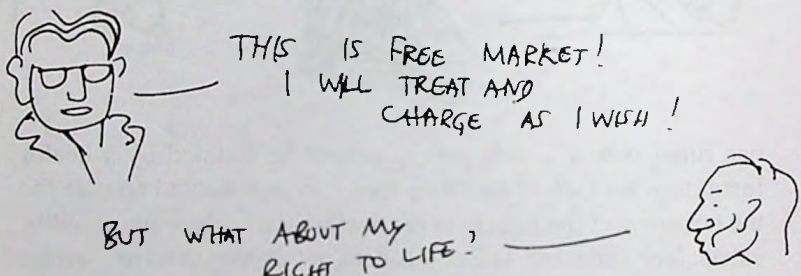


has ruled that if a sick patient cannot be handled by a health institution for lack of facilities then it is their duty to arrange for the transport of the patient to the nearest place where such facility exists. (see annexure 4) But this does not happen. And the private sector has never accepted such a responsibility. Rather providing ambulance services is often an especially lucrative part of running a nursing home.

How far does the responsibility of the state lie. Most would hold for example that the state must be able to provide services for child -birth in complicated cases —irrespective of the ability of the patient to pay for it. It would be a denial of the right to health if this were not available. But could we so insist that the state should provide for chronic hemodialysis or transplantation for kidney failure for all cases — as is provided in many countries of the west.

The central question that emerges is who decides today and what factors influence the decision?. And how do we think such decision-making ought to be shaped?

5. How can these issues in Medical Ethics, Medical Education and Health care be tackled?



The problems discussed so far are complex and the situation is changing all the time, due to not only technological progress but also due to new economic policies of Liberalization, Privatization and Globalization. The so-called LPG policies distort health care systems and affect doctor-patient relationships. In essence they lead to less and less regulations and tend to legitimize anything that makes more profits for investors in health industry while all other considerations are of secondary importance. The assumption is that since consumers will assert their choice the best and most people-friendly options will grow. But as we have seen from the earlier considerations this has not happened.

To understand the problem comprehensively and suggest alternatives, one needs a very thorough socio-economic-political-cultural and philosophical critique of not only the evolving medical/ health care system but also the social context and milieu in which they are changing and evolving. That is beyond the scope of this book. However there is a consensus that some regulations are essential to ensure that such concerns are responded to.

6. How should regulation be organized? Should the regulatory reins required be punishment led or ethics driven?

Regulations are inevitable for any public activity.

But any sort of regulatory regime raises a basic dilemma ?

Should the regulation be through legislation and legal measures, which are essentially punishment driven? Or can there be there be alternative approaches.

The earlier section on regulating the private sector has discussed the various aspects of regulations. The issues discussed include the question of who should regulate, and how to regulate ?

But we now consider the aspect that any regulatory approach has some inherent problems. So even as we ensure minimum regulations

to safeguard the public concerns we need to build on complementary measures to ensure ethical practices.

The regulatory regime now in place is largely a legal-cum-bureaucratic mode. The traditional principles of common law liability are superimposed with a statutory arrangement of consumer protection procedures. However if things are allowed to develop only in this structure, it is feared that we will soon have escalation in costs of health care and lots of unnecessary investigation and intervention as 'defensive practice' i.e. doctors protecting themselves against further cases by patients for malpractices by subjecting them to all sorts of tests and procedures. Only insurance business will benefit, neither the doctors nor the patients.

It would be much better if we could intervene in medical education and medical training to ensure that ethical values are internalized. It would be much better is we could build institutions that would ensure that ethical practice is proactively promoted.

Regulation by the medical profession?

If the medical profession could internally regulate them through setting ethical core standards and if training of personnel would confirm to these standards through an ethics driven professional discipline there could be a major breakthrough. Some of the goals in ethical regulation of the profession would be

- Protection of consumer rights
- Enhancement of the status of the professionals
- Advancing the cause of public interest to provide for competent doctors who are accountable for their acts and omissions.
- Protection of an individuals rights and autonomy over their own bodies.
- Sanctity of contract in the patient-doctor relationship.

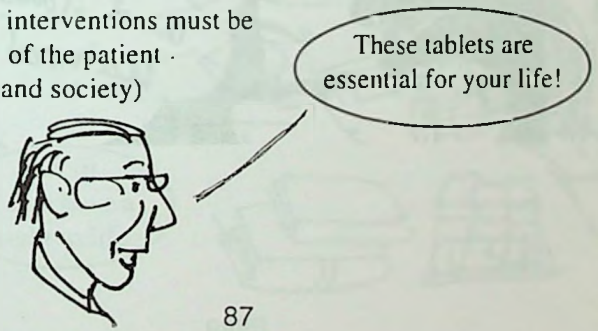
In complex medical decisions there are two sets of issues- The first is the issues which are of a technical in nature which normally medical knowledge and skills should help resolve.

