The Alma Ata Declaration and Elements for a PHC 2.0

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Abstract for a series of three linked articles

Based on understandings from historical experience, we believe that an overly centralised political and economic system is not the most sustainable or best for people’s health and wellbeing, nor is a centralised and monolithic health service system. It tends to get bureaucratised and a ‘governmentality’ takes over rational and progressive democratic intentions. This creates a mechanistic framework that does not organically relate to the marginalised majorities and diversity of communities. Thereby it is unable to respond to people’s urges and sense of wellbeing. At the same time we recognise the essential role the state has to play in contemporary times, as arbiter and re-distributor of society’s power and resources for a democratic and egalitarian society. Thereby what the structure of the state and public systems should be is critical, and this within the context of the relationship of the state, market, society and professional knowledge. Health is political: as in ‘personal is political’ and as public health where the collective’s health has to be taken care of by optimal social organisation. This is what the PHC of Alma Ata and the Social Determinant of Health Commission tell us. Therefore, we believe that while a democratic, egalitarian society is what can deliver best towards an equitous, pluralist, context-specific, and organically linked health system, such a health system is what can contribute to creating a democratic ethos and people’s wellbeing.

It is in this context that we see an integrated critical political economy and politics of knowledge framework as essential to understand the health system, as also to create the vision for a futuristic holistic health system that ensures HFA. We present our understanding towards such an effort in three articles. This first is an analysis of the Alma Ata declaration and related documents, also explaining the combined political economy and politics of knowledge approach to HFA. The second article sets out the politics of knowledge in health and how it influences health governance. The third article presents a vision of health and a healthcare system for India that is pluralist, context-specific, and organically linked to the marginalised majorities. Since the political economy approach has been much in use in analyses of the health system, we foreground the politics of knowledge in these articles, in order to highlight its relevance. Building such a vision is work in progress and needs much more dialogue for inputs from all, as well as drawing of experience from its operationalisation, in whole or in part. Eventually, the vision itself requires that the system evolves from interaction of theory and experience on the ground.
Introduction

Acknowledging the inequities in access to health care and inequalities in health status across and within countries, the Alma Ata declaration focused on strategies for Health for All (HFA).

“In view of the magnitude of health problems and the inadequate and inequitable distribution of health resources between and within countries, and believing that health is a fundamental human right and worldwide social goal, the Conference called for a new approach to health and health care, to close the gap between the “haves” and “have-nots”, achieve more equitable distribution of health resources, and attain a level of health for all the citizens of the world that will permit them to lead a socially and economically productive life.” (WHO and Unicef, 1978, p16)

“The gap is widening between the health “haves” in the affluent countries and the health have-nots” in the developing world. Moreover, this gap is also evident within individual countries, whatever their level of development.” (p37)

“...most conventional health care systems are becoming increasingly complex and costly and have doubtful social relevance. They have been distorted by the dictates of medical technology and by the misguided efforts of a medical industry providing medical consumer goods to society. Even some of the most affluent countries have come to realize the disparity between the high care costs and low health benefits of these systems. Obviously, it is out of the question for the developing countries to continue importing them. Other approaches have to be sought.” (p38)

But, since it was a negotiated international document that had to be acceptable to all political ideologies of governments all over the world, though it referred to New International Economic Order (WHO and UNICEF, 1978, p2), it left much of the political economy unstated. It created a health systems design document that had to be flexible enough for all country contexts to adopt and yet to make a dent in the existing model of healthcare. It succeeded in creating an acceptance for the idea that (i) health is shaped by the larger context beyond medical care and therefore development in other sectors is a significant input for HFA, (ii) importance of the role of outreach of health services and paramedical health workers at community level, and (iii) importance of communities in taking care of their health and ‘participating’ in health care, all to be implemented as a government responsibility.

While this made a dent and did allow for other imaginations of health care to surface more than before, the power of the capitalist economic system, including the medical establishment, created almost a backlash. The commercialisation, privatisation and corporatisation that globalisation brought with it from the 1980s to 1990s in different parts of the world, even more aggressively asserted the techno-centric, bio-medical, institutional model of medical services. Therefore, the PHC agenda could not gather adequate steam. But since it is a powerful idea, it remained as the backdrop to any talk of improving population health.

This is a neat enough narrative and much literature has elaborated on this political economy argument for limited implementation of PHC. Some have evoked individual country welfare policies and their inadequacy of fund allocation for health as the major limitation (Dreze and Sen, 2013). Others have remained focused on health systems development and governance as technical issues, and identified flaws there (Labonté et al, 2017). Still others have forcefully brought out the technocratic agenda being played out internationally and nationally, undermining the Alma Ata agenda (Banerji, 1999; Qadeer, 1995). Earlier analyses of implementation focus on major shortcomings in implementation of community participation, inter-sectoral coordination and promotion of appropriate technology (Rohde, Rifkin et al, 2008). However, some radical critiques of the document itself have pointed out gaps in its content that led to its subsequent undermining and suggested that the WHO should have led the international establishment in taking a more political view of health (Navarro, 1984).

Using an Integrated Political economy and Politics of knowledge framework

In this paper we present the limitations in implementation as an outcome of both the overall international and national political economy, and of the gaps in the document itself. On the gaps in the document, we posit that, in addition to the lack of adequate attention to the political
economy of health, the lack of acknowledgement of a ‘politics of knowledge’ and its implications for PHC and for HFA is a major flaw. We see the concept of politics of knowledge complementing the political economy analyses.

A recent analysis on these lines (Priya 2018), of how the Alma Ata document and health systems development in India had dealt with the entity of ‘community’ and ‘community participation’ as well as ‘appropriate technology’, found it to be a continuity of the colonial mindset and the top-down approach to development. Unless the knowledge and choices of laypeople are valued, there is little possibility of ‘community participation’ especially in decision-making, which is essential for ‘empowerment’. Further, viewing issues from a community perspective, the analysis found “five ‘missing links’ in the dominant discourse of Health System Development (HSD) policy—the complexity of ‘community’ and disparities and diversities within; the validity of plurality of knowledge and its hierarchies; the culture and ethics of health care providers; the unaffordability of the Euro-American institutional model of medical technology-based health care; and the physical, social, and cultural iatrogenesis as elaborated by Illich, 1977” (Priya 2018).

**Summarising the Gaps**

1. Systemic international structural barriers to health and health care were somewhat referred to, but not addressed—the impact of colonialism earlier and commodification of healthcare with its medicalisation and pharmaceuticalisation by the medical industrial complex.

2. The difference and link between Primary level care and PHC as an approach for the entire health system was not spelt out with clarity. The ambiguity led to confusion that facilitated ignoring of the latter and focusing only on the former.

3. Inadequate attention to irrational use of technologies and Institutions, with reference only to appropriate technology for primary care;

4. Medical professionals and bio-medicine continued to be considered supreme as the only source of legitimate knowledge and thereby retain their power.

5. No addressing of issues of ethics of health services and medical practice, of corruption in the health care system, of iatrogenesis reflecting the power of the medical profession and establishment.

6. Romanticised, unreal notion of ‘the community’ Diversity, power hierarchies and conflicts of interest within communities not acknowledged gender, race, classes.

7. Validity of diverse forms of knowledge (‘epistemic pluralism’) not acknowledged, covered merely under ‘culturally acceptable’ healthcare and use of traditional practitioners after training for ‘modern’ primary level care.

Below we briefly discuss these gaps and what it implies for HFA-PHC for the present times. We underscore the fact that the PHC approach and principles need to be applied to the entire health system, which includes the wider determinants of health as well as the health services at all levels.

**Inputs for Redrafting: PHC 2.0 for HFA Now**

**Place ill-health in the context of Globalization**

While the Alma-Ata documents foregrounded social inequities within and between countries, there is silence on their root causes. They mention categories of power but don’t question the asymmetry. They are concerned about rising cost of health care but limit the explanation to medicalization. International trade policies, crafted by World Trade Organization, have allowed exploitation of global south by the global north in the name of globalization. International monetary policies, conceived by World Bank and International Monetary Fund, have consciously spread capitalist ideologies and consumerism, and have destroyed public services in low and middle-income countries. Trans-national Corporations have not only captured local economies, but their greed has irreversibly damaged the environment. These factors have led nations and governments on a path of development which is iniquitous and ecologically unsustainable. Health is an obvious victim of this paradigm. These factors have to be explicitly acknowledged and addressed while re-drafting a PHC statement now. Similarly, the ecological crisis affecting health of populations in various ways deserves a greater discussion.
Be mindful of the politics in/of International Agencies

The World Health Organization claims to be a democratic international organization which represents interests of all its member states. However, it has always been under the influence of countries that have been its major sources of funds. Of late, corporate interests have increased their influence on the organizations, through explicit public-private global health partnerships, such as GAVI and GFATM. The impact of this power-dynamics is visible in WHO’s prescription for Universal Health Coverage which focuses on medical care but amputates social determinants as a set of issues that need to be addressed separately. UNICEF was another UN agency which was a close party to Alma-Ata Conference. The agency took far lesser time than WHO to shun comprehensiveness and to start promoting selectivity. These changes in dynamics of international organizations have to be considered while re-drafting PHC. Participation of people’s organizations at various national, regional and international levels, should be institutionalized for global health decision making.

Expose vested interests behind inappropriate technologies

The documents define appropriateness of health technologies as not only being scientifically sound but also acceptable to their users and beneficiaries, simple enough to be used at peripheral levels, locally maintainable and producible at low cost with local renewable material. The fact that selected technology should also be the safest possible alternative (for individuals as well as for environment) has not been stated. Moreover, the factors that may influence the process of choosing a health technology and mechanisms to counter these factors have been left out. The new version needs to uncover this politics.

Describe the private sector, its problems, and remedies

The private sector in medical care may not have been so problematic in the 1970s, though its unabated and unregulated growth could still have been anticipated. It comprises of institutes offering medical education, clinical facilities, diagnostic centres, pharmaceuticals, medical equipment and devices, software insurance and other health services. It has led to a rise in the cost of care and has brought-in irrational and unethical practices in health care. It has become such a strong lobby that it influences public policies at national and international levels. Consequently, instead of regulating and socializing this sector, the public sector is being pushed into partnerships with private entities. The new version should discuss and address this issue.

Give Modern and Traditional Medicine their rightful place

The documents hold technologies and specializations as responsible for the rising cost of health care. In response, they talk about appropriate technology, referral systems and social functions of professional health workers. But they don’t question the very system of medicine which draws its dominance and commercial benefits from technology and specialization. In addition, the documents do not adequately acknowledge indigenous systems of medicine which are invariably found in all parts of the world. The new version of PHC needs to recognize the existence, popularity and appropriateness of traditional medicine including home-remedies. But it shouldn’t romanticize these systems, and should instead push the scientific community to devise suitable ways to understand and validate these systems and integrate them at the level of knowledge and practice. This approach should be followed not only for health but also for allied issues like water conservation, farming and food storage. At the same time, it should talk about the high cost and iatrogenesis associated with bio-medicine.

Involve Communities in the process of drafting

Health, like the concept of democracy, should be by the people, for the people and of the people. And so should be any policy related to health. The Alma Ata Conference saw huge participation from several governments, UN agencies and non-governmental agencies in official relations with WHO/UNICEF. It was preceded by a series of democratically organized discussions. However, there was an under-representation of people’s organizations in these discussions and in the conference. The process of re-drafting PHC approach should start from the community and should involve community-based and community-oriented organizations.
Flatten the hierarchy to foster team spirit

The documents propose that members of community, community health workers, traditional medical practitioners and professional health workers should work as a team. The social and economic hierarchy between these groups is well known. There is a pecking order even within these professional health workers’ groups. In order to flatten this hierarchy, radical changes are required in the process of selection of candidates for different medical and allied courses. In addition, it should necessitate community-based work at each level of education and training. Besides, it should talk about empowering each of these cadres to work in the best interest of people rather than simply toeing the line drawn by the authority of the medical establishment.

Elaborate what transformation is needed at secondary/tertiary levels

The documents state that principles like appropriate technology apply not only to primary health care in the community but also to all other levels. They also express the need for reorientation of these levels so as to gear them towards supporting primary health care. But due to a disproportionate focus on primary level of care, the documents fail to convey the idea that other levels of care should also imbibe principles of the primary health care approach. The new version should detail how secondary and tertiary levels of care should transform themselves in the spirit of PHC.

Problematize, and address, social vulnerabilities

Alma-Ata documents recognize women as one of the vulnerable groups having special needs. But they limit to biological vulnerabilities by focusing on the health needs during pregnancy and lactation. They don’t question, or even acknowledge, patriarchy as leading to social vulnerability and affecting the health of women. In fact, they essentialize the caregiver role of women and don’t acknowledge this as their unpaid labour. There is no mention of gender violence. The new version of PHC document should explain, and address, women’s health issues in a more comprehensive way. Similarly, the new version should specifically problematize and address vulnerabilities based on colour, ethnicity, sexuality, religion, caste and ability rather than clubbing them all under a single rubric of ‘social’. Besides accessibility and affordability, the new version should also ask for dignity in care, and sensitivity to diversity in general.

Acknowledge the power dynamics within Community

Alma-Ata documents position community right in the definition of Primary Health Care and calls for the community’s involvement in all stages of the planning cycle. It defines community as a group of people living together in some form of social organization and cohesion. But the ‘community’ has been presented largely in a romantic fashion and the fractures within this social organization are only weakly acknowledged.

“A community consists of people living together in some form of social organization and cohesion. Its members share in varying degrees political, economic, social and cultural characteristics, as well as interests and aspirations, including health.” (WHO-UNICEF, 1978, p49)

The documents consider it advantageous if community chooses its Community Health Workers, but doesn’t warn how complex this exercise can be. The power structures within the community may not let certain issues to ever surface, and these need to be explicitly questioned. The new version of PHC has to be more elaborate on this account.

Clarify who all represent the community

At all levels of planning, the documents propose community representatives in decision making to pursue community interests but does not spell out the principles of community representation. The new version should be more specific about who all should represent community interests, including socially conscious and dedicated persons from community/community-based organisations and representation of all communities, especially those lower in the social hierarchy. In addition, the new version should define the processes through which such representatives gather a sense of what people on the ground think.

Empower the Community, give enabling environment

The documents call for managerial control through the community but leaves technical guidance entirely on other levels of the health sys-
tem. They expect that community should be willing to learn, and talk about harmonization of views at community level. By doing so, they disregard the knowledge that the community may already be having. It is confusing whether the documents wish to empower the community to decide for itself by providing an enabling environment, or they want community’s cooperation and acceptance for implementing what has been pre-decided at a higher level. The new version should state the role of community in very clear terms. In addition, it should build-in social audit and grievance redressal mechanisms if communities are to exercise managerial control. It should caution against burdening community volunteers with formal daily duties. Involving them in the technology assessment, monitoring/supervision and planning processes should be undertaken in ways that welcome their bringing the knowledge of local social context and local health knowledge into the health system.

**Elaborate on measures to strengthen individual, family and community levels**

If individual, family and community are to be the central core of health care and self-reliance, people’s control to be its principles, as stated in the Alma Ata documents, then each of these levels needs to be better understood and addressed. Each of these have different dynamics and requirements and it is not enough to address them as ‘community’ alone.

**Acknowledge violence as a determinant and emphasize on peace**

The Alma-Ata Declaration, in its last point, says that health for all can be attained if the world’s resources are devoted to peaceful aims instead of armaments and military conflicts. Armed violence perpetrated by one country over the other, and that staged by state and non-state actors within countries has been a long-standing reality for many parts of the world. Structural violence, within and across countries, has to be acknowledged in this context. Increasing violent crimes, social conflict and communal violence need to be acknowledged as affecting physical and mental health as well as healthcare access. All forms of violence not only affect health care services but also prevent any growth and development activity from taking root. The new version of PHC should devote more space to this issue.

**Explicating a Cohering Theoretical Frame**

To provide a coherent theoretical frame, we suggest adopting what has been proposed as a Holistic Health Systems Approach (HHSA) that attempts to provide health systems analysis a framework that combines political economy and the politics of knowledge. HHSA links the micro, meso and macro levels of health systems incorporating the following: diverse health related world-views and perceptions; technologies and practices of health promotion, disease prevention, diagnosis and treatment, palliation and rehabilitation; the modes of utilisation of health-related knowledge from self-care within families to institutional services at a societal level; ontologies, epistemologies and methodologies of health knowledge systems as well as institutional structures and regulatory mechanisms and their political economy, social and cultural moorings (Priya & Kurian, 2018).

**The bottom line**

Alma-Ata envisioned a health system which caters to preventive, promotive, curative, palliative and rehabilitative needs of all, irrespective of their ability to pay. This system should take health planning and health care services as close to people as possible. The technology deployed to further the services should be empowering and should enhance self-reliance. The system should not be fragmented and should reach out to all sectors which can, directly or indirectly, influence health. The new version has to necessarily carry these basic principles of Primary Health Care forward with a more theoretically coherent and operationally concrete articulation of the linkages.

Thereby, at least three interpretations of PHC are possible from the Alma Ata document (Priya, 2018):

(i) Primary-level care with a feasible, affordable, ‘essential health care’ package that has become known as Selective Primary Health Care, based on primary-level care and ‘community mobilization’ through the campaign mode, as adopted for the RCH and Polio Eradication programmes (Chen and Cash 1988);
(ii) Comprehensive Primary Health Care (CPHC) with primary-level care as central to HSD and appropriate secondary and tertiary care to support it, including conventional (i.e. modern) medical and non-medical interventions that are preventive, promotive, curative, and rehabilitative, relying on community participation, appropriate technology and measures to deal with the wider determinants of health;

(iii) The CPHC as in ii, and including the local folk knowledge-based home and community care at primary level, backed up by the institutional primary, secondary, and tertiary levels. A bottom up structure and functioning of the health system are inherent to this interpretation. Shift to a decentralised, pluralist framing of the health services design, and a polity, governance and economic development model that supports this, would have to happen in tandem.

The vision of the Alma Ata document articulated the second stance most clearly. The ambiguities already pointed out in it, allowed it to be interpreted also as SPHC by those who were more comfortable with or interested in a top down medicalised view. Since the document does acknowledge the role of community participation and of traditional practitioners due to their trust in the community, it opens a window for the third interpretation (Young, 1983; Unnikrishnan, 2010). The Chinese health care system had already demonstrated implementation of this third version, with inclusion of community collectives and use of local traditional knowledge as well as institutional practice of plural medical traditions nationally. The Alma Ata document foregrounded China’s ‘barefoot doctor’ concept while ignoring the other dimensions. Civil society experiments such as of Jamkhed and Deenabandhupuram in India had also integrated local illiterate women of lower castes into their community level care using local traditional practices along with training in modern primary level measures. Over the years, several countries have attempted to officially include local health traditions in their health care system (Bichmann, 1979; Mignone et al., 2007; Campbell-Hall et al, 2010). Yet these continue to be abandoned in the primary level care of UHC, which has advanced down the SPHC path. The Astana documents now do acknowledge the role of traditional knowledge, but in passing (World Health Organisation, 2018).