The second are issues of a moral and ethical nature in which there is scope for variation depending upon the value systems and attitudes to life of the person concerned. It is here that a **Code of Ethics** has to assist individual practitioners to make the right decisions for which one has to be accountable to the profession, to society and to ones own conscience.

Today many of these major principles are recognized

Beneficence:

All Medical interventions must be for the good of the patient · (and family and society)

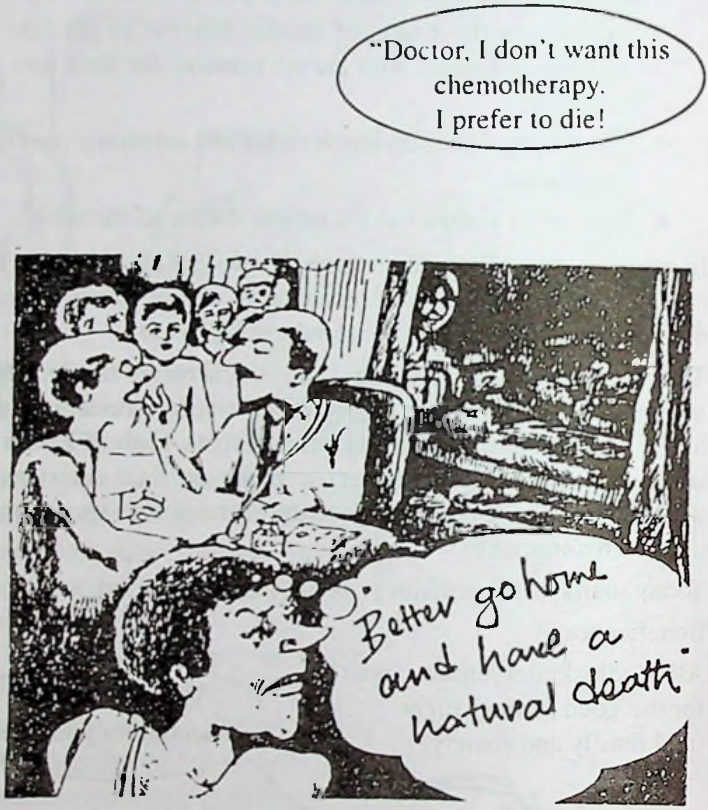


Non-Malficence:

Cause no harm. Where harm might occur it must be minimal and the benefit must outweigh the harm.

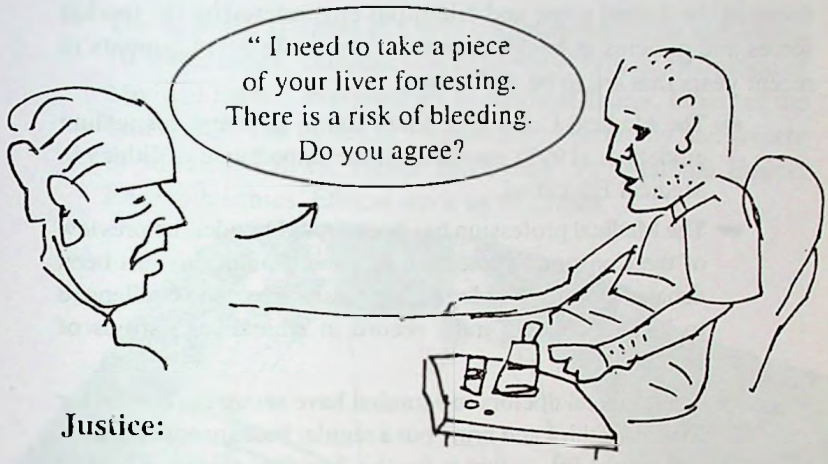
Autonomy:

Patients have the rights to control what happens to them or their bodies..



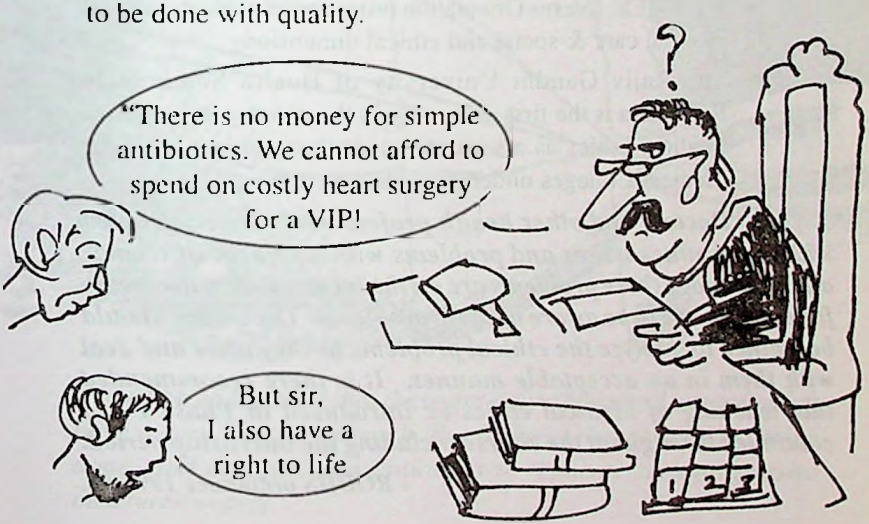
Informed consent:

Patients consent is necessary for all procedures and this must be informed and voluntary.



Justice:

There is need for distributive justice. There is need to allocate resources fairly and evenly. Equity has to be assured and this has to be done with quality.



7. Are there any positive developments towards a more ethics driven process of regulation within the medical community in India?

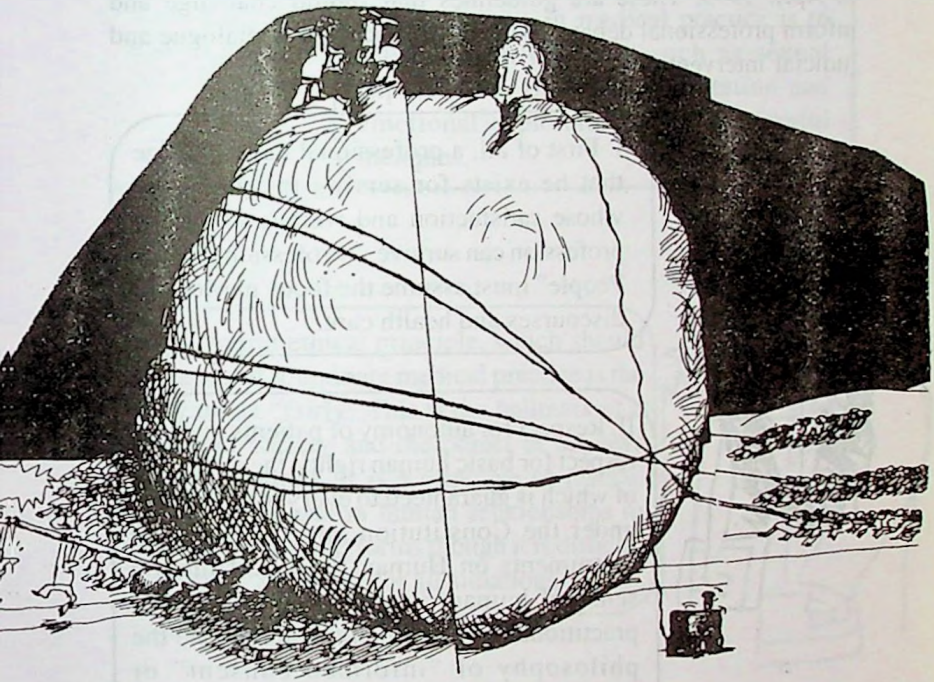
While the situation analysis in the earlier sections of this paper focus on the dismal scene and dilemmas engendered by the market forces and policies in health care there are some developments in recent years that are to be welcomed.

- The Medical Council of India has in its latest curriculum guidelines (1997) emphasized the importance of Ethics in Medical Education.
- The Medical profession has been brought under the preview of the Consumer Protection Act and though this has been debated greatly, the Medical profession has been challenged to look at its own track record in ethical regulations of standards.
- Some ethical doctors in Mumbai have set up the Forum for Medical Ethics and bring out a regular bulletin called Issues in Medical Ethics that is for the first time raising a host of issues for debate and critical reflection within the profession.
- In JIPMER, Interns Orientation programmes address rational medical care & social and ethical dimensions
- The Rajiv Gandhi University of Health Sciences in Karnataka is the first university in the country to introduce Medical Ethics as a separate curriculum subject in all the Medical Colleges under its jurdistiction.