Thereby, the Alma Ata document set out health systems design principles but with no cohering theoretical frame that assessed the social, economic, cultural and political structures that underlie the state of health and healthcare. We argue that inherent in all these factors is the politics of knowledge of lay versus expert knowledge, of ‘modern scientific’ versus ‘traditional non-scientific’ systems of knowledge, and of ‘bio-medical, objective’ versus ‘social science, subjective’ knowledge and ignoring this is part of the political economy of PHC. Therefore, we suggest that the political economy and political of knowledge frames must be integral to the analysis of health systems in general, including that of the vision of PHC.

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Some Thoughts on Health for All: The rationale for engaging with the politics of knowledge

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This paper (the second of three in the series) explains the basis of the focus on Politics of Knowledge that has been introduced in the first paper; it highlights a number of explicit and implicit critiques of the taken for grantedness of the knowledge base on which the bio-medical system is premised. While the paper attempts to delineate some broad directions an alternative framework could take, the next paper (paper three in the series) translates these into health system design for Health for ALL.

Introduction

The continued discussion of Health for All in its fortieth year is testament not only to its continued relevance, but equally to the fact that it has not been achieved. While renewing our commitment to Health for ALL, it is important to reflect on why it has remained unachievable, and attempt to critically look at the adequacy of the various perspectives from which critiques have been made.

Most analyses have framed this critique in terms of Political Economy and have focused on the individual or institutional level for analysis, and have been alluded to in the first paper of this series. The institution is now recognized as a key site/level for the production and reproduction of trends in health outcomes obtaining in a particular socio-economic-political-cultural-ecological (SEPCE) setting. The political economy approach has focused on the distribution of power in these institutions, as well as in the evolution of these institutions. This implies that the institutions/actors have a role in ‘channeling’ the power that constitutes the politics underlying a particular organization, which in turn (and in aggregate) constitute the health system. Thus particular institutional designs are seen as being emergent from the prevalent configuration of power.1

In this paper we follow a politics of knowledge approach to critique the limitations of a political economy model of health care and reflect on alternatives. A politics of knowledge approach urges one to go beyond the political economy analysis of power by pointing to and exploring the taken for granted model of certainty and truth of a given form of knowledge, which both the mainstream institutions as well as their critics (who draw on the Political economy approach) draw on.

We follow this line of exploration in the rest of the paper in the following way – in the next section we present different critiques of the dominant (hegemonic) knowledge system. We follow this with a section that reviews theories of discourse and its role in producing ‘knowledge’ demonstrating the key role played by knowledge and its material and symbolic consequences. We then have a section that integrates these insights and further defines the Politics of Knowledge approach. We conclude by pointing to the criticality of such an approach to the struggle for Health for All, as well as a key avenues for further work.

Critique of the dominant knowledge system

There are a number of perspectives arising out of a diverse range of knowledges and practices that pose a challenge to the dominance of the present, linear, bio-medical knowledge based on ‘science’ that dominates thinking in health and public health. It is useful to first list these before going on to develop a framework for a more overarching critique. In the following sub-sections we will be discussing the critiques (both explicit and implicit) that arise broadly from – (a) within science itself; (b) from lay practice and experience; (c) from other major paradigms/epistemological approaches; and (d) our own critical framework that points to the value of different indigenous knowledge and practice systems.

Each sub-section does not claim to be a comprehensive summary of the critique presented by each of the perspectives, but merely tries to point to the major direction of that critique. The idea being to draw on these broadly as we develop a larger framework for understanding the Politics of Knowledge.

Critiques from within science

Developments within science in the twentieth century have led to the complicating of the notion of truth and certainty.2 Examples are Ilya Prigogine’s work in chemistry, Benoit Mandelbrot’s work in the mathematics of fractals and randomness, Humberto Maturana and Francesco Varela’s work in relation to the biology of cognition, and Stafford Beer’s work in relation to organizational science. These have all
challenged simplistic notions of truth and knowledge about truth. This is not to mention some of the critical work in relation to the uncertainty of knowledge in the field of quantum mechanics, stemming from for example Heisenberg’s Uncertainty Principle.

While these various scientific developments contributed greatly to a more complex and nuanced understanding of reality, one aspect of this development of note is the emerging understanding of the relationship between the legitimacy of knowledge to the dimension at which one tests the results of that knowledge. The most straightforward example of this is in physics where it is now clear that Newton’s laws were not so much proved false by the Theory of Relativity, but were discovered to be relevant in only particular dimensions of experience. Thus in our day to day life and visual reality it continues to play a major role. It is just that in various other dimensions / scale like the sub-atomic or realm of space for example that it is not valid as its assumptions do not hold.

Germane to this discussion of a critique of dominant science from within is also the insight of the inter-dependence of various parts of a system, however ‘distant’ they may seem in ‘reality’, and the extreme sensitivity to initial conditions – which points to the importance of history in understanding various paths of development and evolution of systems. This insight into initial conditions and interdependence destabilizes a naive faith in the universality of a strictly linear view of science.

Philosophers of science, especially those influenced by ‘complexity’ and the study of ‘wicked problems’ point either to different orders or different phases of science. These understandings call for a recognition of the limitations of a purely ‘neutral’ approach to science as data gathering about a ‘single reality’. These approaches call for greater reflexivity on the part of the researcher herself, which includes interrogating the biases, influences and perspectives of the researcher that influence the construction of knowledge. Further ‘harder’ versions call for the similar interrogation of the ‘system’ as a whole of which the researcher is a part. Thus there is a clear emerging strand of thought from within science that questions the universalist assumptions on which scientific legitimacy is premised.

**Distortions in the practice of science**

The increasing exposés of the way in which corporate interests have distorted ‘science’ deeply shakes the confidence of the lay person with regards to the legitimacy of science. However more importantly we have seen the way in which uncertainty inherent in science (either due to the actual topic, or the lack of good quality research) has been exploited for profit, for example in the case of diesel (and other products like chromium, lead and plastics which manufacturers of dangerous products avoid environmental regulation by manufactured uncertainty) and tobacco. Further we have seen the emergence of “corporate epidemiology” and other similar modes of enquiry that studies the distortion of science by corporate profit.

This whole development and struggle points to the way in which the present systems of management of the scientific endeavour have left the gates open for exploitation for corporate greed at the cost of individual and community welfare – especially if the communities involved are vulnerable and marginalized. Such communities do in fact constitute the large majority.

The challenge posed by a number of people’s movements like the Treatment Action Campaign (TAC), the People’s Health Movement (PHM), the Right to Food (RtF) Campaign, and the Environment movement have been at the forefront of critiquing science through the foregrounding of a number of alternative perspectives/ paradigms, challenging the values that facilitate corporate influence. Thus for example TAC, PHM and RtF have all foregrounded Human Rights as a key counterbalance to designs and policies that favour private profit, and the environment movement has foregrounded the “precautionary principle” (which implies that there is a social responsibility to protect people from exposure to potentially harmful substances even when scientific knowledge is lacking, but investigation has found plausible risk) to counterbalance a more short sighted profit driven governance of scientific evidence about various chemicals.

A third example is the tendency to neglect / ignore social and behavioural and structural approaches to health, to the benefit of technological quick fixes. Much of this is emanating from the mindset that technological solutions are the best way to improve and maintain population and individual health. It is the dominant institutional structures and the centralised structure of knowledge itself that allows the chosen ‘experts’ to dictate what is legitimate and what is not in available knowledge(s).
This again is a clear reflection of the fact that what purports to be scientific knowledge may on occasion in fact only be a version of corporate influenced greed dressed up as science. The fact that this is possible and indeed we are coming across more and more examples – points to the vulnerability of the scientific process to hijack – and begs the question of more robust structures of evaluation and governance.

Critiques from practice and experience

Critiques from the perspective of the user / provider can be discussed from at least four points of view – (a) the modification of guidelines during their implementation in practice by frontline providers; (b) inter-system referral of patients by doctors; (c) multiple – system usage by patients and patient dependence particular system / refusal to accept bio-medicine; and (d) the experience and critique offered by various patient’s movements.

(a) Modification of guidelines - Research on the implementation of evidence led to a number of studies that looked at the way in which practitioners interpreted evidence and used it to guide practice. This research showed that despite training and familiarity with the guidelines, practitioners tended to ‘adapt’ the guidelines to suit the local context. The research pointed out that rather than see these adaptations as failings or errors, one needed to see these as ways of “sense making”. This led to a very interesting line of work which drew on various aspects of the concept of “tacit knowledge” and other related aspects to posit the concept of “Mindlines” which are ways in which evidence is interpreted and put into practice based on the opinions of trusted peers and experience in the local situations.

(b) Cross – referral – Despite the obvious fundamental differences between various systems of medicine and the dominance of the so-called modern medicine in large parts of the world – at least at the Global / national level – there are a number of instances where doctors from one system refer to doctors from another system – either at the request of their patient, or indeed from individual conviction of their usefulness. Thus there is a seeming willingness at the level of frontline practice to engage with widely different approaches to reality.

(c) Patients choice – there are a number of instances where patients reject allopathy / modern medicine completely, alternatively patients and communities develop sophisticated rules / algorithms to access a number of systems for different illnesses. Again showing the willingness of those who consume health care to be eclectic and open to experimentation.

(d) Finally there are a number of examples of patients who organize themselves and attempt to influence various aspects of the way knowledge is produced. This potentially leads to changes in priorities of research, the questions asked and indeed potentially the uptake of research into practice.

Critique from academic perspectives

Bodies of knowledge like poststructuralism (Foucault), and Subaltern Studies and the work of those such as Illich, Ashis Nandy, Vandana Shiva, Shiv Vishvanathan, Manu Kothari and Lopa Mehta etc., all are examples of strong critiques of modern science and application of the scientific method in particular fields or at the philosophical level. Feminist approaches to knowledge including non-hierarchical and multiple epistemological approaches have been applied to health-related knowledge and practices, critiquing the hegemony of doctors and of bio-medicine.

(Note this is a partial list, but just aims to give the reader a sense of the various critiques. We have tended to lump various systems together – this is definitely not good practice. But we are doing so as the main aim is a critique of bio-medicine. A further differentiation within the broad umbrella terms is definitely called for and exists too).

Our critique from the perspectives aligned with indigenous / alternative knowledge systems

Like all knowledge systems, each indigenous/alternative system arose from an eco-social context. It is unlikely that any one knowledge system may be considered perfect therefore, each knowledge system has its own issues strengths and limitations. There have been unrelenting criticisms of such alternatives. Critiques of various indigenous systems include pointing out the way in which more formalised and text-based systems tend to dominate over the more experience based folk medicine. There are some serious critiques as to the caste, class and gender biases of some of the more text based and formalised systems like Ayurveda and so on.

More recent academic work has also pointed out to the way in which streams within these systems have responded to and adapted to the market-based economy with commodification and
packaging which is clearly against the basic tenets of these systems. The whole range of Patanjali products in the market may be taken as the ultimate expression of this neo-liberal influence on traditional systems like Ayurveda.

Despite the above critiques we believe that non-modern knowledge systems provide an invaluable perspective from which to critique the present hegemonic system. A very preliminary listing of the strengths of this perspective would in our opinion include:

- Using completely different ontologies – or conceptualizations of reality. Thus concepts like tridoshas, or yin and yang for example are quite inexplicable in terms of modern bio-medicine. The doshas, humors etc., also closely link to the question of balance which is a key aspect of many knowledge systems. The concept of balance points to a more dynamic conceptualization. Further balance also is conceptualized in a multi-level way which again challenges a purely static and universalist view of health.

- Some systems, especially folk traditions and to some extent ayurveda, siddha, sowa rigpa (Tibetan medicine) and unani are deeply connected to local eco-systems. And further, these codified textual systems (such as ayurveda, unani, siddha and sowa rigpa) are closely linked to the folk knowledge and practices. While modern medicine is now talking about patient tailored medicine, indigenous systems have at their core the uniqueness of each individual and factor in layers upon layers of influences to conceptualize a truly complex set of determinants. Again this sort of holistic approach is lacking in modern science / medicine.

- There is a critique of the objectification of the patient in pursuit of the standardization of treatment in bio-medicine, and thereby its implicitly coercive bureaucratisation, with, on the other hand, a celebration of the singular and the diverse by most other knowledge systems. The decentralised nature of folk medicine and also to an extent of the textual forms, allows systemically for greater diversity and context specificity. De-commodified / de-commercialised practice of (while Ayurveda has been intensely commodified, Patanjali being the peak example) folk healers continues to a large extent with their not charging for consultations, leading to an alternative imagination in terms of commodified practice. Healing is then viewed as a vocation and knowledge acquired and held in trust for the benefit of all.

- The above leads to Trust – with trust being such an important part of the doctor-patient relationship. However the rise of commodified technological solutions, and the consequent rent seeking that is possible has created a situation in which trust no longer is seen as essential for efficacy – of the technology or for the profit of the system. This clearly undermines all healing – as seen in the growing dissatisfaction with the technology driven health system and the violence against doctors. Trust leads to, and also results from, a legitimation of lay people’s/subaltern knowledge and practice. The legitimation of lay people’s/subaltern knowledge and practice will also promote self-confidence to enable questioning of the dominant forms of practice and a more critical utilisation of even allopathy, contributing to creating a politics of health with the lay people/subaltern sections.

- Knowledge management in terms of the creation of new knowledge, its legitimation process, governing the uses of new knowledge etc.— Each system has many implicit rules for these which are quite different from modern science / bio-medicine. These need to be mapped and studied.

Towards a framework

In order to develop a framework for a critique of science from the perspective of the Politics of Knowledge, we draw upon three broad strands. These include – (a) the insights from complexity in terms of the different orders / phases of science; and (b) the strengths of dealing with the issue from the vantage point of discourse theory. These are discussed next.

Approaches from within science

Thomas Kuhn points to the way in which a paradigmatically dominant way of thinking will relegate to the periphery all the questions that challenge it. This shows the importance of ‘institutionalized’ science and the power of the institution to define what is legitimate and what is not. This defines a period of normal science. At specific points in history, there are ruptures that shift the paradigm. We call for such a paradigm shift in our pursuit of meaningful and effective healthcare.

Insights from complexity and second-order science

As already discussed in the first section of this paper the insights from understanding complexity and uncertainty point to the need for increased reflexivity, not only demanding that we focus our attention on the researcher, but also the very system of production of knowledge within which the researcher is embedded.
Discourse

Discourse theory points out that institutions draw on rules and norms defined by the dominant/hegemonic discourse currently in place (there may be many competing discourses with one being dominant at any given point of time). Discourse is said to create particular ‘subject positions’ - which in essence define what legitimate roles people may take on / play out in a given situation, and ‘ways of seeing’ - which include what are considered as legitimate ways of seeing the world and the legitimate questions that one may ask of it (Kuhn’s concept of the paradigm defines such questions). Such discourse also defines the implicit order and relationships between these positions and roles and ways of seeing. Over time these positions / relationships and rules of acceptable behaviour crystallize or get sedimented into forms of institutions that we come to recognize in society, acquiring as it were a taken for granted nature.10

It is increasingly understood further that institutions themselves depend for their legitimation on ‘knowledge’. This knowledge is in turn produced by these very same institutions. Institutions and knowledge are thus to be seen as very closely related and constitutive of each other over time. Thus power ensures that what may in fact be arbitrary choices in terms of knowledge are sedimented into ‘truths’ through this interplay.9,10

Thus it is important for us to appreciate that power acts (ie. Has material consequences) through both ‘rules of distribution’ (in other words how institutions will act) which is covered by political economy, as well as the reference to ‘knowledge’ that is used to prop up a system. We propose thus that any attempt at understanding ‘knowledge’ that is used to prop up particular institutions / roles / ways of seeing and doing. It also highlights the manner in which a shift in the paradigm can result in the collapse and regeneration, i.e., the transformation, of old institutions.

Thus we find that in health systems today the power of the knowledge generated from randomised clinical trials as being considered the ‘truth’ and thus those associated with such trials – scientists and funders (increasingly drug companies) – have the most power, compared to other forms of knowledge including qualitative, and even lay forms of knowledge. Here we find that a particular conceptualization (and seemingly natural perception) of what is considered ‘the best’ research method – creates the situations of particular formulations and relations between experts and lay persons.

The question with regard to clinical trials is not a solely methodological question, but it asks us to explore the effect of considering it as the most accurate / highest form of research – on the study of and understanding of reality. Not only is there the need to convert everything into objective, verifiable data that can be collected in a blinded fashion – thus necessarily narrowing / blunting the scope of what can be measured. The other process of controlling and randomizing – done to create circumstances of being able to measure the ‘pure’ effect of a particular intervention – belies the understanding of reality based on complex interdependencies and multi-level and intersecting causation.

Another role which knowledge plays very influentially is in the problematization of a given issue. Thus a particular research paradigm defines out / crowds out competing paradigms. Thus research has shown the way in which technological quick fixes crowd out socio-behavioural approaches (referred to above).

Similarly one can talk about the effects of the Green Revolution as being remarkable along particular narrow dimensions related to grain
output and that to for a limited period of time. Equally it may be considered a spectacular failure in terms of other dimensions such as soil quality decades later, consequences on equity of land ownership and ecological damage. Again here the choice of the dimensions in which to evaluate particular forms of knowledge and the end points / outcomes chosen are political decisions.

This privileging of certain forms of knowledge, and consequent de-legitimizing of other forms – under particular discourses and the resultant institutional arrangements is what we refer to as the politics of knowledge.

Towards an articulation of a politics of knowledge

As mentioned above a politics of knowledge would mean the field of inquiry that attempts to ask the question – why are these particular forms of knowledge considered legitimate and trustworthy and not others? And what are the mechanisms / institutional arrangements / norms that enable this? Of course even while critiquing science we need to acknowledge its inherent self-reflexivity that has ensured the continuous questioning and / or updating of knowledge and its forms that have taken place over centuries.

Before going to the key elements of a proposed framework of the production and reproduction of particular forms of dominant knowledge(s) it is important to understand our broad conception of knowledge in the first place. Generically knowledge, springing from experience can be seen as a particular society’s attempt at making sense of the world, solving practical problems and attempting to avoid future recurrences. Seen in this way then the particular approach taken by a particular society depends firstly on the cosmology / world view of that particular group, and further on the way that particular society is organized – the hierarchies, the power distribution, the institutions that evolved to manage these etc. Taking these into account then – knowledge systems need to be seen as particular, context specific bodies that depend on the world view as well as institutional evolution of the particular communities from which they emerged. Posing the problem in this way means that hierarchy between systems of knowledge is not automatic – in the sense of natural – and in fact each system can be seen as one way of looking at reality. Of course the solutions of one system may be more effective in solving particular problems – but this is where the crucial role of institutions and the unquestioned assumptions of legitimacy come in.