"Doctors and other health professionals are confronted with many ethics issues and problems with advances in science and technology these problems are on the increase. It is necessary for every doctor to be aware of these problems. The doctor should be trained to analyze the ethical problems as they arise and deal with them in an acceptable manner. It is there recommended that teaching of Medical ethics be introduced in Phase I and continued throughout the course including the internship period.

- RGUHS ordinance 1997-98.

- St. John's Medical College, Bangalore is the only college in India, which had been training Medical students in Medical Ethics as a separate subject since 1965. The curriculum of this college with some modifications has become accepted as the university ethics curriculum.
- The RGUHS syllabus in a very comprehensive one and covers 10 major areas. Introduction to Medical Ethics; Definition of Medical Ethics; Perspectives of Medical Ethics; Ethics of the Individual; The ethics of Human life; The family and society in Medical Ethics; Death and dying' Professional Ethics; Research Ethics, Ethical work up of causes.



It must be understood that these are only a few small examples that have a very limited outreach. But it shows that something can be done. And one can take initiatives to replicate such progressive measures widely.

8. *What are the fundamental principles of ethics that should underscore all our efforts to tackle the problems outlined in the earlier part of this paper?*

Five fundamental principles of ethics based on commonsense which should continue to govern the sophisticated systems of regulation even in the complex and challenging situations resulting out of technological progress and the new economic policies have been outlined by Prof. N.R. Madhav Menon in his keynote address to the workshop on Medical Ethics in Medical Education organised by the Rajiv Gandhi University of Health Sciences on Karnataka in April 1999. These are guidelines that should challenge and inform professional debate, medic and civic society dialogue and judicial intervention.

I. First of all, a professional has to realize that he exists for serving the people in whose satisfaction and welfare alone the profession can survive. "Professions for the People" must assume the focus in Medical discourses and health care.

II. Respect for autonomy of patients involves respect for basic human rights, the minimum of which is guaranteed to every human being under the Constitution and International Instruments on Human Rights. Unless a sense of human rights is imbibed by the practitioner, he is unlikely to appreciate the philosophy of "informed consent" or "confidentiality" or principles of patient-centered therapy.

III. Duty to help in protecting life and reducing suffering is part of the Hippocratic tradition. The principle of beneficence involves duty not to hurt or refrain from any behaviour, which would be detrimental to the patient's health and well being. In concrete situations the principle would raise dilemmas particularly when doctors are called upon now-a-days not only to respect the sanctity of life, but also the quality of life. The ethical imperative of the principle of beneficence in medical practice is to refrain from practices such as sexual exploitation, financial exploitation and emotional exploitation through harmful therapies.

IV. A fourth ethical principle, which should inform and illuminate medical practice is the duty to act "fairly" This is the hallmark of a civilized society and the object of all laws and regulations. It is a principle of justice, which manifests in human relationships in different ways and forms though it is difficult to define "fairness" for all situations.

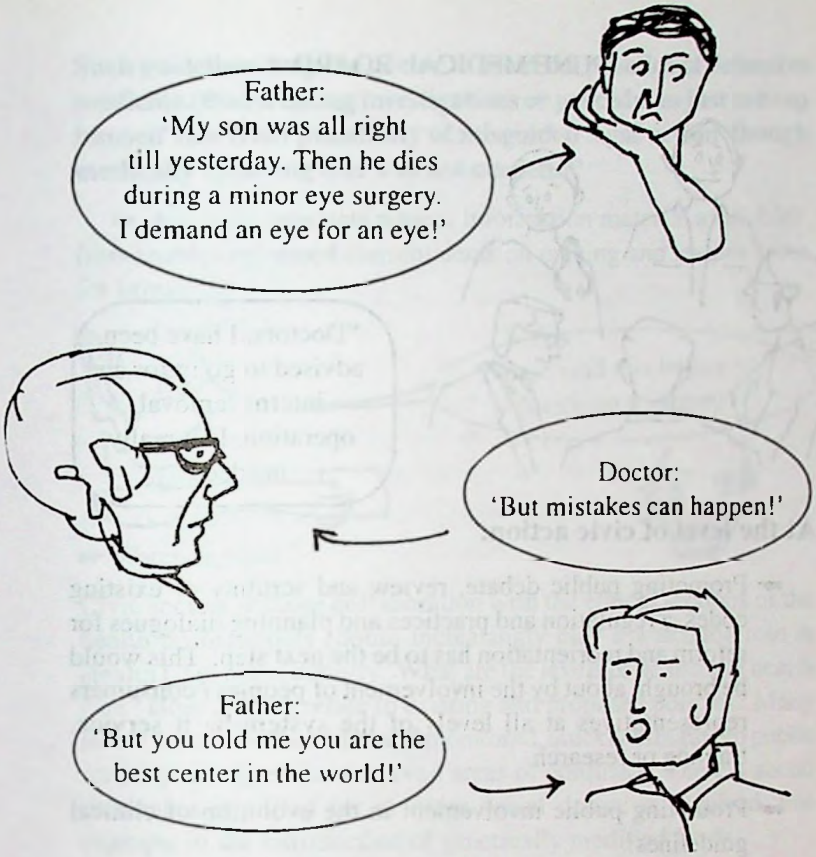
V. The final ethical principle, which would go into defining doctor-patient relationship, is one of accountability whereby the earlier principle of justice or fairness is manifested whenever transgression occurs.' The entire jurisprudence of medical malpractice gives instances in diverse situations as to how a functional code of ethics can be constructed for promoting ethical practice.