The brief exploration of some of these perspectives point to some key directions to further develop a framework for analysis using the politics of knowledge as an entry point. This critique may broadly consist of the following (this is not a comprehensive list – but more an indicative one):

• Questioning the paramount nature of universality – and its need as sole criterion / key criterion for the definition of legitimacy. The corollary of this would be the importance of the local context, and the need to bring it centre stage in the scientific endeavour.
• Questioning the automatic neutrality of the scientific endeavour, and recognising the susceptibility to hijack, and conversion / distortion of science into a tool for control and corporate profit. This points to the critical need for democratization of the scientific project.
• Appreciating the importance of history, and thus the importance of taking that into account while planning a path of development, for a given community.
• Appreciating multiple epistemologies.

The discourse approach identifies the ways in which knowledge, institutions and subject positions are intertwined and co-constitute each other. Critiques presented from various perspectives, both from within science and from lay and traditional / indigenous knowledge systems point to various specific assumptions which dominant science takes for granted. The experience with corporate distortion point to the susceptibility of such take over by groups with power.

To us the politics of knowledge is precisely this combination of institutions legitimizing that is turn constituted by particular forms of knowledge, susceptible due to these very assumptions to corporate take-over (in the context of a particular institutional structures and governance).

A politics of knowledge approach / framing thus not only questions the institutions producing this knowledge (and their structures and design and normative assumptions) – but more importantly focuses / points to the assumptions underlying the legitimacy as well as the governance of the overall knowledge production process as a whole.

Application to governance of health systems

The application of a politics of knowledge framing to the issue of governance forces us to go beyond issues of managerialism, efficiency and sustainability to look at underlying assumptions of the knowledge base on which these institutions
/ programs are based. It calls as well for the management of multiple perspectives / epistemologies – and equally importantly of underlying values.

The politics of knowledge approach uncovers the effects of dominant knowledge especially through pointing to the various underlying “problematisations” through which knowledge and its consequent action derive legitimacy.

Thus like in the approach of second order science – the questions the politics of knowledge in fact asks turns the spot light on the researcher and the research process (that produces knowledge).

This points to the need to

● Be more open to multiple epistemologies.
● Democratization of the planning and management of knowledge production and its assessment.
● And ultimately the development of an institutional eco-system to reflect these values and processes.

Any talk of governance reform for Health for All, in our opinion needs to engage with these questions if it is to make a real impact on the possibility of achieving its goal.

The next set of questions

The core of this note consists of three contentions:

● Analysis of power is not complete without an analysis of the politics of knowledge.
● For an analysis of the politics of knowledge we need to draw on many sources of reflexivity and imagination.
● The various indigenous knowledge systems are an important source of knowledge that have been ignored / neglected till now in the predominantly political-economy based critique of health system development.

What we need for the struggle for Health for All is to be able to use all resources that are available for this struggle and that communities can control. We call for an urgent dialogue between those of us struggling for health for all and the people themselves and the resources (used in the broadest sense of the term to include all forms of knowledge) they use in their daily struggle for survival and vitality. We need to undertake a mapping and engage with humility. It is the responsibility of all who are committed to Health for All to make full use of ALL available resources. With open minds and without romanticizing of any one form of knowledge.

While there is a call for the democratisation of knowledge and its uses, most calls for such democratisation seem to privilege the system based on modern science / bio-medicine. We call for a fuller interpretation of the word democracy and urge the inclusion of diverse knowledge systems as well as knowledge management systems into the discussion as equal partners and in the spirit of democracy, as we progress towards Health for ALL.

Note

We have used the term indigenous knowledge system here fully aware of the diversity it encompasses and the politics and discussions around the use of other terms such as TCAM and Alternative systems, AYUSH etc., Please note that we have used this term merely as a place holder in this note and are open to the use of what may emerge as more appropriate terms during the discussion.

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References


Abstract

This article is the third in a series of three, where the first sketched out an integrated critical political economy and politics of knowledge framework, while the second set out the politics of knowledge in health and how it influences health governance. This third article presents a vision of health and a healthcare system for India that is pluralist, context-specific, and organically linked to the marginalised majorities. Rooted in health culture, it attempts to foreground the knowledge and role of individuals, families and communities as the core around which health service institutions have to be conceptualised. These institutions along with being towers of medical excellence should have an image in the community of being support structures when needed and community should have sense of ownership over these institutions.

Being healthy is a constant process requiring continuing efforts and adaptation of individuals and of communities with self and the surrounding. This is embedded in an eco-social reality having power dynamics and spiritual desires; material conditions; other living species and geoclimatic conditions constituting environmental conditions.

The journey/trajectory/spectrum of being healthy starts with being at peace and comfort with self, comprising of bodily self, psychological and spiritual self. This can further be nuanced at the level of different organ systems or organ levels within a system till cellular or molecular level; or as balance between different humours whether it is vata, pitta and kapha (dosha) in Ayurveda or balgham, dam, safra and sauda (akhalat) in Unani; as balance between yin and yang and energy flows through qi meridian as suggested in traditional Chinese medicine etc. The modern biomedicine also uses the notion of homeostasis or allostasis by which bodily processes respond to changes in internal or external environment to ensure optimal functioning.

There is substantial evidence even in modern medicine arguing the need of addressing social determinants of health. The effect of gender, race, class, caste, ethnicity, religion, economic status, sexuality, occupation etc. along with the larger developmental process has been documented to have significant influence on health of individuals and communities. In today’s epidemiological thinking, especially from the Latin American School, there is a detailing of the conceptualization of social determinants by emphasising the societal determinants and the processes of social determination of health (Starfield, 2006; Eslava et al., 2015). It has been observed that the pursuit of development, especially economic development and the processes adopted for it, have generated new patterns of health and disease and resulted in increasing inequalities including health inequalities, especially in developing countries.

Environmental conditions have been attributed disease causation since the time of Hippocrates. These conditions affect various determinants of health (such as food systems, agriculture, water bodies, forests and climate), and consequently health and disease patterns. Climate change has become another important contributor to changing patterns of health and illness. Vulnerable sections of the society are usually the worst affected by change in environmental conditions. Having to live with unsafe environmental conditions already make them more susceptible to disease and death. The larger developmental paths chosen by different countries have further contributed to significant deterioration of environmental conditions that are affecting health of the population.

Thus, one finds that all systems of medicine have inter-related concepts of balance, multi-level effects, and historicity. The imaginations of health and health care, therefore, have to start from individual self and must include larger social determinants of health, developmental processes and environmental conditions traversing through the levels of family, community and different societal organizations, be it geo-political and administrative units such as village, blocks, districts, states countries; or occupational groups, ethnic or racial groups; or other social organization/structures viz. caste class, gender, religion etc.

Health Care Spectrum and Its Organization as a Social Process

Death, disability and disease are as old as human beings. The attempt to preserve health, prevent disease, and restore health from disease conditions is also as old as human beings. The knowledge and methods for this have evolved in different parts of the world depending on the
prevailing disease patterns, available resources and world views that emerged in that society. With changes in societal organization, emergence of modern nation states and development of modern science, there have been rapid changes in the way body and human disease were understood, leading to a more reductionist and mechanistic approach. Especially with welfare states, there has been systematic effort in understanding ill health at population level, and organized response to ill health through state supported (state recognized/funded/provided/regulated) health service systems that found reductionist understandings of health and diseases conducive for mass application (Bynum, 1994).

State supported health services, whether in public sector or private sector, mostly provide modern medicine. However, some LMIC countries like India, China, and now some HIC countries like Canada, UK also, involve health care from other systems of medicine. It needs to be recognized that state supported health services have been an addition to already existent health care services and practices. Rapid changes and expansion of state and its patronage of modern medicine as superior knowledge system has contributed to deligitimization and decline of the non-modern medicine and non-state based health care practices and services. Over and above state supported health services, based on different systems of medicine, there is a large component of non-state-non-modern medicine based health services (where even health care providers are not formally trained in institutions recognized and regulated by the state) that continue to thrive and serve as an important resource and recourse for the population for relieving suffering, preserving and restoring health (Payyappallimana, 2010).

Health care institutions are after all social institutions with their own social processes and distinctive components and dynamics aimed at preserving and restoring health. Culture of these institutions evolve over time with change in components such as health technologies, institutional forms, cadre of service providers, and the dynamic relations between different components or actors. Modern health care institutions like hospital and clinic over time have become part of most of the cultures and serve an important social function.

Ideally health services’ planning has to start with assessing and analysing existing health status, health practices, burden of disease, available resources etc. (Banerji, 1979). Epidemiology as a basic science of public health is essential in doing that. From its early stage of germ theory paradigm to eco-social theoretical frameworks in understanding and resolving health problems, epidemiology also has evolved over time (Krieger, 2001). However, the way health and disease are defined, measured, understood and intervened upon continues to be predominantly based on modern bio-medicine’s scientific rationale. Hence, there is a tendency to leave out many disease conditions, etiological frameworks, and implications for choice of intervention measure and designs of health care systems (Guarnaccia and Rogler, 1999; Burtscher and Burza, 2015; Expert committee on tribal health, 2018). To our mind, a truly holistic health care system should comprise all knowledge resources in order to give the opportunities to individuals and communities to reduce suffering, preserve, restore and advance health.

Thus, conceptualizing health care systems and designing of health services has to take into account all available resources, monetary, human and knowledge, for their efficient use to improve health by any society or country. The services designed have to support and complement, not replace available health services and practices.

**Health Service System Design: A Bottom Up View**

As our previous two papers have pointed out, the Alma Ata declaration had two major limitations in its proposed health service system design. One, that primary level care did not spell out how non-institutional community level care was to be addressed and two, it did not focus adequate attention on how to operationalize PHC principles at what it called the secondary and tertiary levels of care. Therefore, we focus our attention on these two dimensions.

If one analyses health care practices of all people, the health care spectrum will be seen to be comprised of different levels of health care or organization of care processes. Health seeking behaviour begins from self, including family and resources at home when required, and then if needed extends to one’s community resources and institutionalised service providers depending on nature of requirement, preferences and options available. Bulk of health practices (health promotion, prevention of illness, caring during illness, to name a few) happen at the individual, family and community level, often as a matter of community cultural practice. Some of the practices at individual or family level might be aided by expert advice from experts in the community or experts from medical care institutions. These community level practices are either ignored or are largely seen as barriers by the state supported health systems, and addressed primarily through interventions of health education/IEC/BCC.

In reality, this bulk of health care practices at the individual-family-community level form the core of healthcare from a bottom up perspective,
while the institutions play a peripheral role, lying at varying distances from the core. However, with the dominant top-down thinking, the modern institutions (hospital and clinic) solely constitute the soul of the imagination of health care. Medical care institutions (from different systems of medicine) with trained doctors and paramedical workers along with the services that they offer form only a part of the total spectrum of health care. Yet, most of the discussion on health care for improving health of the population is on strengthening and expanding these institutions and delves into distribution and use of expert human resources, medical technologies and the services offered at what are viewed as different tiers of institutions.

The civil society pressure, in some places, has managed to bring some representation of lay people in oversight of services delivered through these institutions. Otherwise, people are seen as mere users of health services offered to them and ‘community participation’ has been mainly about facilitating utilization of the services by the community, planned for them by experts. Resource scarcity and efforts of making services acceptable to community has brought out innovations like ‘community health workers’, ‘village health guides’ or ‘ASHA’ which are serving the purpose of providing outreach services of these modern institutions. Though a step forward, these initiatives are fundamentally different from what was suggested by the ‘Sokhey committee’ in 1948, and many national and international policy documents subsequently, for using the local vaids, hakims, dais and other local health care providers in rural health care (The National Planning Committee, 1948; MoHFW, 2005; WHO, 2014).

The most progressive imagination of health systems design, such as the Alma Ata declaration, added the community and paramedic based health care to institutional care, but continued to consider people operationally ‘peripheral’. Its notable contribution of formalizing a three-tier system of levels of care centering the role of institutional care even at primary level was useful for resource optimization for health service delivery by the state, but did not adequately reflect the centrality of the health practices of the individual-family-community complex (Priya, 2018). However social reality of health culture was different and continues to be different, partly because of inaccessibility of care from modern institutions, delivery of a pre-determined package of services through such institutions that failed to meet felt need and unaffordability of modern biomedicine. It was also a matter of resistance to modern institutions and biomedicine from their alternate world views and health cultures or due to its iatrogenesis.
The model proposed in this paper, we think, is better suited for conceptualizing health systems that will help in empowering people for realizing the dream of ‘Health for All’. The proposed model rooted in health culture is informed by a politics of knowledge framework and comprises different levels based on a bottom up approach and the functions performed at such levels of social organisation. The levels consist of self-care, family care, community care as the core and institutional care as peripheral to it. Realizing the complexities of the last level of institutional care it has been further categorised on a functional basis into outreach service delivery level, institutions with OPD services and those with IPD. District Resource Centres, health system research institutions and medical research institutions are conceived as support institutions to the health care delivery structure. All these are briefly discussed below:

A. Non-Institutional care

1) Self-Care: It encompasses all the deliberate activities done by an individual for promoting, preserving and restoring health. Consuming healthy and balanced diets, doing exercise, ensuring adequate rest and leisure, avoiding hazardous conditions, mechanisms an practices to ensure hygiene and sanitation, resting to allow healing of the body by itself when there are minor departures from health, using home remedies etc. represent life patterns which have developed culturally in the context of health. Self-medication using over the counter drugs, self-moderating intake of oral or injectable medicines, deviating from what was prescribed by doctors or health workers from different systems of medicine or healers etc. would all be examples of how these patterns are evolving with the times. Given the wide prevalence of such practices, self-care needs to be an essential and crucial element in conceptualizing healthcare. Even by WHO’s own admission, while self-care has not received much recognition ‘in this era of high medical technology and medical treatment’, it is an ‘integral part of primary healthcare’ (World Health Organization, 2009). With the advent of digital age and health related information being widely available, acknowledging and engagement with self-care becomes even more necessary.

Self-care can further be nuanced for analytical purposes as those practices which are dependent on regular expert advice and on commercially produced and marketed commodities or ones where one is socialized into these practices as part of their culture, which may or may not require market based resources. This differentiation can be useful as the level of empowerment of persons practicing self-care is different if it has to be dependent on expert advice as compared to knowledge base from cultural practice.

Highlighting the level of self-care in this proposed model has potential for more health technologies and health knowledge being demystified and more health technologies being available at that level. This, however, has the potential danger of over medicalization, but also the promise of more health technologies becoming locally produced and culturally acceptable (appropriate technology) and social control of health technologies will become requirement and demand.

2) Family level care: Family acts as a major location of healthcare decision making, especially in the context of India. When there is illness and suffering then commonly care is provided by immediate family and friends. This care can be in different forms, such as physical therapy involving massages, stretching; nursing care, providing food, medicine and other comforting conditions required for a person suffering from illness; emotional, social, and economic support required to go through the illness experience. For children, individuals with different disabilities, and the elderly, much of the aspects covered under self-care have to be undertaken by the family or friends constituting ‘family care’.

Family care would also bring in an inter-generational knowledge base to individual level ‘self-care’ from elderly/experienced family members and aids the care process with additional knowledge elements, personnel and resources. This knowledge is not just limited to care process of illness but also involves understanding of physiological processes like growth, fertility, pregnancy, birthing and of different determinants and processes of health and ill health, helping in promotion of health and prevention of ill-health. Despite these promises, the family as an institution also reflects the social hierarchies and has its own power dynamics, most commonly with relation to age and gender. These tensions need to be constantly addressed.

3) Community Level Care: There are many health events in human life that require specialized knowledge for assessing, navigating and resolving them. The compilation, systematization and transfer of this specialized knowledge about health has been a process as long as human beings have existed as social beings as it was necessary for their survival and advance. These knowledge processes have been found to be different in different community groups based on their illness experiences, environmental conditions and resources available, social organization, and power dynamics within society. The levels
of expertise of these knowledge holders also have been different, ranging from experts in the community having knowledge and skills to deal with common health problems (e.g. dais), or healers and experts of specific disease condition or group of disease conditions (e.g. poison experts, bone setters), or experts having advanced knowledge of diverse and complicated or rare disease conditions as well (e.g. vaids, hakims and siddhars). Expert knowledge holders for common illnesses and health events have been crucial for survival of communities. Such experts are available in most of the communities except where modern state structures have either banned/criminalized, actively replaced them or made them redundant by giving patronage to any one knowledge system. Some examples of these kinds of experts would be dai, bone setters, herbalists, faith healers etc.

The larger systematization of the practices and knowledge about health and ill health in formal knowledge systems such as ayurveda, homeopathy, sidhha, unani, acupuncture, chinese system of medicine, modern bio-medical system etc leads to advancement of this specialized knowledge. Different health knowledge systems have evolved and continue to thrive in different civilizations. In different historical periods, one or more traditions become the dominant ones, legitimized by the power structures and institutions. Thereby hierarchies are created between different traditions of health knowledge, as we see in the contemporary times from colonial period onwards.

In all these different traditions, there have been integral mechanisms of training and transfer of this specialized knowledge. Those who have gone through this systematic training (be it pre-modern era or in the era of modern state) get designated as experts of health care. Studies show that the folk and the textual systems have developed organically, mutually learning from one another, as in India, China and other Asian countries (Sujatha, 2007). The textual forms allow for easier examination and standardization of the knowledge and practice than in contexts where only folk exists. It may therefore be instructive to see how societies such as Latin America and Africa, where the textual does not exist, are now attempting to revitalize and integrate folk traditions into the mainstream healthcare systems. It is in these societies where folk practices and practitioners are getting more recognition than in India where they have been sidelined for years, by the codified systems which fall under the acronym AYUSH.

At the community level, these folk experts, whether tending to few and basic conditions or providing more comprehensive care, have been available and continue to provide health care to the population, despite delegitimization by the state. It is estimated that there are about a million of such practitioners in India (Shankar, 2015). At times, these community-based healers have arrangements for keeping the patients under observation for short or long duration, if the nature of ailment and care process demands it (e.g. bone setters, spiritual healers, vaids, hakims, amchi and siddhars). The setting may be similar to hospitalization but has its own peculiarities.

The practice of these community healers depend primarily on locally available raw material in the form of different plants and plant products, animal products, metal, and mineral resources and to some extent on raw material procured from market. The sustainable requirement of these raw materials for their practice makes them important stakeholders in conserving village commons (grazing lands, ponds), forests, rivers and environment in general. If given due legitimacy they can act as important catalysts in making people once again value the worth of what is available in their vicinity, the interconnectedness of human, plant and animal health, and help them in conserving the environment.