9. Beyond professional regulation — what can state and civic society do to counter the vested interests that are promoting the commercialisation and de-ethicalisation of Health Care and Medical Education today?

For too long the medical professions and the medical education and health human power development sector have been directed by professional control and debate. It is time to recognize the role of the community, the consumer, the patient and the people in the whole debate.

Even in the interests of the medical professional such an opening up of the debate is long overdue. People's expectations of medical science grow more rapidly than does the actual curative powers of medical science. And commercial promotion is partly responsible for these unreasonable expectations. The medical professions' mystification is also responsible for these unreasonable expectations.

After all, death is far from abolished! Accidents and errors occur as professionals are human too. A mystified profession where only professionals are allowed to speak and regulate becomes a trap for the professional. Much better to demystify the medical profession and involve all sections of society in evolving the code of ethics and in evolving suitable regulations.



So what is to be done?

At the level of help to the individual patient:

- ❖ Bringing Medical service under the preview of the Consumer Protection Act has been the first of these required changes.
  - ☛ One can also talk of setting up medical boards where patients are not seeking redressal but at least can get a reliable second opinion when they are in doubt about the correctness of treatment in a given case.

"Doctors, I have been advised to go in for an interns removal operation. Is it really needed?"

At the level of civic action:

- Promoting public debate, review and scrutiny of existing codes, a regulation and practices and planning dialogues for reform and reorientation has to be the next step. This would be brought about by the involvement of peoples / consumers representatives at all levels of the system-be it service, training or research.

- Promoting public involvement in the evolution of clinical guidelines:

Are there treatment protocols available?

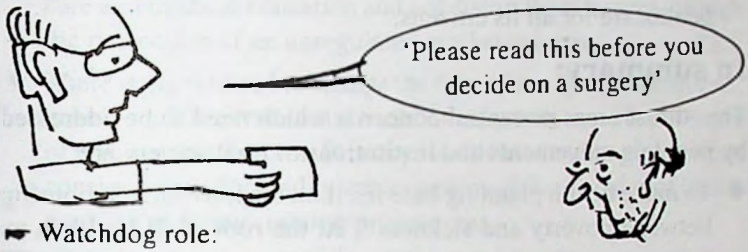
Are there guidelines available on when it is expected for a doctor to order investigation?

Are there clear ethical guidelines available regarding in controversial areas or newly emerging technologies:

Are such guidelines drawn up at the level of a hospital or state or central government or at the professional body after adequate discussion where different sections of society, especially those representing women and the poor, are heard.

Such guidelines help the doctor to avoid the practice of defensive medicine.(that is taking investigations or procedures just to keep himself safe from possibility of misguided legal action though medically speaking this was not needed.)"

☛ Are there adequate patient information material available? (this enables informed consent decision making and lessens room for litigation)



☛ Watchdog role:

Civic society in close collaboration with the ethical sections of the health professionals should increasingly play a watchdog role in Health Care in the country. What are the levels of health and health care? How do they relate to existing and proposed policies? Many issues need to be looked at and monitored, quickly bringing to public scrutiny transgressions or even areas of confusion where a social consensus is called for or more social debate is required. For example in the introduction of genetically modified foods.

- Social mobilization for medical reform: Given the pressures for commercialization of medical care with all its attendant problems, what is needed in a strong countervailing movement by health and development activists, people science movement activists, consumers organizations not-for-profit health care providers and peoples movements that will bring medical education and their ethical orientation, high on the political agenda of the country -as part of the effort to ensure an adequate healthcare for all its citizens.