The state’s recognition of care provided at this level, facilitation through creation of enabling environment and appropriate quality control mechanisms (voluntary certification mechanism with peer assessment and training), will go a long way in addressing communities’ health needs optimally.

B. Institutionalized care

This level comprises all the modern institutions of health care from different systems of medicine with health care professionals, trained in state recognised medical education institutions. We propose that three pronged functions or capacities- technical (for curative, preventive, rehabilitative and palliative services, epidemiological assessment etc.), administrative (for efficient and optimal functioning) and social (for social determinants of health and for intersectoral coordination)- have to be envisaged at each institutional level. Capacity building for technical and administrative functions is well recognized and necessary expert human resources are attempted to be provided for in health care systems. The capacities for social functions of these institutions are usually missing or are not provided for or are expected to be performed by doctors being ‘social physicians’. Experience, however, shows that it has not worked, and, hence, requires special attention. An efficient system at each level/institution requires adequate human resource for these specific responsibilities with relevant training
Health care delivery institutions need to be classified differently depending on extent of infrastructure and resources available, the speciality of services delivered, and the systems of medicine available. These institutions have to be reorganized based on epidemiological rationale, and optimal use of available resources (workforce, money, materials and knowledge). The internal processes of functioning of these institutions (human resource management, Total Quality Management (TQM)/Quality Assessment, patient safety mechanisms, user friendly infrastructure and institutional processes, supply chain and logistics, HMIS etc.) will have to be worked out based on responsiveness to local context, people’s expectations and rational health care. Overlap between felt need, expert assessed need and epidemiological rationality should form the basis for designing of institutions, choice of clinical interventions and relationship between different institutions with optimal utilization of resources.

The institutions, currently classified as secondary and tertiary levels, have undergone significant transformation with wider penetration of technology, availability of expert human resources, and isolated specializations in the institutions themselves, thus making these categories redundant and requiring other ways of classification.

State will have a significant role to play in organizing and regulating this institutional level viz. its existence and nature whether it is in public or private sector. This level of health care should play a crucial role in evolving socially just, ecologically sustainable societies by performing its key and critical role in relieving suffering of people.

Institutionalized care will have the following components.

1) Health care Delivery Institutions

1.1) Outreach services delivery

This component of the institutional level is the closest to the community and acts as its interface with the earlier three levels of non-institutional care (self, family and community level). This interface’s role will be in organizing and oversight of activities of national health programs and assessing and intervening in social determinants of health and health service utilization. This level functions can be performed by the existing PHCs albeit with revitalization and restructuring to perform the role that they were originally conceived for in the Alma Ata declaration. The existing PHCs with medical officer in charge have ended up becoming health centres providing curative services as done at any OPD with other outreach services being managed by ANMs and MPWs now along with ASHA. One way of restoring the social functions of the PHC is by having a designated person for ensuring action on social determinants of health and intersectoral coordination. The technical functions (for curative, epidemiological services among others) will be performed by the medical and paramedical personnel. Depending on the requirement, administrative capacities and skills will also need to be built. As this is the level of interface of the institutional level with the community setting, this institution should be headed by persons with interdisciplinary expertise in social sciences and health, supported by doctor and other required paramedical workers, with their clinical and technical capacities, to ensure health for all sections of that community.

1.2) OPD (outpatient department): This is an institutional component of formally trained practitioners from different systems of medicine, be it in the public or private sector. They usually address simple and common health problems, but at times also managing some serious and life threatening conditions (e.g. snake bite, foreign body in the eye, first aid before referral) and chronic disease conditions. In our country, it is the most common and widely used institution of care. Recognizing the crucial role of this level, countries like UK and Canada have made general practitioners an important component of their service delivery, also entrusting them with gatekeeping functions. The state in our context can explore such possibilities, while regulating and standardizing existing OPD care mostly provided through the private setups.

1.3) Institutions with IPD (In patient department): These consist of wide range of institutions and hospitals with varying bed strengths and expertise from different systems of medicine. It caters to illnesses requiring close and continual observation of the patient under supervision of health care team and advanced interventions like surgery. It also serves the purpose of isolating patients and offering patients required rest for recovery and of administering health care interventions. Similarly, for this level too, state regulation will be crucial. Public system IPD institutions will have to provide care from different systems of medicines, ensuring a wide set of choices to the people. It is assumed that democratic sharing of resources among institutions of health service delivery from different systems of medicine will also help distribute and share the patient burden, while also enriching the healthcare practices through mutual learning.
Institutions of ayurveda, unani, siddha, sowa-rigpa, naturopathy if given roles in production of therapeutic preparations in their own rashalla or dawakhana from locally available resources and raw materials might catalyze change in attitude towards environment and open up possibilities of self-reliance of medical care institutions in therapeutic materials wherever possible through inter-sectoral coordination with agriculture, forests etc. These alternatives might over time reduce burden on and demand from polluting chemical dependent pharmaceutical industry.

Gate keeping mechanism for movement of patients from first contact health care delivery institution to other for specialized care and referrals channels will have to be worked out depending on epidemiological profile and resource availability for rational and efficient use of resources. Rational roles and relationships both within and across different systems of medicine will have to be evolved for diverse contexts.

2) Support Institutions

2.1) District Resource Centres: These centres, already part of recommendations of integrated health systems (Priya and Shweta, 2010) would comprise intersectoral and interdisciplinary team with representatives of formal health care providers, traditional healers and lay people. Their primary responsibility will be to assess knowledge and material resources for health at the level of district, optimize their use, and create enabling environment for the levels of self, family and community care to function optimally. Sharing of knowledge and health related practices across districts with similar ecological and social conditions would help in aggregating knowledge and contribute to systems planning. This institution while dealing with levels of individual, family and community can play an important role of promoting and supporting healthy practices. It can also attempt to explore, along with community, in identifying what are harmful and undesirable health practices from different world views on health and vantage points.

It acts as an intermediary and facilitator for mutual learning and sharing of best practices and knowledge elements across institutional and individual-family-community levels of health care. When it supports the levels of individual, family and community levels, it can promote healthy practices and avoid illness and un-necessary or irrational usage of institutional care and optimize available health resources.

2.2) Health systems research: Health systems research would have to be oriented for research of internal processes of each of the above levels of care and their interlinkages in keeping with the reverse design of core and periphery. Research for mutual learning across different levels and across different systems of knowledge, and for informing other sectors, would require facilitation by reorienting the institutional structures of health research (Priya, 2011).

2.3) Medical research institutions: These would therefore require to engage in integrated research across different systems of medicine for understanding health and disease processes, evolving and experimenting with new modalities of intervention, assessment of health technology and so on, as relevant for all levels of care.

2.4) At the level of the nation and state, institutions and mechanisms will need to be developed for implementing ‘Health in All Policies’ (World Health Organisation, 2014). These institutions should play an important role in evolving mechanism and modalities for public health clearances and regular audit mechanisms for any developmental project, like environmental clearances are required.

The above framework is about translating a conceptualization that addresses the PHC approach and politics of knowledge from a peoples’ perspective into ideas for concrete operational design. As can be seen, it is not only about new institutions, new human resources or technologies. It is about recognizing and engaging with what is there in terms of health practices of people, health knowledge and material resources. It is about an approach in dealing with contextual reality, new institutional processes and arrangements for democratic dialogue among existing and evolving health knowledge and material resources. Highlighting the individual-family-community levels as ‘core’ attempts to bring back focus on bulk of health care practices. This has potential to bring back health promotion and prevention which is not solely about medical technological interventions. It has potential to empower people in intervening in their health and may be in opening up possibilities of addressing social determinants of health and generating pressure for societal action on them. It has potential to make health care delivery institutions more rational, patient centered and care oriented.

It is an attempt at framing of a health care imagination where people are empowered and health care evolves organically in response to local context to preserve, restore and advance health in ecologically sustainable societies. It is not a fully developed model of health care organization design but is an indicative approach which has potential for evolving context-specific health care systems that would be meaningful for the goal of ‘Health for All’.
Starting from peoples’ health related practices and perceptions, engages with individual, family and community level and care seeking practices including institutional care of various systems of medicine whether it is simple or technologically advanced.

**Non-institutionalized care**: self-care, family level care and community level care

**Institutionalized care**:

- **Health care delivery institutions**: outreach service delivery, OPD care, OPD + IPD care ± professional health workforce education and training
- **Health care support institutions**: District Resource Centre, Health systems research institutions, medical research institutions, Regulatory bodies, State and national level public health research institutions, Health governance institutions

Self, family and community level care made core of health care organization as bulk of health practices happen at these levels.

If empowered in appropriate manner has potential to reduce the requirement of sickness care delivered by institutions.

District Resource Centres for documentation, validation and support to local health traditions.

Voluntary certification mechanism with peer assessment and training of traditional community healers.

Codified systems of healing (8 recognized systems consisting of Allopathy and the various AYUSH systems)

Non-codified health knowledge and practices from oral traditions or family texts/script on healing available with traditional community healers like dais, bone setters, herbalists, faith healers etc

Using PHC principles; based on sound epidemiological basis, optimal use of resources; with well-defined relationships between different institutions with objective of providing health for all

**Components Operational Design**

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Role of State

State will have a crucial role in creating enabling circumstances for each of these layers to play their role in the maintenance of health and welfare of the community. At the level of individual and family level care, role of the state will be limited to giving recognition to these levels, highlighting the nature and care process of this crucial level. State can play a facilitatory role at this level by advising and generating information about what are desirable and undesirable practices, disseminating information about recognized best practices and knowledge that can be used at these levels. Promoting holistic understanding health encouraging rational approaches and critical thinking through school level education and other socialization processes.

At the community level, state will have an important role in terms of re-legitimizing the traditional healers, supporting and encouraging peer review assessment within traditional healers, recognizing and rewarding their knowledge and practices after due assessment and evaluation of their value and worth. It would be a very difficult and crucial level for state to deal with, needing utmost care, as too much of intervention, regulation or engagement by the state of the traditional healers at this level has the risk of making them formal or state workers which is undesirable and would be counterproductive. Intervention by the state where they are either seen as superstitions or ignoring them as ritual and cultural practices would mean missing on the tremendous knowledge resource available. The traditional healers and their knowledge is already dwindling at a very rapid pace with advent of state patronized systems of medicine and institutionalized health care delivery. There is tacit recognition of their knowledge bearer status from classical Ayurveda texts like Charak Samhita to pharma industry doing bio-prospecting in search new drug molecules. The state too needs to formally acknowledge them as health knowledge bearers.

At the institutionalized care level, modern institutions enumerated above are product of state patronage and involvement, and state should be an authority in deciding every aspect of this level whether institutions are in public sector or private sector.

Aim should be of complete responsibility of state in funding and providing Institutionalized care. The strategies should be evolved as such. Depending upon nature and extent of existing private sector and public sector in provisioning of health care, the modalities and strategies can be worked out by different societies to reach a goal of health for all.

Conclusion

Health system design, as envisaged in Alma Ata declaration, has service delivery institutions as the core, bringing health to the community situated at the periphery. This gets reflected in the elaborate discussion on institutional levels as primary, secondary and tertiary levels with very limited recognition of community healing practices and resources. Although Alma Ata repeatedly mentioned individual, family and community level care, there was a tendency to collapse these three into primary level of care without detailing any operationalization specifics. While elaborating on institutional service delivery, Alma Ata focused on the primary level of institutional care, without much on the community’s own levels of care. By not elaborating on the secondary and tertiary levels of care and application of PHC approach to them, it created the possibility of interpreting PHC approach as only primary level of care. The intent was however to make this level key in all health related development activities with medical care as one of the functions. Without ‘social physicians’ (Bhore, 1946), over time this institution degenerated into a clinic with limited resources offering medical care, and as a delivery centre for activities of national health programs.

The over emphasis on the institutional health care delivery has made health care unaffordable and over-medicalized, bringing iatrogenesis as an important consequence. This core periphery configuration of the Alma Ata three tier design, needs to be re-imagined, informed by the politics of knowledge approach. This has been attempted in the above model where communities, families and individuals along with their health seeking practices act as core whereas providers and institutions serving the health care requirements of the community are at the periphery. By centering the continuum of individual-family-community and their healthcare practices, this model gives primacy to a bottom up perspective in conceptualising the health system.

However, merely an alternate model of health care organization is not sufficient to restore the spirit of Alma Ata declaration of health for all. There is need for the reorientation of mindset of health system thinkers, health bureaucracy, health policy makers, health service providers, and the community at large. We believe that the recommended model has potential to trigger the change but might not be sufficient in itself. A larger societal thrust towards sustainable and empowering development models and political processes would be conducive for and be strengthened by such a systems design. Institutional ar-
Arrangements that create enabling conditions for the non-institutional levels as well as research institutions that facilitate democratic knowledge management, as suggested in the proposed model, open the possibility for realizing a health system which is for the people, of the people and by the people.

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Notes

*Marginalized majorities* generally refers to the large number of people across the world whose views and interests get marginalized by the much fewer in number global elites and their interests. In the context of political economy and politics of knowledge of health it is applicable to different world views of life, health and illness that have been marginalized to make space for one Cartesian/ anatomical/physiological notion of body and biomedical understanding of health and disease. It also implies the process of marginalisation effected by ‘standards and desirable practices’ defined by the global elite and dominant experts, that have to be followed by all people and imposed on populations in all aspects of health including health services.

References


Priya, R. and Shweta, A.S., 2010. Status and Role of AYUSH and Local Health Traditions under the NRHM.


I write this article driven only by one ideology, one dream – that people are as healthy as possible and when they do fall ill, they can access health care that is affordable and of the best possible quality with minimum barriers. While recognising that drinking water, nutrition, income and inequality are some of the main determinants of health, I limit myself (in this article) to the health system, not because this is the most important, but because this is my area of expertise and this is where I can make any difference. This article is divided into 3 sections: i) what I think an ideal health system should be like, ii) what the current system is like and iii) what I think are some possible steps forward. In sections ii) and iii) I will substantiate my statements with facts (not opinions).

Imagine - an ideal health system

Let me start by describing what life would be like in a country with an ideal health system. The community are aware about healthy life styles and have the means to practice those life styles. However, like anywhere in the world, some people fall sick due to various reasons. The patient can either take care of their own ailments (if it is minor enough) or they can go to the nearest health facility for treatment. This facility is close to the community and is staffed by a health care team that knows the community very well, its social and cultural practices, the economic conditions of individual families and the mental status of individuals. The team provides the necessary care (consultation, diagnostics, medicines and counselling) and sends the patient home. The care is provided in a respectful manner, is culturally appropriate and meets the standards expected. If the patient needs follow up, a staff member from this facility will visit the patient’s home to provide the necessary service and ensure that he/she recovers and is able to get back to ‘normal’ life as soon as possible. If on the other hand, the patient has a condition that requires a little more advanced treatment, e.g. a surgery or an ultra sound scan, then the patient is referred by this team to the nearby referral hospital for further management. Following the treatment, the patient returns to the primary care facility with information on the treatment provided and the follow up that is required to be provided by the primary care facility. In many western European countries, this primary health care facility also has functional links with the local government, with the social service department, with the education department and also with the public works department. Below is the diagrammatic representation of a primary health care system as envisaged by the WHO in 2008.

The current Indian health system

Most of the readers maybe aware of the poor state of the Indian health system where people have little access to quality health care. In fact a recent article in The Lancet shows how 1.9 million South Asians die every year because of poor quality of health care and another 1.0 million die because of the inability to pay for the care. What this article does not capture is the stress that most Indians have to go through when seeking care. Two case studies are described below, one from urban and another from rural area to highlight the current situation.

Seetha is having loose stools. She cannot go to work today as her floor manager at the garment factory will not permit her to visit the toilet.
frequently. What is preoccupying her mind however is – where to go for treatment? She has tried the usual home remedies but none of them have worked. At 9 am none of the private clinics near her PG accommodation is open. She decides to go to the nursing home in Banashankari, her room mate had gone there for an abortion and apparently the place was neat, and the charges were reasonable. Arriving at the nursing home, she was told that the doctor was in the labour room and that she must wait for another hour. Luckily there is a toilet near the waiting area. After 3 more bouts of stools, the doctor arrives, examines her and prescribes a slew of medicines including broad spectrum antibiotics, a couple of vitamins and a tonic. Seetha leaves the nursing home, clutching these medicines but without any advice on more fluids or any ORS. She is not aware that an obstetrician specialised in delivering babies has little competency in treating diarrhoea. By the time she reaches her accommodation, her purse is lighter by about Rs 1500 not to mention the loss of that day’s wage.

Nagamma’s medicines for BP are over. In fact, it has been over for the past 3 days. Normally her son would have picked a few days supply from the local pharmacy in Devesandra, but he has gone to Bengaluru for work. She also doesn’t have any money. She knows that she can get free medicines at the PHC, but only if the doctor is present. There have been times in the past when she walked the 3 kms to the PHC, only to find the doctor away on a meeting or on leave. She had to return empty handed. So, is it worth trudging the 3 km on her arthritic legs or should she wait a couple of days more for her son to return? Normally this would not have preoccupied her; but since yesterday she is feeling dizzy, a sure sign that her BP is high. And she remembers what the doctor told her; if the BP is high, vessels in the brain can explode and then she will become paralysed. She doesn’t want that to happen, who will then look after her? She sighs and picks up her stick and sets out hopefully to the PHC.

There is enough and more evidence that due to a failure of our current government run primary health care system, patients are migrating to the government hospitals or to private clinics.
The NSSO data shows that only 23% of ambulatory care is provided by the government health care services, but a careful reader will also note that 2/3 of this is provided at hospitals and teaching hospitals, not in the PHCs or CHCs. If one looks at the HMIS reports from the government, one finds a similar trend, institutional deliveries are happening more in the hospitals and less in the PHCs. The overcrowded government hospitals are not able to cope with this resulting in poor quality of care, disrespectful behaviour of the staff and unnecessary morbidity and mortality. We boast that while people go to the private for curative services, most of the preventive services are still provided by the government. But a careful reading of the NFHS 4 report shows that only 43% of infants receive the basic immunisation on time. Obviously, our government system is not doing this also too well, three decades after the introduction of the Universal Immunization Program.

The ubiquitous private sector is no better. The private sector is mostly made up of individual doctors who practice dubious medicines as their current source of knowledge is the pharmaceutical industry representative. Jishnu Das showed that the competence of the solo private practitioner was no better than the less than qualified ‘quack’. They rarely have support systems in terms of referral systems or second opinions and practice medicine that is market based rather than knowledge based. They charge on a fee for service basis, which is an automatic incentive to increase the number of unnecessary services.

The usual suspect for this situation is the consistently low allocation of government funds to the health sector. Everybody talks about how our spending has stagnated at around 1% of the GDP, however, this is a wrong measure of our spending. If one looks at the per capita spending over the past two decades, one sees that there is a regular growth in the government spending, at the rate of 20% per annum (base year 2005). While Int$ 61 per person is still very low, there is also the issue of inefficient utilisation of this fund.

The evidence of our inefficient health system is clear when we compare the infant mortality rate of our country with Bangladesh. Our poor neighbour started off at a disadvantage but managed to overtake India on this basic indicator. And that too by spending only Int$ 13 per person per year, compared to our Int$ 61.

There are other issues that we have not investigated deep enough. How can a health system function optimally if its leader, the health secretary, moves to another department every year, if its technical leaders (directorate and district health office) do not have the necessary public health competency, if it has more than 20 channels through which information flows and if it makes uniform plans for the multitude of states and districts? While the usual statement is “what works for Kerala will not work for Kashmir”, I would like to add that “what works for Mysore will not work for Gulbarga”.

And that brings me to the state of our government referral centres. As per the current guidelines, the Community Health Centre (CHC) is the referral centre, 1 per 100,000 population. This means that we need at least 13,400 CHCs to meet the needs of our population. As per the government, we have only 5,624 CHCs, but only 325

![IMR and Per Capita Govt Health Expenditure](source: World Bank Databank (accessed in Dec 2018))
have all the four specialists8. In other words, only 6% of our current CHCs have the capacity to work to their full capacity. When we look at the outputs, then we see that only 2 or 3 CHCs in a district are conducting any C sections. In other words, the other women are either crowding in the district hospital and receiving poor quality of care or are going to the private hospital and selling their land to pay their bills. The third possibility that they may deliver at home and die is very much in evidence in states like UP and Rajasthan where the MMR are 201 and 199 respectively. In a recent study in a district hospital in a southern state we found that the DH hospital had about 8 obstetricians. One of them would be in the OP ‘disposing off’ more than 1000 women between 10am and 1pm, another was in the wards doing the rounds for 300 admitted women while the rest 6 were in the operation theatre conducting caesarean sections. Three staff nurses manage the labour room of a referral centre, all of them coming in rotation from the paediatric ward or the surgical ward every month. All the specialists packed up at 1 pm sharp and left for their private practice, leaving the duty doctor to manage the hospital from 1 pm to 9 am next day. This is the quality of care that our government referral hospital is providing in a ‘developed’ southern state. Is it any wonder that every day in that hospital, there is an average of one neonatal death and god alone knows how many babies born with birth asphyxia and ending up either with cerebral palsy or as slow learners. This is not an isolated situation in one district hospital, it is the norm in most of the district hospitals in the state. However, the Commissioner claimed her inability to take any action against these specialists as they are a rare commodity and any disciplinary action will lead to them going on leave, worsening the situation and inviting political ire.

The way forward?

What do we need to strengthen our health system so that we move towards health for all? One of major steps is to strengthen the primary health care system. Our government has also recognised this and has introduced the concept of “Health & Wellness Centres”9. It talks about a health facility that is close to the people (1 for 5000 population) with professionals who take responsible for their community, have an in-depth knowledge and understanding of this community as well as have the necessary technical competence to treat most conditions. This team is supported with regular supply of quality medicines and diagnostics. However, already this program has run into problems as there are not enough ‘mid-level providers’ to staff the 150,000 HWCs nor are there adequate training centres to fast forward the production of this staff. And here we are only talking about the rural areas, the urban areas will need another 90,000 such HWCs. The government itself admits that it has built only 3000 (2%) of the 150,000 HWCs in the first year10. It only plans to build 15,000 a year, so if India must be covered with comprehensive primary health care, it will take at least another 10 – 15 years. Can we wait so long and watch pregnant women, infants and young adults die unnecessarily every year because of government constraints?

One way out is to purchase primary health care from private providers. In the urban areas, where there is hardly any government facility providing primary health care, the government could appoint private practitioners to provide essential primary health care. The Mohalla Clinics in Delhi was a good beginning till it got caught in political imbroglio11.

Many of the readers will balk at this blasphemy, primary health care by private sector! If one takes an unbiased look at this matter, then one will recognise that most of the high-income countries in the world (socialist or capitalist) purchase primary health care from private practitioners. In most of these countries, the government contracts in private practitioners to provide a specified set of services and in return they are paid either on a fee for service basis or a capitation basis. This includes countries that have some of the best primary health care systems in the world, including the famed UK / NHS model. The map above provides the evidence.

Can we consider this model to cover our urban areas to begin with? The government can identify select private practitioners in each urban ward and invite them to partner with the government in providing primary health care. They would provide ambulatory care, maternal and child health care including routine immunisation, care for patients with diabetes, hypertension, COPD and arthralgia. The other services that they would provide includes counselling, diagnostics and pharmacy services. All these services would be available at times convenient for the local community and in a patient centric manner. Families in the ward would be informed that they can
receive free treatment if they seek care from any one of these practitioners and because the patients will be voting with their feet, the provider will ensure patient satisfaction. This will not only improve access to primary health care for the urban poor but will also substantially reduce out of pocket payments by these vulnerable sections of society. Our study in a ward in Bangalore showed that 16% of the families experienced catastrophic health expenditure due to medical expenses12. More important, this would be a first step in regulating the private sector, as the government can insist on minimum standards, generic medicines and rational therapy, using financing mechanisms as the tool.

Primary health care works well only if it is supported by a good referral system. Evidence both internationally and nationally confirm this model. We are all familiar with the successful PHC stories from Jamkhed, Gadchiroli, Bilaspur, Bissamcuttack, Gudalur, Sittilingi, CINI, etc. One of the common factors is the presence of a strong referral centre that is able to manage the conditions that cannot be managed at the primary health centre level. I still remember a meeting of the Adivasi Sangam leaders in 1989. We were discussing the health program and they were appreciating the fact that many of the children were being immunised and pregnant women were being checked up regularly. We asked their advice on how to increase the immunisation coverage and one of them looked me straight in the eye and told me – “Doctor, it is nice that you are immunising our children and giving the health workers ORS packets. But when our child has breathlessness (pneumonia), then you tell us, go to the government hospital. You abandon us at that time. If you start a hospital then your health care will be complete, our people would get care for simple ailments, but when they have complicated conditions, our hospital will take care of that also.” I learnt the basic truth of health care from the mouths of an illiterate Adivasi and how we (activists / professionals / governments / donors) have been artificially dividing health care into preventive and curative. The people need a health care service that will be able to meet all their needs, preventive, curative and rehabilitative. That is when I realised that this divide between primary care and hospitals, between preventive and curative is created by us elites and makes no sense for the average individual.

It is also a fact that we do not have adequate specialists in the government sector to provide the secondary and tertiary care that is required. For example, in Karnataka, there is just one government hospital that does cardiac surgeries like CABG. Patients from north Karnataka must travel more than 24 hours to avail this hospital’s services. So, can we instead purchase this care from the private sector that already exists? That too at a price that is substantially less than what the government is spending currently on their own hospitals? Evidence from different experiments with government financed health insurance schemes have yielded varied results. In a state like Kerala, where the RSBY is well implemented, nearly 50% of the population was covered under the scheme and the utilisation rate was around 30/1000 insured individuals, the highest in the country. On the other hand, there has been much criticism of the RSBY from other states, where it was poorly implemented.13,14 Similarly, while there has been much criticisms of the ‘tertiary health insurance schemes’ like the Rajiv Arogyashree Scheme,15 Neeraj Sood’s elegant and large study covering nearly 60,000 people shows that the Vajpayee Arogyashree Scheme can im-
prove access to tertiary, protect patients from OOP expenses as well as poor quality of care and finally actually prevent premature mortality.16

For the sake of ideology, should we throw out the baby with the bathwater? While many readers see the private sector as “bad”, I consider the non-performing government sector also as “bad”. Over the past 70 years, the government has not been very successful in making this government health sector work optimally, so why not try this experiment of purchasing the care from the private sector. The bottom line being improved access to care for the people with minimum financial barriers.

Conclusions

It is time that we accept that the government has failed its citizens miserably in the field of health care services and because of this, millions of Indians are dying prematurely. Babies dying because they did not get the right antibiotic, mothers dying because their risk factors were not detected, young males dying because there was no blood to transfuse, young adults dying because their blood sugars or blood pressures were not controlled, women dying of cancer, because there is nobody to do a pap smear. Many others dying because they do not have the luxury of falling sick and taking a day off to seek care or because they do not have the capacity to pay the bills subsequently. Shall we be silent spectators and watch this genocide and ‘hope’ that the government will improve and provide better services in the future? Shall we submit the people to our biases and opinions or shall we use that government money effectively and efficiently to purchase care that the community needs and thereby ‘killing two birds with one stone’: improving access as well as regulating the providers?

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Notes: * The clinician may be a medical officer specialized in Family Medicine, or a general medical officer or a nurse practitioner or a medical assistant, depending on the country.

³Usually the services provided are comprehensive, ranging from treatment of diarrhea to management of an uncomplicated fracture, from treatment of a child with pneumonia to titrating the doses of antihypertensives medicines, from providing birthing services to extracting caries teeth, from providing counselling services for a depressed patient to incising a gluteal abscess, from vaccination of children to provider training and huge quality gaps.

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4. NSSO. *Health in India.* (Government of India, 2017).


6. Das, J. *et al.* In urban and rural India, a standardized patient study showed low levels of provider training and huge quality gaps. *Health Aff.* 31, 2774–84 (2012).


Isn’t it about time we see mental health at the core of ‘Health For All’? Where is health without mental health? True, people have been concerned about mental disorder for a very long time but fear and stigma have persisted to impede efforts at facing and engaging with it. This resource paper gathers relevant developments over the last seventy years or so at global level as well as in India.

**Definitions and Defining Moments**

In 1948, the World Health Organisation defined *Health* as

“... a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity…”

Thus, at the very outset, ‘mental’ was fitted into the space between ‘physical’ and ‘social’. It is only in the last decade or so that at global level one starts to see mental health appear as an urgent health goal and action focus. In health terms, moreover, even social wellbeing hasn’t ever really taken the stage as, under the prodding of global capital, bio-medicine tightens its noose around health and human society.

In 2014, WHO refined the definition of *Mental Health* as:

“... a state of well-being in which individuals can realise their own potential, cope with normal stresses of life, work productively and fruitfully, and contribute to their communities.”

Despite the gesture towards communities this view of mental health roots itself in the experience of individuals, like most other standard definitions for mental health. The idea of ‘individual health’ is a legacy of 18th and 19th century Western clinical medicine. With no disrespect at all to individual experience, we know mental health is determined by a morass of external factors – like political violence, war, economic exclusion, gender discrimination etc. Aren’t these impacting societies worldwide and blasting the illusion of individual human wellbeing? Indeed the spotlight appears to be stuck on individual health since it suits the global capitalist project of creating consumers (or ‘users’).

In the latter half of the 20th century faith arose in a common worldwide thrust towards economic and social development. In that spirit the International Conference on Primary Health Care (ICPHC) was held in 1978 in Alma-Ata, USSR (now Almaty, Kazakhstan). The Declaration of Alma Ata was the first international assertion of the importance of primary health care (PHC) and enunciated the call for ‘Health For All’ by the year 2000, 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 people. ‘Alma Ata’ emerged as a major twentieth century public health milestone.

In 1981, WHO’s former DG Hafdan Mahler defined *Health For All* (HFA) as follows:

“HFA means health is to be brought within reach of everyone in a given country. By ‘health’ is meant a personal state of well being, not just availability of health services but a state that enables a person to lead a socially and economically productive life. (It) implies removal of obstacles like malnutrition, ignorance, contaminated drinking water and unhygienic housing, along with solution of medical problems like lack of doctors, hospital beds, drugs and vaccines.”

Mahler further stressed that HFA means that health is to be seen as

1. **an objective of economic development**, not merely a means of attaining it.
2. demands **literacy for all**, enabling every person to experience what health means.
3. depends on **continued progress in medicine and public health**, making basic medical services available to all, backed by specialised referral and including universal immunisation.
4. calling for **holistic efforts** in agriculture, industry, education, housing, communications, as much as in medicine and public health, requiring new ways of life and fresh opportunities.
5. implies **governments’ commitment** to promote advance of all citizens on a broad front of development and resolution to encourage individual citizens to achieve higher quality in life.

Further Mahler declared…

“HFA is the basis for WHO’s primary health care strategy to promote health, human dignity and enhanced quality of life.”
In 1985, WHO set “HFA by Y2K” as the programming goal that was adopted in the World Health Assembly by the governments of all 195 member countries. Others here in MFC may explain how and why after the year 2000 the pledge of HFA was not renewed and how in its place the Millennium Development Goals (MDGs) were set for the period from 2001 to 2015. Review of performance under the MDGs then led to the framing and acceptance of the Sustainable Development Goals operational from 2016 to 2030. However, it looks like the fight for sustainable development of our planet is a dream without enough support. Now in the 21st century we watch aghast as Western-slanted medical corporations romp to all corners of the earth to convert as many humans into globalised individual ‘users’ and ‘consumers’ as possible, excluding the rest who are left to perish. Even so, let us note that in the 2003 World Health Report the WHO’s Director General at that time, Lee Jong-wook, reaffirmed HFA’s relevance…

‘Health for All’ is not just an ideal but an organizing principle—that everybody needs and is entitled to the highest possible standard of health—a principle that remains indispensable for a coherent vision of global health.”

Today, about fifteen years since that reaffirming statement was made, is indeed a good time for MFC to be revisiting HFA.

(For further chronology, kindly refer to Tables 1 (World) and 2 (India) on pages 36-38.)

Importance of the National Mental Health Programme, 1982

Envisioning mental health care as part of general health care began with the Bhore Committee Report (1946) and continued with the Mudaliar Committee Report (1962) that detailed a plan of district mental health units, school mental health program, training of health personnel and public mental health education. The Srivastava Committee Report (1974) foresaw the village level community health worker programme as including basic mental health care at peripheral level.

NMHP 1982 was significant in its three broad objectives, namely,

- availability/accessibility of minimum MH care for all, esp. vulnerable and underprivileged
- application of MH knowledge in general health care and in social development, and
- community participation in MH services development and effort toward community self-help.

Approaches for implementation were to be: diffusion of MH skills to the health services periphery, appropriate appointment of MH care tasks, equitable and balanced distribution of MH resources, integration of MH care with general health services, and linkage to community development. It gave a framework for planners and health professionals to develop the MH programme for the country. Hence, even though we see mental health action at global level picking up post-2000, in India we need to recall that hard work went on earlier too.

Mental Health Determinants and Range of Conditions

Mental health in human beings is affected at any point of time by diverse groups of factors — psychological, biological, socioeconomic, cultural, political and environmental — and their interactions. Violence with persistent socio-economic pressures, like sexual violence for instance, are known risks to mental health. Rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, physical ill-health and human rights violations all affect mental health in their way. Some psychological and personality traits make people vulnerable to mental health problems, as do biological risks from genes or injury. Climate change already stresses mental health, now understood as a factor in farmers’ suicides. Medical debt, accident sequelae and substance abuse play part as well.

Along the spectrum of mental ill-health conditions the range is great: from autism, intellectual disability, depression, anxiety, substance use, psychosis to dementia and more, especially with neurological conditions and substance addictions. Often one or more of these co-exist in a person. Within our closest social networks probably each of us knows someone affected with a disabling mental challenge. Caregivers bear heavy stress while caring for persons who are mentally ill, and stigma imposes suffering and isolation on the survivors as well as their caregivers, covering up untold hidden suffering, shame, discrimination and abuse of basic human rights.

The Global Burden of Mental Ill-Health

In 1990, as the Global Burden of Disease (GBD) Study began, a new term “Disability-Adjusted Life Years” (DALY) was introduced to combine both mortality and morbidity in a single common metric, enabling comparison of overall health-cum-life expectancy of different countries. DALY is a global measure assigned to a certain disease or disorder, the sum of ‘years lived with disability due to the condition’ plus ‘years of life lost due to it’ in the total population. In other
words, it expresses the disease burden as number of years lost due to ill-health, disability and early death.

According to WHO, nearly 450 million people worldwide (45 crores) are affected by mental, neurological and substance use disorders. The most recent Global Burden of Disease Report of 2017 presents the burden of mental disorders in all world regions. Together these conditions contribute 15% of DALYs in the full global burden of disease (GBD). Of non-communicable diseases, they make up 28%, or more DALYs than cardiovascular disease or cancer. However, estimates suggest that the real contribution of mental disorders to GBD is even higher due to the complex interactions and co-morbidity of physical and mental illness.

Of the top ten global contributors to “years lived with disability” (YLD) worldwide, five are mental disorders: unipolar depression, alcoholism, schizophrenia, bipolar depression and dementia. Among all the people living with health-related disability in the LMICs, these conditions represent nearly 20%. Mental health disorders lead the causes of disability and inability to work, depression topping the list. Suicide, now causes the most deaths in young people with high incidence across all countries. Every year worldwide almost a million people take their own lives. Moreover stigma against people living with mental disability has been found to produce a gap in life expectancy of over 20 years.1

The ‘Treatment Gap’ and Possible, Feasible Interventions

While access to life-transforming care in Europe is 50%, in the LMICs it is beyond the reach of 90%. In developing countries healthcare costs are spiralling and health personnel are increasingly professionalised, of which there is a huge shortage. According to a Ted talk by Vikram Patel, until recently in Zimbabwe there were only 12 psychiatrists, or two for a 9 million rural population; in India there are about 3000 psychiatrists, while according to UK standards there should be 150,000. The financial and infrastructure resources to meet this need would obviously be prohibitive. Dr. Patel argues radically that, in parts of the world where so few mental health professionals are available to meet the enormous needs, spreading out the system of care through ordinary people – using whoever is available in communities and training them to use a range of health care interventions – is the way we should go. It has been done by SEARCH (Abhay Bang and team) for childhood pneumonias.

Three Experiments that focus on treatment of Depression have already yielded results:

1. **Uganda** (Paul Bolton et al.): villagers deliver interpersonal psychotherapy for depression: 90% responded positively compared to 40% in the control group.
2. **Pakistan** (Atif Rahman et al.): LHV used CBT (cognitive behaviour therapy) for mothers with depression, with positive response in 75% compared to 45% in comparable villages.
3. **Goa, India** (V Patel et al.): Sangath’s experiment showed that lay counsellors could deliver 70% positive response alongside 50% response in comparable PHC (primary health centre) settings.

Mental health task-shifting is “fundamentally empowering and provides the ultimate example of democratisation of medical knowledge” (see the BOX). In the journey to HFA we need to involve all, particularly the people affected. Interventions to relieve the distress of mentally challenged persons are broadly three types: social, psychological and medical. The surrounding context and conditions of living determine how interventions can be organized, for example in zones of conflict it can be provided through rescue and relief organisations. According to Dr. Patel, there is growing evidence of efficacious drug and psychological treatments for a range of mental disorders that non-specialist health care workers can deliver effectively through stepped care intervention.