In summary:

The thrust areas or central concerns which need to be addressed by people's movements and institutions of civil society are:

- To make health planning base itself on the intricate relationship between poverty and sickness . At the root of ill health is an iniquitous and unjust distribution of the means to health. All health programmes must therefore be an integral part of human development and poverty alleviation programme. Only constant pressure from the representatives of the poor can ensure that this focus is retained.
- The growing commercialisation of health care and the growing market economy related distortions in health care options and health care responses need to be countered carefully. We have to fight for more comprehensive solutions evolved socio-epidemiologically and not allow top down, selective technological fixes promoted by an international market economy in health
- Health human power development institutions and colleges should be challenged to be less ivory towered; less high technology centered; and become more community oriented and primary health care inspired. This can only be done if faculty and students are exposed and involved in primary care and community health situations within the curriculum framework.
- Strengthening the university and Medical Council regulatory structures and countering the nexus between the capitation fees

college lobby and the political system through active lobbying must counter the commercialisation of medical education.

- There is urgent need to study the trends in privatization and in private sector health care to ensure that they contribute to Health care and medical education and not distort them further through the promotion of an unregulated market economy.
- There is urgent need to change the focus from Doctors to nurses, health workers, traditional birth attendants to establish a sense of priority and focus on Primary Health care and to give serious considerations for quality enhancement of these grades of health workers and their training programme.

The Peoples Health Assembly at Dhaka, the Jana Swasthya Sabhas in all the states and finally the National Sabha in Calcutta and all the district level meetings need to include these issues on their agenda.

The focus of the Peoples Health Assembly is on

- Recommendations to Government and professional bodies on measures - legal and administrative needed to check this commercialization and keep medical practice effective, safe, cheap and holistic.
- On peoples initiatives and mass mobilization to educate the people on their rights, help them with strategies to cope individually and as communities with the problems due to commercialization of healthcare and to build up public awareness for reform of the medical sector.

All those concerned about Peoples Health needs and Peoples Health will have to take on this emerging challenge as we begin the new millennium. Our efforts will determine whether in the years to come, health care and medical education will primarily respond to the peoples health needs and aspirations or will professional expectations and market phenomena continue to distort the process.

Market or People? What will be our ethical choice?

Annexure - 1

HEALTH CARE INFRASTRUCTURE AND FINANCING 1880 - 1940

	1880	1890	1900	1910	1920	1930	1940
1.Hospitals & Disps.	1212 (only state financed)	1736	2313	4262	5067	6448	7441
i)Percent State Owned	na	na	na	68.5	72.2	72.0	87.3
ii)Percent State Financed	na	na	na	74.5	78.0	81.9	92.4
iii)Total Beds	na	na	na	45639	55772	67245	74111
iv)No. of Patients Treated (millions)	na	12.98	20.49	35.06	45.53	67.87	na
v)% treated in state financed institutions	na	na	na	80.4	82.7	84.6	na
2.Total Public Health Expenditure, includes local govt.(Rs.million annual avg. of last decade)	18.5	23.3	38.8	53.5	76.3	143.4	145.3
-percent spent by local govts.	43.8	45.1	51.8	58.3	61.6	63.7	60.8

-percent public health expenditure to total govt. expenditure	3.14	2.92	3.78	4.23	4.54	5.35	5.47
3.Medical Practitioners as per census	91607					304544	
-percent qualified (only allopathy)	14.51					25.58	

Sources : Expenditure Data - Roger Jeffery: The Politics of Health in India, Univ. of California Press, Berkely, 1988

Hospital Data - Statistics of Britiish India, Part V - Area, Population and Public Health, Directorate General of Commercial Intelligence, GOI,

1909 (upto 1900) and Statistical Abstract for British India, GOI, relevant years (for other years)
Practitioner data: Census of India 1881 vol.III, GOI and 1931 vol.I Part II, GOI, includes Burma etc...

Annexure - 2

HEALTH INFRASTRUCTURE DEVELOPMENT IN INDIA 1951-1998

			1951	1961	1971	1981	1991	1995	1996	1997	1998
1	Hospitals	Total	2694	3054	3862	6805	11174	15097			
		% Rural	39	34	32	27		31			
		%Private				43	57	68			
2	Hospital beds	Total	117000	229634	348655	504538	664135	870161			
		% Rural	23	22	21	17		20			
		%Private				28	32	36			
3	Dispensaries		6600	9406	12180	16745	27431	28225			
		% Rural	79	80	78	69		43			
		% Private				13	60	61			
4	PHCs		725	2695	5131	5568	22243	21693	21917	22446	
5	Sub-centres				27929	51192	131098	131900	134931	136379	
6	Doctors	Allopaths	60840	83070	153000	266140	395600	459670	475780	522634	503950
		All Systems	156000	184606	450000	665340	920000				1155000
7	Nurses		16550	35584	80620	150399	311235	562966	565700		
8	Medical colleges	Allopathy	30	60	98	111	128		165	165	
9	Out turn	Grads	1600	3400	10400	12170	12086				
		P. Grads		397	1396	3833	3139				