Indian Initiatives in Mental Health outside Government

Varied and diverse non-governmental and autonomous mental health initiatives keep crucially contributing to develop models of extending MH care in urban as well as rural areas, raising MH awareness, providing and monitoring MH services, training health care workers in mental health, working with traditional healers, contributing to research efforts, critiquing MH policy, forming peer groups with persons with mental illness and with caregivers, tackling human rights abuses in institutions and society and so on.

With space limited space to explore them, I

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**SUNDAR: Five key lessons for MH Task-shifting**

- Simplify the messages
- Unpack complex medical interventions
- Deliver it where people are
- Affordable and available human resources
- Re-allocate specialists to train and supervise.

-V Patel and co-workers, Sangath, Goa
can mention just a few of the pioneers across the country from acquaintance or personal experience: Basic Needs India (BNI), The Banyan, Bapu Trust, the Schizophrenia Awareness Association (SAA), and MANAS (Mon Foundation). Along with two other peer ‘survivors’, I was a co-founding member-facilitator in the Sihaya Samooh (Pune) from 1992-1999, succeeded by the self-help group Eklavya under SAA’s umbrella. They are all brave-hearts.

‘Global Mental Health’: Perspective and Critique

The standard international perspective on mental health has been known for some time as “Global Mental Health” (GMH) – it aims to strengthen mental health worldwide by assembling the mental health information of all countries, identifying their specific mental health care needs, and developing cost-effective interventions to meet those needs. The GMH field encompasses research and practice that prioritises improvement and equity in mental health care services. In theory it takes country-specific conditions including cultural differences into account while ascertaining mental health epidemiology, needs, treatment options, education lacunae, aspects of politics and finance, care structures, human resources, and human rights status for each country.

Wikipedia notes a growing body of criticism of the global mental health movement, charges ranging from being a neo-colonial or ‘missionary’ project to providing a front for pharmaceutical companies to expand their markets for psychiatric drugs. Very interesting critiques are to be found in Ethan Watters’ Crazy Like Us: Globalisation of the American Psyche and in Diana Mills’ Decolonising Global Mental Health: Psychiatry of the Majority World as the titles suggest. I highly recommend these books, especially the first one.

So, “isn’t this all part of a plot to support the growth of global drug industries?” Dr. Vikram Patel insists not, reasoning that, “A large body of cross-cultural research and narratives of health workers and people living with mental disorders puts to rest any notion that mental disorders were a figment of western imagination and that imposition of such concepts on ‘traditional’ and ‘holistic’ models of understanding amounts to little more than an exercise in neo-colonialism.”

The Position Today

Vikram Patel’s assessment is that the field of GMH is poised for rapid growth.

1. Funding available from donors who are pledging (DFID, Wellcome Trust); NIMH (USA) distributes over 400 action-oriented research grants nationally and internationally.

2. Academic initiatives: Centre for GMH in London (www.centreforglobalmentalhealth.org);

3. Capacity building: 1) Masters in International MH Policy, Services & Research by University of Lisbon; 2) Grand Challenge in GMH led by NIMH & Global Alliance for Chronic Diseases.

Of course, much remains to be done and advocacy must continue that “mental health isn’t a luxury item on the health agenda of less resourced countries”. It is highly relevant to the management of existing health and development priorities all over the world. Scaling up services can take two distinct paths.

1. Integrating mental health care into the programs already in place for other health conditions is a pragmatic and efficient approach which may require only marginally additional resources; e.g. HIV/AIDS, chronic diseases and maternal and child health.

2. For the most vulnerable with serious, endur- ing and disabling conditions (intellectual disabilities, schizophrenia and dementia) there is urgent need for deinstitutionalisation with provision of acute and continuing care closer to their communities.

More research is a critical need. While essential ingredients of care packages already identified, there remains uncertainty on how to deliver them. There is need to direct attention to implementation science, focusing particularly on interaction between specialist and non-specialist care providers and the extent to which tasks can be shifted, with duration, type and frequency of training and supervision required. Addressing the large treatment gaps in the LMICs is a clear moral and ethical priority. The field will reach maturity only with improved care outcomes and reduced inequities in all world regions and in the many under-served subpopulations in the HICs. Moreover in the globalising world need arises increasingly to address trans-national influences on mental health, such as migration, war conflicts, disasters and impact of global trade policies. Further, knowledge needs to flow both ways between HICs and LMICs. Researching mental disorders and treatments in diverse populations and translating advances in neuroscience to the benefits of patient care are “grand challenges”. Ultimately the search for a better understanding of the causes of mental disorders and affordable and effective treatments and healing is of importance to improving the lives of people living with these disorders in all countries – the ultimate goal of global mental health.
Conclusion

In reading for and preparing this paper over the last two months, my own eyes have opened wide! In these pages I hope MFC friends will find a useful resource to begin their own journeys to grasp the full significance of mental health in Health For All’s rich context. As information is very easily available by relevant online searches, I have given only some specific references in the text or footnotes. All together I hope we can play a part in pushing the vision towards realisation in all lives on planet Earth.

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Notes:
1. Mental Health for All by Involving All, a TED talk by Vikram Patel. ([https://www.youtube.com watch?v=yzm4gpAKrBk](https://www.youtube.com watch?v=yzm4gpAKrBk)).
2. See preceding note.
3. For the moment please forgive me – I’m sure I’ve left out some individuals and groups who skip my mine just now.

Table 1: World Mental Health Policy: Post Millennial Events & Developments

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Lancet’s ‘Call for Action’ to scale up mental health services on twin principles of scientific evidence and human rights... it was soon adopted by WHO as focus of action. Time to Change (UK) to halt mental health-related stigma and discrimination. Movement for Global Mental Health (MGMH) arose as voluntary collaborative coalition committed to closing the treatment gap, with secretariat in Johannesburg, South Africa. WHO’s Mental Health Gap Action Programme (mhGAP) began, to close huge treatment gap.</td>
</tr>
<tr>
<td>2008</td>
<td>EU’s Pact for Mental Health stressed early intervention through education with socio emotional learning and promotion of parenting skills.</td>
</tr>
<tr>
<td>2011</td>
<td>NIMH (USA): National Prevention Strategy including mental and emotional well-being, also stressing better parenting and early intervention.</td>
</tr>
<tr>
<td>2015</td>
<td>Sustainable Development Goals 2016-2030 (SDGs) – including mental health and substance abuse – were passed in the UN General Assembly. 4th Global Mental Health Summit (MGMH) in Mumbai: “Nothing About Us, Without Us - Voices from the Global South”.</td>
</tr>
<tr>
<td>2017</td>
<td>The Lancet named its Commission on Global Mental Health and Sustainable Development. The World Mental Health Atlas 2017 carried latest data of 177 countries on MH governance, financing, human resources, service availability, promotion, prevention and surveillance. The Global Mental Health Peer Network (GMHPN) initiated within MGMH to strengthen mental health care ‘users’ voices worldwide (officially launched at 2018 summit, below).</td>
</tr>
</tbody>
</table>
Notes to table 1

1. Time to Change was formed by UK charity groups MIND and Rethink Mental Illness.

2. The MGMH derived inspiration from the ‘Treatment Action Campaign’ that had achieved worldwide access to drugs for HIV. It is now a broad-based international coalition of over 200 institutions and 10,000 individuals, including persons and families affected by mental health problems, health care providers, activists, decision makers and researchers worldwide. It focuses on the low- and middle-income countries (LMICs) to improve mental health services according to core principles of scientific evidence and human rights. With its secretariat in Johannesburg, South Africa, MGMH is guided by an Advisory Group in accordance with the Movement’s Charter. Through volunteerism and collaboration, the members share ideas, initiate activities and seek resources. MGMH publishes a newsletter and manages a website (www.globalmentalhealth.org).

3. The Commission proposes that the global mental health agenda “be expanded from a focus on reducing the treatment gap to improving the mental health of whole populations and reducing the global burden of mental disorders by addressing gaps in prevention and quality of care.” It outlines a blueprint for action to promote mental wellbeing, prevent mental health problems, and enable recovery from mental disorders.

4. The mhGAP Forum is an annual partnership event that follows World Mental Health Day (10 October) and provides a platform to exchange information and perspectives on implementing the Mental Health Action Plan 2013-2020 and to strengthen collaboration. This time the forum also celebrated the theme of World Mental Health Day 2018, “Young People and Mental Health in a Changing World”. https://www.who.int/mental_health/mhgap/forum_report_2018/en/

Table 2: Key Events in Development of Mental Health Policy and PH in India

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>1912</td>
<td>Indian Lunacy Act 1912, under the British Government.</td>
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<tr>
<td>1946</td>
<td>The Bhore Committee Report, first to envision mental health care within general health care.</td>
</tr>
<tr>
<td>1962</td>
<td>The Mudaliar Committee Report (under Dr. Sushila Nayar’s leadership) detailed a plan of district MH units, school MH programme, health personnel training and public MH education.</td>
</tr>
<tr>
<td>1974</td>
<td>WHO Mental Health Expert Committee Meeting in Addis Ababa, Ethiopia (on “organisation of mental health services in developing countries”) introduced idea of NMHPs.</td>
</tr>
<tr>
<td>1975</td>
<td>The Srivatsava Committee Report, proposed a precursor to the village level community health worker programme which included mental health at the most peripheral health care level.</td>
</tr>
<tr>
<td></td>
<td>GoI initiated the Integrated Child Development Services (ICDS), or Anganwadi Karyakram, with UNICEF + WB funding.</td>
</tr>
<tr>
<td></td>
<td>The WHO seven country exploratory project (“Strategies for Extending Mental Health Care, 1975-1981” was launched in Brazil, Colombia, Egypt, India, Philippines, Senegal and Sudan.</td>
</tr>
<tr>
<td>1977</td>
<td>The National CHW Scheme (Rashtriya Swasthya Rakshak Yojana) was initiated to provide basic health care in villages across the country.</td>
</tr>
<tr>
<td>1979</td>
<td>WHO Mental Health Advisory Group Meeting in Manila, Philippines, in which a formal resolution was passed urging all Member States to develop National MH Programmes.</td>
</tr>
</tbody>
</table>
1980 | **Indian NMHP Working Group** met several times with funds from WHO-SEARO, New Delhi.

1981 | The **Draft NMHP** was readied in a crucial 3-day working meeting in Lucknow in February. **1st National Workshop**, New Delhi: about 70 leading Indian MH professionals met for two days in July to consider the draft NMHP, discussing it in detail chapter by chapter. The revised document then went for further consideration of the MoH&FW.

1982 | In August, **2nd National Workshop** was held prior to and in tandem with the biennial meeting of the Central Council of H&FW, attended by all State Health Ministers, two weeks later. The resolution to start the NMHP 1982 was unanimously adopted in the CCH&FW meeting. NHPs were released in 1983 and 2002

1983 | India’s (**1st National Health Policy 1983** …

1987 | (New mental health legislation said to have been enacted, but details/significance not found).

2005 | **National Rural Health Mission** launched, with ASHA workers, a new CHW cadre.


2017 | **National Health Policy 2017** (India’s (**3rd**), approved by the Union Cabinet, called for focus on non-communicable diseases, emergence of ‘robust healthcare industry’, catastrophic expenditure due to health care costs and economic growth to enhance fiscal capacity.

2018 | Indian Government’s participation in **2nd Global Conference on PHC** in Kazakhstan.

**Notes to Table 2**: 1. The information in this BOX is drawn almost entirely from: N N Wig and R Srinivas Murthy (2015). The birth of a national mental health program for India. Indian J Psychiatry 57(3): 315-319. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623656/. The senior author (Wig) has been part all WHO-level MH events and developments from 1974 onwards.

2. As India’s first CHW programme, through ICDS two local village women (anganwadi ‘worker’ and ‘helper’) were selected, trained and monitored to provide antenatal and postnatal care; the programme functions fully to date.

3. Experiences of the Bengaluru (NIMHANS) and Chandigarh (PGI) psychiatric centres provided technical support to decentralise and deprofessionalise MH care. The studies revealed large numbers without essential mental health care and impacts on ill persons, families and communities; further they demonstrated the feasibility of integrating MH care with general health care; the two centres prepared training tools and manuals – all providing background to developing NMHP 1982.

4. In a few years ~ 400,000 swasthya rakshak (male CHWs) were in position across India, but the scheme was left to fizzle out.

5. At this workshop, as expected there was not total unanimity on various provisions. While almost everybody favoured the national initiative, sharp differences arose on the model to be adopted for extension of MH care to the total country.

• Some senior professionals insisted that all MH care should occur directly through psychiatrists only, fearing dilution of psychiatry’s importance if other personnel start to treat patients with drugs.

• Others were in line with the working group’s thinking of extending MH services through the existing primary health network by training general doctors and health workers to recognise and treat common mental disorders, feeling equally strongly that provision of at least minimum essential MH services to the majority demanded the PHC approach.

The choice was between ideal psychiatric care for a limited urban few and essential services for both serious and common MH disorders for the vast rural and urban majority. The experiences of both Bengaluru and Chandigarh centres to integrate mental health care with general health care supported the latter approach as feasible and useful. Ultimately consensus favoured the 2nd alternative.

6. More selective than the first workshop (1 year earlier), the participants comprised leading psychiatrists, clinical psychologists and sociologists of India, representatives of DHS, ICMR, Indian Medical Council, WHO, SEARO, NIMHANS, IMA, and Ministries of H&FW and Labour, Planning Commission, UGC etc.

7. Based on NMHP 1982’s premise of integrating MH care within the PHC approach so those in need can be identified, referred and followed up “with medication and telemedicine linkages”.

8. Otherwise, the NHP 2017’s goal is ‘to achieve the highest possible level of good health and well-being for all Indians through preventive and promotive healthcare orientation in all developmental policies, and to achieve universal access to good quality health care services without anyone having to face financial hardship as a consequence.’ (italics are mine)

9. A recent issue of Airports INDIA (Dec 2018), AAI’s magazine for air travellers, features an article that reports this 2nd Global PHC conference from the viewpoint of the Indian Government participants, including Minister of Health Shri J.P. Nadda. Entitled ‘Primary Health Care’, it is further headlined: ‘Achieving Universal Health Coverage is a major area of focus of the global health community, with Primary Health Care as a foundation of these efforts’. While worthwhile to note stated Government position, it is little more than politically correct, shallow government propaganda tailored for the elite class.
Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

WHO, 1948

Abstract

1948, the World Health Organisation standardises the health by defining it comprehensively. But, gradually the extensiveness of definition confined to marginal population due to increasing life expectancy, mortality burden shift from acute to chronic diseases. Furthermore, inbuilt limitation of definition such as the overlooked aspect of quality of life in terms of rehabilitation and productivity which is adding value to individual life and society.

Key words: Health, redefinition of health, WHO

The case study

The story of 49-year-old Mr Subodh is a seismic instance of the unpredictability of life, but the bravery he showed and the struggle he underwent to overcome that situation equate an expedition to the summit of Mount Everest.

Five years ago a road traffic accident stole the treasure of normal healthy life status from Subodh’s life. He was solely responsible for his family household’s financial freedom. The accident uprooted his whole life and threw him on bed number 2280 as his new identity, along with numerous unpleasant and unexpected changes. His ambulatory state suddenly converted to bedridden, 100% dependent on others even for ablutions and restricted movement either onto a stretcher or wheelchair. This incident left him in an unbearable never-ending dream. All he knew about himself was that he was paralysed due to a complete spinal injury at T4-T5 and wouldn’t be back on his feet in this lifetime. Gradually he encountered the other truths of his new life which were hardest to believe. In the first few months in the hospital, he was silent and in denial. Then he decided to accept the truth, to make progress, to take a leap, as an example for his new peers.

Now, five years after that incident, Subodh is a full-time working professional. He has rehabilitated himself back into his previous life with limited capacity but new capabilities. He accepted the tough challenges thrown up by his life as opportunities and is now living happily. This new life is not simple. There are lots of variations and adaptations, trivial and crucial which makes his activities of the daily living troublesome task, but he has adjusted and is doing his best to avoid dependency on others.

Now the question comes up: Can Subodh be covered under the definition of health proposed by the World health organisation (WHO)?

Subodh now considers himself healthy. Despite his remaining disability from the accident, he is doing well physically (with new special capabilities), mentally, socially and economically. Moreover, he is happy and enjoying the quality of life.

Another question; is Subodh in a complete state of health? People think of him and see him as disabled, but he feels that he is especially abled now. He is more conscious and aware of his health and he manages it better now. Subodh is an example representing 15% world population (as per world bank data) suffering from one or another disability and fighting to be fitted into the WHO’s most widely quoted definition of health, as enshrined into its constitution in 1948. Similarly, new buzz to the healthcare system is also contributing a huge burden of the population suffering from one or many chronic diseases (approx. 45% as per world health report 2002). Therefore, the part of the population which is being categorised under disabilities and chronic diseases cannot be fitted under the existing definition of health despite their best of adaptability, adjustability and productivity.

Robustness of WHO definition

When WHO enshrined this definition into its founding constitution in 1948, it was not only ground-breaking and thought-provoking, it also set the ambitious goal for the health care system. It breached traditional narrow thinking about health by asserting that ‘health is not merely the absence of disease’ and increased the scope of health enormously to touch the physical, mental and social aspects, thereby gifting us a broader vision of health that all of us are enjoying today. The WHO definition helped to revolutionise world health culture. The concept of disease prevention is also the result of this health definition, which compels the healthcare system to proactively combat future challenges. Hence, we can say a visionary approach to opt for an aspiring definition of health was a great achievement of the WHO, it was a milestone and turning point in the history of health care.

Limitation of WHO definition

The WHO definition was proposed with two aims, firstly to broaden the concept of health beyond the mere absence of disease, and secondly to hold up the idea of ‘attainable health for all’. With traditional definition we have achieved the
The word complete give the essence of the measurable verb and measurable outcome is a mandatory parameter to analyse the quality, therefore, health needs to be quantified. Furthermore, the complete term contributes towards unintentional medicalisation of the society, subsequently, to achieving the complete state of health in today’s scenario is challenging and leaving all of us unhealthy. Therefore, researchers and the public health fraternity have been criticising this definition since its inception.

In the first half of the twentieth century (the 1940s and ‘50s) the health ecosystem was in a vulnerable state due to high mortality and low life expectancy, especially from acute communicable diseases. Therefore, subconsciously, the definition of health endorsed state-of-art management of acute diseases and developed a robust acute health care system for the world. But a paradigm shift in the population, life expectancy and pattern of diseases has accentuated the need to amend the accepted traditional definition of the health once again. Therefore, the Ottawa Charter for Health Promotion affirms social, economic and environmental aspects of ‘health’. This document extends the scope of health by incorporating the satisfaction of necessities and adaptability to the environment. Moreover, it makes the definition comprehensive and applicable to a larger population.

The absence of health determinants such as quality of life (QOL) which is adding value to the individual life, rehabilitation and economic components have made health a government affair and burden on legislative authorities. QOL and adaptability are two imperative components, playing a vital role in the productivity from the people perspective. Consequently, this could be another reason that health, despite being an individual right and a shared responsibility, could not engage people actively. The impact of the definition can also be seen in national health policy development and therefore a comprehensive, visionary and prospective definition is a dire need for reformation of today’s health care system. The inclusion of the productive or economic part in the health definition will change the concept of the health budget from spending to the investment for the growth of the Nation’s economy.

Conclusion:

The unpredictability of life makes the planning process intricate and perhaps ultimately futile, but adaptability is the unlocking key for that. As per Darwin’s theory adaptability is a chief characteristic of human beings for revolution and sustenance. Facing and overcoming the worst faces of life as a warrior and becoming exemplary is a direct showcase of mental health.

Hence, the definition of health proposed by WHO needs renovation, otherwise it represents only a marginal portion of the world population and will lose its purpose of being comprehensive, visionary and futuristic.

The definition of health is fundamental to the development of any health plan and it directly influences health policy. We could make 70 years of successful journey of health revolution due to the visionary definition and adopting challenging goals in 1948. Health is dynamic in nature and that makes it different from great art. We can appreciate the painting of ‘Mona Lisa’ even after 100 years without a single suggestion for improvement. But health care develops through evidence-based practice which requires regular upgrading and renovation to match the pace of the world and its changing environment.

It is time we introduce a dynamic, inclusive and futuristic renovation in the definition of health to give affirmation to the life achievements of people like Subodh and better guidance to policymakers. The anticipatory renovation in the definition should include the following aspect: firstly, promoting health as a human right as well as a shared responsibility. The involvement of the public perception about health will share the responsibility of health between the government and the public thereby they will engage actively to obtain attainable health. Rehabilitation and productivity are the other two important aspects which again makes the definition personalised as well as the national agenda, as a result, policy maker and budgetary authorities will be intended to invest in health budget more as an investment for the Nation’s economic growth rather than spending on health.

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References:

Community women’s idea of health

YK Sandhya

What do women from marginalised communities think about health? This is a question that is often neglected, although today, more than ever before there is talk at global and national level of ‘people centric’ approaches and of ‘leaving no one behind’. There are increasing number of targets set (first it was the Millennium Development Goals [MDGs] and now it is the Sustainable Development Goals [SDGs]) which has led to competition between middle income nations to outshine their neighbours. Indian officials, for instance, were most unhappy when it was revealed that the maternal mortality rate of Bangladesh was better than India! But in all this anxiety to meet national and global goals and to portray India in a positive light at global platforms, are the concerns of women living in rural areas and from marginalised communities being lost? Do policymakers, health officials and providers even know what these women want, what their ideas of health are?

SAHAYOG in its long journey in working with women from marginalised communities in Uttar Pradesh since being set up in 1992, has held conversations with the women to understand their ideas around health. Discussions with women held over the years revealed that pregnancy was treated as a natural process, something that women had been doing for generations and that did not require any special treatment. As one woman who had delivered five children at home remarked “A woman must continue doing her normal every day work even when she is pregnant. Women who work and remain fit have an easy delivery.” The entire process of delivery, as perceived by women is natural, requiring no intervention at all.

Initially, in our conversations with the women, we found that ill health, especially maternal deaths were attributed to the woman’s destiny and there was a sense of fatalism among the women and maternal deaths were considered God’s Will. There was a belief that complications and death, if they have to occur, will occur anyway and nothing can really be done to stop them. This kind of understanding of women has informed the way in which health officials tend to treat women, viewing them as being ‘irrational’ and therefore not reaching hospitals at all, or not reaching it in time. We have also found that health officials have used this to cover up their own and the system’s failures and shortcomings, thereby escaping from being held accountable for their actions/inaction. For instance in a case of death of a woman in Varanasi district, Uttar Pradesh, in 2017, following sterilization, the doctor who had performed the surgery said, “the woman died of a heart attack and not due to the sterilization procedure”, while the Medical Superintendent of the Community Health Centre told the mother-in-law, “no one is to be blamed except her fate, who can avoid what was destined”, thus washing their hands off the business. With the coming of the MDGs, the Government of India and in turn the health system has further perpetuated the global health perspective (that if all women put themselves in the hands of an obstetrician in time, none of them would need to die), by locating the problem with “poor pregnant women” rather than with its own crumbling health system plagued by under-investment and poor management. As the person who needed to be ‘governed’, the benevolent state offered the poor pregnant uninformed woman a potentially life-saving option if she could meet a rigid standard of ‘good behaviour’, which was reaching the hospital “on time” during labour. However, if she failed to conform to this carefully-defined governmental standard of behaviour for any reason, the state did not take responsibility to ensure her safety: she then deserved to be at risk of maternal death.

However, after SAHAYOG began organising these marginalised women (Dalits, Tribals, Muslims and rural poor) in 10 districts of Uttar Pradesh into a grassroot organisation called the Mahila Swasthya Adhikar Manch (MSAM) in 2006, the idea of health as a right took root in the minds of the women. Women began to analyze cases of maternal death, negligence and abusive behaviour to identify system failures that had lead to the death. They were now able to identify systemic issues such as the dilapidated state of health services, the unethical and often abusive attitudes of the health providers, the costs incurred in seeking skilled care, lack of roads and regular public transportation, as being critical factors causing maternal deaths. The women also began to recognize that the very basic requirements for a safe pregnancy and delivery include a number of socio-economic determinants such as the cost involved not just in transportation while accessing services during pregnancy but also the costs associated with consulting a doctor. The problem of poverty which forces a choice between food and seeking care and the issue of nutrition which resulted in complications such as anaemia was also pointed out as being a major determinant in a woman’s health status.
These considerations influenced the decision of whom to approach in times of need; should one spend substantial sums of money to travel to the nearest health facility or should one seek treatment from traditional birth attendants or informal providers who are cheaper and readily accessible. Poverty was also cited as a reason for women not being able to get adequate amounts of rest which resulted in complications during pregnancy.

As part of an action research carried out by SAHAYOG, interviews and focused group discussions were conducted with MSAM leaders of Muzaffarnagar and Chitrakoot in 2009 to understand their perceptions of maternal health, among other issues. In the absence of these basics, women are often forced to forgo antenatal care. This point was reiterated by a woman from Muzaffarnagar, who said that, for poor women maternal health was all about going to a dai when in pain, as a visit to the doctor would mean spending money on medicines, which could have been spent on food instead. She further added that it was only the better off who could afford to think about maternal health. Another woman from Chitrakoot felt that the main problem associated with maternal health was the fact that women had huge work burdens; they had to work at home and in the fields; women only went to the hospitals when they had a complication. Another woman from Muzaffarnagar stated that the main problem associated with maternal health was that women suffered from general weakness as well as pains in various parts of their body. In contrast four women from Chitrakoot felt that the main problem was that of transportation and the costs associated with it given that hospitals were far away and there were no proper transport facilities available. One of the women mentioned that in the absence of a health facility close by, they had to go to facilities that were far away which took time and was expensive as transportation was hard to come by; hence they often had to rely on bicycles to transport the women. Explaining further, another woman added that in cases of complications the absence of transportation became a critical factor; the distance of the hospital and the lack of transportation meant that pregnant women had to walk 4kms before being able to find some transportation that would take them to the hospital.

The presence or indeed the absence of providers was seen as another factor which influenced the provision and seeking of care. Women linked ANC to maternal health and on being asked about their understanding of maternal health talked either about fact that ANC that was available or the lack of it. As a woman stated, a good doctor and a well-run facility (like Purkazi in Muzaffarnagar in 2009) ensured that the condition of maternal health in their area was good and there were no problems as women were well cared for. She narrated an incident where a woman who was being taken to the PHC in a tractor, delivered en route. The child’s head was very big, and his eyes were protruding. The doctors at the hospital took great care of them and although the child died, they could save the woman. However, another woman felt that the problems associated with maternal health was the absence of dais in villages; according to her, dais had been the first line of contact and in their absence women had to entirely depend on the health system which was not always dependable. Narrating an incident, she said that after reaching the health centre in Purkazi, they found the two ANMs asleep and reluctant to get up and attend to the patient. Finally, it was a dai who helped to deliver the baby.

The development of this critical thinking has enabled women to clearly articulate their expectations from the health system; and foremost among this was respectful treatment at the hands of health providers. They wanted providers to talk to the women and encourage the women to describe the problems they faced. They also wanted a system that took care of the complications without shunting the women around and without forcing them to spend huge amounts of money. Until such time that this should happen, the MSAM women leaders are ready to continue with demanding for accountability and improvements in the provisioning of maternal health services in Uttar Pradesh. As a woman from Muzaffarnagar mentioned, “It was no longer possible to hoodwink us and we are ready to challenge people like the chemist outside the hospital who made a huge bill for the medicines we were asked to buy.” The interrogation revealed that he was trying to cheat them out of their money. Another woman from Chitrakoot mentioned that as a result of her association with the MSAM, she no longer feared government officials, “I can go to the medical officer and to the CMO also to demand for what is rightfully ours”.

To conclude, dramatic shifts towards institutionalized accountability that was envisioned in conventional human rights frameworks, have not taken place. But the small local changes in power relations and negotiations between the MSAM women as users of public health services and their providers and health managers are also significant markers. We are hopeful that these indicate the slow movement towards greater agency among poor, non-literate women, who were only meant to be the passive ‘beneficiaries’ of the various developmental programmes.

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Public Health Nursing: Contemplation from Joseph Bhore to NRHM
Mansingh Jat, Bhawna Arora, Roopa Rawat, Santosh Mahindrakar

Abstract

The United Nations summit was held in September 2015 in New York for the adoption of post-2015 goals. The strategies to achieve the Sustainable Development Goals (SDG) are a buzz for discussion in majority of the fora. Availability, recruitment, skills, distribution, and retention of the health workforce is the major issue to attain any of the health goals. Nurses, a major health workforce of the health system are well recognized in the western world but their skills and expertise are not acknowledged adequately in our own country. There are a series of promises in the Committees and in health plans to strengthen the nursing workforce but how best they were executed needs to be analyzed. Hence, the objective of this paper is to analyze Bhore’s vision of the Public Health Nursing concept via a series of committees and health plans. A systematic review of the entire committee and health plan was adopted to achieve the objective.

Keywords: Public Health Nurse, Health Workforce, Nurses, Nursing

Public Contemplation from Joseph Bhore to NRHM

On the eve of International Nurses Day, the International Nursing Council observed 12th May 2017 with a discussion of the theme “Nurses - A Voice to lead achieving the SDG (sic)”. In any state, the major health workforce in its given settings is of the Nursing professionals (Cometto et al., 2013). This profession is well recognized in western countries: they perform their skill in varied capacities, even as Independent Nurse Practitioners and Nurse Specialists. In India, Nursing professional education was delivered through trainings for Auxiliary Nurse Midwife (ANM with a training of 1 year 6 months), Diploma Nursing (with 3 year 6 months), B.Sc Nursing (of 4 years duration), M.Sc Nursing (of 2 years duration), and PhD in Nursing. All these health work force personnel get registered under their respective state’s nursing councils. Except ANM all others are recognised as Registered Nurses. There were many promises assured in policy papers to strengthen the health systems by developing the nursing workforce, but in practice it was a mirage. The present paper analyses development of nursing profession in India through various health committee and other health reports.

Introduction

The aftermath of the Second World War was evident in the poor health and nutritional status of most countries. The state of public health in British India was low as was evidenced by the wide prevalence of diseases and the consequent high rates of mortality (Crude Death Rate was 22.4 and Infant Mortality Rate 162 per 1000 live births in 1941) in the community as a whole, and in particular among such vulnerable groups as children and women in reproductive age period (Bhore Committee 1946). India, reeling under the pressures of the colonial rule, was struggling with misery and poverty coupled with inadequate food and illness when the Planning Commission began to look into these issues so as to ensure the minimizing of barriers in development. Thus, came the series of sub-committees in the early years to the first decade of the 20th century.

Health care, particularly in rural areas is laden with the triple burden of communicable and non-communicable diseases and of nutrition problems. Housing condition, education and economic status, gender disparity, health culture, health services availability and accessibility also pose as barriers for access to rural health service. From Bhore Committee (1946) to the 12th five year plan (2012-2017), health workforce especially in rural areas has remained an unresolved issue so adequate health manpower in India is a mirage.

Bhore committee, brought about a comprehensive health report in the history of Indian in 1946. It recommended a long term optimistic, holistic health service system for the both rural and urban parts of India. As a short-term goal, the committee has recommended the provision of socially oriented, skilled mixed health care team in both institution and domiciliary services for every 40,000 population. In domiciliary services, it specifies one doctor, four public health nurses and four auxiliary nurse midwives. This Committee recommended a planned public health nurse cadre which was envisaged to meet the comprehensive health needs of the country at the domiciliary level.
Bhore committee’s concept of public health nursing.

Health Survey and Development Committee was formed in 1943. It gave its comprehensive report in four volumes in 1946. The Committee reviewed the status of health and its role as a factor in development. In doing so, it also revived the then nursing profession and recommended the concept of public health nursing for both domiciliary and institutional care.

Public health nursing was envisaged to include all nursing services organized by a community or an agency to assist in carrying out any or all phases of public health programme. Services were to be rendered on an individual, family or community basis in home, school, clinic or business establishment. Thus Public Health Nurses’ main function would be Maternal and Child Welfare, school health and tuberculosis related work.

In 1946 there were 750-800 health visitors serving the British India, among them very few were registered nurses, and others were certified midwives with 9-18 months of training in the duties of health visitors. Their work was entirely limited to maternal and child welfare (MCW) and maternity supervision where they trained and supervised Dais who assisted child birth at home. They were certified nurses with minimum training programme. Therefore the Committee recommended replacing them by fully qualified individual nurses called Public Health Nurses (PHN). However till this cadre was ready, health visitors would be deputed for higher studies and can function as public health nurses. These cadre personnel were entrusted with the following responsibilities:

1. Assist in analyzing health problems and related social problems of families and individuals; help them use the community resources to formulate an acceptable plan for the protection and promotion of their health, and to encourage them to carry out the plan.

2. Helping to secure early diagnosis and treatment for sick

3. Rendering nursing care of the sick, teaching through demonstration and supervisory care given by relatives and attenders

4. Assisting families to carryout medical, sanitary and social procedures to prevent disease and promote health.

5. Helping to secure adjustment of social condition which affects health.

6. Influence the community to develop public health facilities through participation in appropriate channels of community education for the promotion of a sound adequate community health programme and shares in community action leading to betterment of health condition.

Public Health Nurse was envisaged to earn the position of a “family friend” and one to whom the family will turn to, during their troubles. She becomes in fact the “minister of health” in the home.

As regard to educational qualification, PHN would be a fully qualified nurse and midwife with 4-5 years of teaching and a practical exposure to Indian situation. The content of the course should be a balanced integration of classroom instruction in science, art of nursing/caring and social sciences and to be taught in the place where we have medical college and nursing college with higher education facility.

Sideling or deskilling of public health nursing theory and practice

However, the positive intent of the Bhore’s committee could not sustain the political and professional pressure of the times. The coming years saw a gradual deskilling of PHNs. First five year plan adopted the recommendations of the Bhore committee and specified that two colleges who were present will inculcate in their curricula (First Five Year plan, 1951). In the second and third five-year plans, the same was considered but more emphasis was given to capacitate health visitors to take up this position. There were also plans for a higher training of health visitors/public health nurses in Indian Institute of Public Health and Hygiene, Kolkata. The Shetty Committee (1954), and the High Power Committee (1990) both recommended the public health nurse by supporting Bhore’s PHN concept. Mudaliar Committee (1961) reviewed the decade progress after the Bhore’s Committee and revealed that there were only two college of nursing in 1959 in the country. This committee recommended for the five-year nursing degree course where the public health and midwifery course, both would be included and they would replace the health visitors in the coming future. The same would be adopted in the fourth Five Year Plan. Mudaliar Committee recommended PHN, and ANMs at subcentre level (Annexure 2). Pubmed provided a rich source of information on the concept of public health nurses, during 60s and 70s and about mid
80s too. Ample literature on PHN in mental health, schools, industries, etc is available. But from the second half of the 1980’s there is no literature available and it’s unfortunate that there were no attempts to enhance the College Of Nursing which was planned to bring out this cadre of health professionals.

During the 1970s, many developing and developed countries were experimenting with auxiliary health workers model. The most popular was “bare foot doctors” in China. India also stepped into their shoes, by manoeuvring policies to steer up an auxiliary health force. India had two committees i.e., Mukherjee Committee (1965) and Kartar Singh Committee (1973) which reframed curriculum, eligibility criteria and responsibilities. Srivastava Committee (1975) recommended for Reorientation of Medical Education (ROME) and proposed village health guide scheme. These volunteer health workers were the certified health worker on part time basis to act as a liaison between health services and community. But down the line the promotion, capacitating or empowerment of these workers was over and done.

The subsequent Five-Year Plans expressed shift towards building infrastructure (especially in 5th FYP and under NRHM) and raising health manpower. A shift was evident from qualified health workers to auxiliary or volunteer health workers. This lead to the shifting the home based comprehensive care to institutional based curative health services. Relevance of “safe delivery” too moved to “institutional delivery” effortlessly.

It was mentioned in all the policy documents at national and international level that auxiliary health workers should be under the supervision of the qualified health workers. In India’s health care delivery system auxiliary nurse midwives are located at the subcentre and they need to carry out home visits. Auxiliary health workers are supervised by a lady health visitor who is posted in the Primary Health Centre. In a real scenario, neither were there any efforts to empower lady health visitors (LHV) professionally, nor were auxiliary health personnel provided adequate These domiciliary health workers were burdened with the heavy reporting and recording work (Mavalankar, Vora 2006). Under the flagship program: National Rural Health Mission (NRHM), Accredited Social Health Activist (ASHA) is a new cadre of social worker with the 22 days of training programme. ASHA has a motto to provide the health facility information to the family members. However, given their socio-demographic characteristics their effectiveness to provide the comprehensive health care service at the door step need to be evaluated and revisited.

After more than six decades there is a plethora of health workers at community level (ASHA, ANM, Anganwadi worker, Male Health Worker, Health Visitor, Physician Assistant, Nurse Practitioner, etc. Added to this list are the recent most programmes of Bachelor of Rural Medicine and Surgery and B.Sc Public Health, which are expected to produce yet another cadre. The notion of PHN envisaged by Bhore Committee remains a mirage.