10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3		60.5			160.0 (1999)
11	Health outcomes	IMR/000	134	146	138	110	80	74/69	72	71	
		CBR/000	41.7	41.2	37.2	33.9	29.5	29	25	24	
		CDR/000	22.8	19	15	12.5	9.8	10	9	9	
		Life Expectancy years	32.08	41.22	45.55	54.4	59.4	62	62.4	63.5	
	Births attended by trained practitioners	Per 1000 live births				18.5	21.9		28.5		
12	Health Expenditure Rs. Billion	Public Private@ CSO estimate of pvt.	0.22 1.05	1.08 3.04 2.05	3.35 8.15 6.18	12.86 43.82 29.70	50.78 82.61	82.17	101.65	113.13	126.27

@ Data from - 1951:NSS 1st Round 1949-50; 1961: SC Seals All India District Surveys,1958; 1971: NSS 28th Round 1973-74; 1981: NSS 42nd Round 1987; 1991 and 1995: NCAER – 1990 and 1994.

Source : 1. Health Statistics / Information of India, CBHI, GOI, various years
2. Census of India Economic Tables, 1961, 1971, 1981, GOI
3. OPPI Bulletins for data on Pharmaceutical Production
4. Budget Papwers of Central and State Governments, various years
5. National Accounts Statistics, CSO, GOI, various years

Annexure - 3

MODEL CITIZEN'S CHARTER FOR GOVERNMENT HOSPITALS

(Extract of letter No. Z28015/131/96-H, dated 13-12-1996 from the Ministry of Health and Family Welfare, Govt. of India, New Delhi)

1. Preamble

Government hospitals exist to provide every citizen of India with health care within resources and facilities available. Such care is to be made available without discrimination by age, sex, religion, caste, political affiliation, economic and social status. This Charter seeks to provide a framework which enables citizens to know what services are available, the quality of services they are entitled to and to inform them about the means through which complaints regarding denial or poor quality of service will be addressed.

2. Objectives :

2.1 To make available medical treatment and related facilities, for citizens who seek treatment at the hospital.

2.2 To provide the appropriate advice, treatment and support that would help cure the ailment to the extent medically possible.

2.3 To ensure that treatment is based on well considered judgement, is timely and comprehensive and with the consent of the citizen being treated.

2.4 To ensure users are aware of the nature of ailment, progress of treatment, duration of treatment and impact on their health and lives, and

2.5 To redress any grievance in this regard.

3. Components of service at hospitals :

3.1 Access to hospital and professional medical care to all.

3.2 Making provision for emergency care after main treatment hours, whenever needed,

3.3 Informing users about available facilities, costs involved, and requirements expected of them with regard to treatment as well as use of hospital facilities, in clear and simple terms,

3.4 Informing users of equipments out of order,

3.5 Ensuring that users can seek clarifications on and assistance in making use of medical treatment and hospital facilities,

3.6 Collecting fees and charges that are reasonable and well known to public, and

3.7 Informing users about steps to be carried out in case of most of the common deficiencies in service.

4. Commitments of the Charter :

4.1. To provide access to available facilities without discrimination,

4.2 To provide emergency care, if needed, on reaching the hospital,

4.3 To provide adequate number (to be defined) of notice boards detailing location of all facilities,

4.4 To provide written information on diagnosis, treatment being administered, and costs that will be recovered, each day in case of in-patients,

4.5 To provide a receipt of all payments made for medical care,

4.6 To record complaints round the clock, and designate Medical Officers who will respond at an appointed time the same day in case of in-patients and the next day in case of out-patients.

5. Grievance redressal :

5.1 Grievances that citizens have will be recorded round the clock.

5.2 There will be a designated medical officer to respond to requests deemed urgent by the person recording the grievances.

5.3 Aggrieved users would, after having their complaint recorded be allowed to seek a second opinion from within the hospital.

5.4 Have a Public Grievances Committee outside the hospital to deal with grievances that are not resolved within the hospital.

6. Steps that will be taken :

6.1 Hospital staff, Department of Health and citizens representatives will discuss the utility and content of the Charter before it is formulated.

6.2 The areas on which standards are prescribed will be selected on the basis of feedback from users of problems and deficiencies, collected by an independent body.

6.3 Systematic efforts will be made to create wide awareness that a Charter exists, among the users of the hospital, and

6.4 Performance in areas where standards have been specified in the Charter will be compiled and displayed publicly.

7. Responsibilities of the Users :

7.1 Users of hospitals would attempt to understand the commitments made in the Charter and demand adherence,

7.2 Users would not insist on service above the standards set in the Charter, particularly because it could negatively affect the provision of the minimum acceptable level of service to another user;

7.3 Instructions of the hospital personnel would be followed sincerely, and

7.4 In case of grievances, the redressal machinery would be used by users without delay.

8. Feedback from the users :

8.1. The perceptions of users on the quality of service of hospitals would be systematically collected and analysed by an independent agency, and

8.2 The feedback, would cover areas where standards have been specified as well as other areas where standards are proposed to be set up.

9. Performance audit and Review of the Charter :

9.1 Performance audit may be conducted through a peer review every year or every two years.

92. The audit would look at user feedback, records on adherence to committed standards, the performance on parameters where standards have not yet been set, and other indicators of successful goal realisation.

9.3 Identify areas where standards can be introduced, tightened, etc., opportunities for cost reduction, and areas where capacity building is required, and

9.4 Through re-assessment of the contents of the Charter every five years.

Annexure - 4

EMERGENCY SERVICES IN HOSPITALS

(Extract of letter No. Z28015/131/96-H, dated 13-12-1996 from the Ministry of Health and Family Welfare, Govt. of India, New Delhi)

The Honourable Supreme Court in their judgement dt 6-5-96 in SLO (C) No. 796/92 - Paschim Banga Khet Mazdoor Samity and others Vs State of West Bengal and another suggested remedial measures to ensure immediate medical attention and treatment to persons in real need. The State Government of West Bengal alone was a Party in the proceedings of the case. The Hon. Court has given directions that other States though not parties should also take necessary steps in the light of recommendations made by the Enquiry Committee which was set up by the State Government of West Bengal and further directions as given by the Court.

The following guidelines may also be kept in view while dealing with emergency cases in addition to the existing guidelines :-

i) In the hospital, the Medical Officer in the Emergency/Casualty services should admit a patient whose condition is morbid/serious in consultation with the specialist concerned on duty in the emergency department.

ii) In case the vacant beds are not available in the concerned department to accommodate such patient, the patient has to be given all necessary attention.

iii) Subsequently, the Medical Officer will make necessary arrangement to get the patient transferred to another hospital in the Ambulance. The position as to whether there is vacant bed in the concerned department has to be ascertained before transferring the patient. The patient will be accompanied by the resident Medical Officer in the Ambulance.

iv) In no case the patient will be left unattended for want of vacant beds in the Emergency/Casualty Department.

v) The services of CATS should be utilised to the extent possible in Delhi.

vi) The effort may be made to monitor the functioning of the Emergency department periodically by the Heads of the institution.

vii) The Medical records of patients attending the emergency services should be preserved in the medical record department.

viii) The Medical Superintendent may coordinate with each other for providing better emergency services.

3. With regard to maintenance of admission register of patients, following may be kept in view :-

a) Clear recording of the name, age, sex, address and disease of the patient by the attending Medical Officer;

b) Clear recording of the date and time of attendance, examination/ admission of the patient;

c) Clear indication whether and where the patient has been admitted, transferred, referred;

d) Safe custody of the Registers;

e) Periodical inspection of the arrangement by the Superintendent;

f) Fixing of responsibility of maintenance and safe custody of the Registers.

4. With regard to identifying the individual medical officer attending to the individual patient approaching OPD/emergency department of a hospital on the basis of consulting the hospital records, it has been directed by the Court that the following procedure should be followed in future :-

a) A copy of the Duty Roster of Medical Officers should be preserved in the Office of the Superintendent incorporating the modifications done for unavoidable circumstances;

b) Each Department shall maintain a register for recording the signature of attending medical officers denoting their arrival and departure time;

c) The attending medical officer shall write his full name clearly and put his signature in the treatment document;

d) The Superintendents of the hospital shall keep all such records in safe custody.

e) A copy of the ticket issued to the patient should be maintained or the relevant date in this regard should be noted in an appropriate record for future guidance.

It is appreciated the Hospital Superitendent/Medical Officers-in-charge may have difficulty in implementing these guidelines due to various constraints at the ground level and as such, feedback is vital to enable Government to refine and modify the order as it will ensure a valid working plan to regulate admission on a just basis. Detailed comments are, therefore, requested with constructive suggestions.

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