21st century Nursing: Optimization for public health nurse

Comparing the broader concept of PHN and BRMS/B.Sc we find that public health nursing (3.5 yr diploma, 4 yr degree and M.Sc Community Health Nursing) is the only curriculum which fulfills the criteria of PHN (annexure 1). Nursing curriculum is an amalgamation of sciences, art of care, sociology and of behavioural sciences with a well-tailored theory and a rich hand in practice. Nursing degree course has had midwifery theory classes in third year (90 hours) and community health theory in second and fourth year (180 hours). In total, including the internship programme, total hands-on experience was 600 and 465 hours in midwifery and community health theory in second and fourth year (180 hours). In total, including the internship programme, total hands-on experience was 600 and 465 hours in midwifery and community health respectively. Nursing students have to carry out minimum specified midwifery procedure in assistance and independently. Nursing training includes home visit and survey in both rural and urban area. This includes home visit, social mapping, carrying out various diagnostic procedure, individual health education and group health education. Among Bachelors level health course, nursing graduates are the only one who had trained in areas of psychiatry and de-addiction with 365 hours in the third year of internship. This hands-on experience is getting depleted due to inadequate opportunity to practice. If we consider the M.Sc. Community Health Nursing, in total two years they have more than 365 days of hands on experience in various level of community programme.

The twenty-first century came with hope and a great scope for nursing by advertising the need of 2.2 million nurses in USA alone (National Center For Health Workforce Analysis, 2002). In India, the 10th and 11th Five-Year Plan focusing on the advanced nurse practitioner course for post
graduate students specially in a clinical setting. But these programmes did not consider the community health nursing specialist. There was an upsurge of nursing institutions which had two dimensional growth, a) comparatively usual in south Indian states [Karnataka where out of 294 nursing colleges, 227 were established during 2003-2005 (“Task force against sanctioning new nursing colleges,” 2006)] opened the degree colleges, and b) some states focused auxiliary health workers as their strength of manpower (Maharashtra, Chhattisgarh). Within a short span of time how did these institutes get the permission? Was there enough trained faculty to teach and supervise? Who are the game players? These are the genuine questions need to be answered.

Study on Nursing and Midwifery in India:
A Critical Review by National Institute Of Health And Family Welfare in collaboration with World Health Organization (2012) reveals that there are 3291 ANM training centres, 5251 GNM schools, and 2449 colleges of current nursing B.Sc.) and 405 college running M.Sc. nursing courses with various specialties. Among these, only 14% ANM training centres, 7% GNM schools, and 3% B.Sc. nursing colleges were government institutes. Staff nurses salary was 4600/- per month, which is Rs 200/- more than for ANMs and Rs 200/- less than a Lady Health Visitor and there are a large numbers of human resource issues related to training, faculty and clinical.

Only a small share of this huge upsurge of nursing professionals that occurred in this institution was accommodated in government institutions. Most were absorbed into private institutions which did not have a good working environment. In a majority of the states (except in West Bengal and Tamil Nadu) registered nurses in the sector are mostly working at all levels of care centres (PHC, CHC and other hospital) as a staff nurse and not as public health nurse. In a few years, the recession in the European countries has reduced the Indian nurse migration and supplemented the growth of professionals in India.

This huge accumulation of manpower has reduced their demand in the health market and is forcing them to shift in other courses and professions like health administration, management, call centres, banking and finance. This is a huge loss of qualified health manpower. It is all the more felt when the expenditure has been incurred in training them. This is fatal for a country like India which has a long way to go on the health road.

Since last few years, health policy makers have planned to start a new cadre of health professionals i.e., Bachelor of Rural Medicine and Surgery and B.Sc Public health referred earlier, to serve the rural population. A comparison of the syllabus between the BRMS and B.Sc Public Health with that of the existing public health nursing courses (3.5 yr diploma, 4 yr degree and M.Sc Community Health Nursing which cause the present the glut of nursing professionals) shows that there are not many differences except that the new course will be taught in the medical institutions. Benefit that nursing professionals have as hand on experiences in both clinical and domiciliary settings is likely to be missing in the new programmes. Nursing professions with a short course of clinical assessment and diagnosis may serve the purpose better than upcoming curative health providers. It may be more economic and conducive to use the already trained rather than create such scenario.

All these post independence developments, health policy makers’ step mother attitude, and dominant medical model of health care made the Bhore concept of public health nurse a day dream.

Conclusion
Public health deals with whole systems of health; it can be achieved only through integration of all the sectors. Bhore Committee recommended the comprehensive model of a public health professional that is socially oriented and knows the Indian situation i.e., the Public Health Nurse. This concept of health was considered useful and was promoted in the policy document till about 4th Five Year Plan. However, later it got submerged by dominant medical health professional planners. This cadre was sidelined and given a secondary place largely because of the step mother attitude of the policy makers towards the nursing profession, dormant state of nursing profession’s formal and informal association and dominant role of private health care institutions.

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References
### COURSE OF STUDY

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**Annexure 1**

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<th>Practical</th>
<th>In weeks</th>
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<tbody>
<tr>
<td>1</td>
<td>Medical surgical Nursing (Adult including geriatrics)-II</td>
<td>120</td>
<td>270</td>
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</tr>
<tr>
<td>2</td>
<td>Child health Nursing</td>
<td>90</td>
<td>270</td>
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</tr>
<tr>
<td>3</td>
<td>Mental health nursing</td>
<td>90</td>
<td>270</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Midwifery and Obstetrical Nursing</td>
<td>90</td>
<td>180</td>
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</tr>
<tr>
<td>5</td>
<td>Library work / self study</td>
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<td>50</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Co-curricular activities</td>
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<tr>
<td></td>
<td>Total</td>
<td>390</td>
<td>1090</td>
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<tr>
<td></td>
<td>Total = 1480 hours</td>
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**THIRD YEAR**

**FOURTH YEAR**

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<td>Midwifery and Obstetrical nursing</td>
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<td>180</td>
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<tr>
<td>2</td>
<td>Community Health Nursing</td>
<td>90</td>
<td>135</td>
<td></td>
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<tr>
<td>3</td>
<td>Nursing Research &amp; Statistics</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Management of Nursing Services &amp; Education</td>
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<td>30</td>
<td></td>
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<td></td>
<td>Total</td>
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<td>315</td>
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<td></td>
<td>Total = 540</td>
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**INTERNSHIP (INTEGRATED PRACTICE)**

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<th>Practical</th>
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<td>Midwifery and Obstetrical nursing</td>
<td>240</td>
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<td>2.</td>
<td>Community Health Nursing</td>
<td>195</td>
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<td>3.</td>
<td>Medical Surgical Nursing</td>
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<td>9</td>
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<td>4.</td>
<td>Child health Nursing</td>
<td>145</td>
<td>3</td>
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<tr>
<td>5.</td>
<td>Mental health</td>
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<td>6.</td>
<td>Research project</td>
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<td>Total</td>
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Annexure 2
Mudaliar Committee recommendations (volume 1, page 93)

1. Primary Health Centre (6 beds) (existing set-up)
   - 1 Medical Officer
   - 1 Sanitary Inspector
   - 1 Public Health Nurse (or Lady Health Visitor)
   - 1 Midwife
   - 1 Pharmacist

2. Primary Health Centre (10 beds)
   - 2 Medical Officers
   - 1 Sanitary Officer
   - 2 Public Health Nurses
   - 3 Aux. Health Workers
   - 2 Midwives
   - 1 Pharmacist

3. Primary Health Centre (10 beds)
   - 2 Medical Officers
   - 1 Sanitary Officer
   - 2 Public Health Nurses
   - 3 Aux. Health Workers
   - 3 Midwives
   - 1 Pharmacist

4. Primary Health Centre (10 beds) (The final picture)
   - 2 Medical Officers
   - 1 Sanitary Officer
   - 2 Public Health Nurses
   - 3 Aux. Health Workers
   - 1 Pharmacist
   - 3 Midwives
Health workforce in India: towards realising Health for All

Jashodhara Dasgupta and Dr. Sandhya YK

This paper examines the crisis of the health workforce in India and proposes some ways forward to realise the goals of Health for All. The paper is largely based upon in-depth discussions at the Mid-Annual Meet and subsequently the 44th MFC Annual Meet (February 2018, Wardha).

India’s health workforce is a combination of both registered, formal and informal healthcare providers (Hazarika, 2013). Although the public health system is plagued by persistent vacancies, this paper argues that the issue is not just about numbers of health workers, since India has the largest number of medical and paramedical colleges in the world. Examining the skewed policy orientation in India, the paper argues that it is the quality, practice, distribution and regulation of the health workforce that is leading to a crisis in the public health system of the country. The foundation of a functioning health system is a capable, well-deployed and accountable workforce; and unless these aspects are addressed on an urgent basis, it will not be possible to realise the goals of Health for All in 2019.

Policy Alignment

Currently various kinds of public health services are provided to different categories of Indian citizens, who may be either Central or State Government officials, employed in the Armed Forces, or employed in the paid workforce and eligible for ESIC benefits. Beyond these categories, other excluded populations can access the private sector with its attendant costs; however the least privileged population usually has access only to the general public health services. The general public health services have been eroded over the years owing to very low public spending by the Central government and uneven spending by state governments (NHRC 2016), leading to high out-of-pocket expenditure (OOPE) for the population that can least afford it.

Data indicates that costs are highly concentrated in drugs and diagnostics, and consultation charges for out-patient services (NSSO 2004). Yet the solution that has been proposed in the current Ayushman Bharat programme is the coverage of hospital-based care through private insurance companies. This does not address OOPE for OPD, drugs and diagnostics. It, once again diverts public spending from strengthening the general public health services for the poor. It also enables private players to compete with the general public health system, attracting those medical personnel whose training was publicly-sponsored towards joining the private sector. Additionally it makes tertiary care a key focus of health system’s thinking. Therefore, the entire production of health workforce is geared towards a doctor-centric super-specialised hospital-based approach to health, heavily dependent upon medical technologies.

The discussions at MFC questioned this doctor-centred model, with its emphasis upon specialisation; proposing instead other models based upon family care practitioners, general practitioners, general nurse practitioners, towards ensuring accessible available primary health care for all, that includes not just primary health services, but also health education and health information.

Production of the health workforce

Despite an increasing shortage of health professionals in the general public health system, it is ironic that India has emerged as the most important source country in the global health workforce market (Anand Sudhir and Fan Victoria, 2016). However, the distribution of the training institutions is extremely inequitable among Indian states: although the EAG states account for almost half of the country’s population, only about one-fifth of the medical colleges and a quarter of the dental and nursing institutes are located there (Hazarika, 2013). Moreover, there is no updated Census information on the health workforce in India, which needs to be disaggregated on the basis of qualification, gender, caste and religion.

Both the public and private medical colleges in India are equipping physicians primarily for urban-based tertiary care rather than essential community-based services, because the site of teaching is itself a multi-specialty tertiary care centre. The doctors produced in this setting
are unable to relate to the living conditions and health issues of the populations that are served by the public health system, and they are oblivious to sensitive issues of gender, caste and religion. They are under-equipped to handle the health needs of the community and aim for postgraduate studies towards further specialization and commercial gains. The state’s encouragement of medical tourism is further contributing to this inclination.

The discussion in the MFC led to a consensus that anyone who wants to go into health care provision should have a two years’ common foundation course on pre-medical sciences, which used to be offered earlier. Following this course, the students could branch out into clinical medicine, nursing or other paramedical training, choosing Allopathy or AYUSH but all sharing the same foundation. There was a strong conviction that the State should invest more in training schools and colleges that are linked to the public health care system, to the community based health provision, to the clinics and primary health facilities, but not to a tertiary health care model. The more grounded model of care would enable these colleges to produce nurses, paramedics and clinicians who actually understand the health needs of the community. The proposal for a two-year compulsory posting of freshly trained doctors might fill in the vacancies in the short term but it will not orient providers towards the community.

Deployment /Distribution of the health workforce

There are serious inequities in the distribution of the health workforce in India. The 2001 Census reveals that at the national level the density of doctors of all types (Allopathic, Ayurvedic, Unani and Homeopathic) was 80 doctors per 100,000 of the population, and the density of nurses and midwives was 61 per 100,000 (ibid). In India the ratio is 1.5 nurses to a doctor in 2009 instead of 4:1 as recommended (Hazarika 2013, figures from the MoSPI report 2011); while as many as 73 districts had no nurses with a medical qualification. Further, the distribution is four times higher in urban areas than rural areas, although 72% of the population resides in rural areas (Census 2001 as cited in Anand Sudhir and Fan Victoria, 2016). On the other hand, the private sector now accounts for 85% of doctors and 93% of hospitals in India (Planning Commission 2011) while government-funded primary health care in India is plagued with poor infrastructure, staff vacancies, shortage of specialists and inadequate facilities (MOHFW 2012), with CHCs in rural India suffering from ‘missing doctors syndrome’ (IIPS 2014).

The MFC discussions recognized the immense role played by corruption and nepotism in the deployment of health workforce, transfers and postings, starting from the ASHA Worker who also paid Rs. 20,000 to get the post, up to the medical officer who at the last count was paying Rs. 40 lakh to get to high demand post. A long term sustainable solution is required to break this vicious cycle. The situation is further aggravated by chronic absenteeism which reflects lack of supervision and accountability within the system.

Additionally, 57% of those who call themselves ‘doctors’ in India do not have medical qualifications and 31% were educated only up to Class 12 (WHO report, 2016). Beyond the AYUSH, there is a wide range of preventive and curative medicine that is passed along through oral traditions and comprises the traditional healing practices of marginalized communities. In fact, informal providers are often the first point of contact for a large proportion of the population. With the growing burden of non-communicable diseases, re-emergence of communicable diseases and changing health demands of the population, MFC recommends that public health planning should recognize and include other streams of alternative medical education as well. This would include the AYUSH practitioners, and people who may not be formally trained and yet are providing services: MFC would recommend that health planners think of different ways in order to use their experience and accessibility for the poorest.
Private sector

The lack of adequate infrastructure and personnel at public health care facilities, the poor quality of services provided, have all contributed over the last few decades towards nudging users towards the private sector. Studies show 78 per cent rural and 81 per cent urban patients are availing private clinics for OPD services (NSSO 2004). In recent years, new medical technology has added another dimension to the private sector expansion by enhancing the participation of corporate sector in health care provisioning, especially in the tertiary level. This has further implications on the availability of specialists in the public health sector, while the fear of catastrophic costs has led to a burgeoning private health insurance industry.

Prior to 1991, 70% of the medical colleges were government colleges, but by 2013, about 67% of the new institutions set up are private (recognized or approved) for-profit colleges. These have serious shortages in faculty, infrastructure and quality of education; but young people pay exorbitant amounts to obtain medical training, after which they avoid public service as they hope to recoup their investment (Dasgupta 2018, Sandhya 2018).

The MFC discussions also drew attention to the pioneering not-for-profit private health sector in India: there are examples of preventive and curative health care services being provided to the most deprived and marginalized people, especially tribal communities such as Jan Swasthya Sahyog Bilaspur, Shahid Hospital Dalli-Rajhara, Lok Biradari Prakalp Hemalkasa, SEWA-Rural Jhagadia and many others. The voluntary sector demonstrates much experimentation and innovation with community and self-financing methods including user charges, community based prepayment schemes, fund raising commercial schemes (Dave P, 1993).

Working conditions and career paths

Since personnel costs took up 70% of health department budgets with abysmal performance, consequently, health sector reforms moved in the direction of informalization and casualization of health workers. Despite additional resources injected into the public health system during the National (Rural) Health Mission, essential posts were filled only with contractual workers (Ministry of Health and Family Welfare, 2014). The National Health Policy 2017 further encourages greater contractualisation of services at different level of health care provisioning, which will aggravate the situation of workload, low job security, few social security benefits, unclear career path and high dissatisfaction, thereby contributing to lowered performance.

On the other hand it is undeniable that the permanent workers feel no obligation to be accountable since they have spent lakhs to get into the government job. While opposing informalization and contractualization, MFC recognized the need to work closely with unions and associations of health workers on the issue of accountability and regulation. While unions do talk about the rights and entitlements of workers, there is almost no conversation about their own accountability. However, it is imperative that the accountability issue become a part of the overall struggle of workers’ rights, working conditions and proper career path of workers.

In a sector where quality of care given is influenced by the working conditions of the workers, MFC was also concerned about the conditions of work, the labour laws and their implementation in the plethora of varied health institutions in the country. In order to encourage doctors and skilled health workers to serve in rural and remote areas, availability of decent accommodation, facilities for children’s education and avenues for personal and professional socialization also become important. For rural areas to be seen as a desirable location and as a learning opportunity, the type of medical education provided also play a role in developing the right attitude. One way out is the mandatory service in public hospitals after training is completed, in order to fulfil the shortage of trained workforce. The Chhattisgarh government’s innovative policy approaches seek to improve retention through additional pay and bonus points for post-graduate training, which provide considerable incentive for doctors and nurses to work in the public sector.

Additionally MFC deliberated upon the lack of a gender sensitive and supportive environment for women workers. While the lakhs of community-based ASHA workers across the country are showing great potential, they are unable to fulfil the roles of the formal cadres, and there are many issues with the ‘voluntarism’ enforced upon them despite inadequate financial compensation. The
whole emphasis on women as overworked, underpaid volunteers which matches the gender role in society needs to be challenged and re-examined. The earlier multipurpose male workers appear to be missing or under-utilised, and the heavier load is on the ANM who has now becomes the manager, disregarding her role in health provision. The current scheme of setting up ‘Health and Wellness Centres’ appears unrealistic given the inadequate skillset among the ANMs and overall lack of clinical personnel.

Task-shifting (from a higher cadre to a lower cadre) and multi-tasking (adding un-related responsibilities like digitizing medical records) are issues which not only affect the health workers’ job-satisfaction levels, but also lead to professional and legal tensions. If the career path is clear, multi-tasking could be seen as a short term measure until we get adequate teams in place. But MFC recommended a clear system of rewards, incentives, remunerations and career path along with increase in workload.

Regulation

Once qualified, allopathic doctors are meant to be regulated by the Medical Council of India, but rampant corruption within this body has made it the subject of intense parliamentary scrutiny (Rajya Sabha, 2016). The MFC discussions proposed a ‘competent authority’ which will regulate the selection and education of health workforce, the curriculum, their selection, content of their training, and their practice. There were debates about what would be the composition of this ‘competent authority’ for the recognition and regulation of the health workforce, but we agreed that it has to be a robust and respected institution.

Beyond this, the MFC discussions also reiterated the importance of departmental and social accountability for quality care, ethics and responsibility. The current lack of supervision and monitoring in the general public health system is aggravated by the assumption that it is the most marginalized and underprivileged who are using it, leading to a notion of impunity for all transgression of rules and standards. Therefore it is essential that departmental or managerial accountability should be supplemented by robust and accessible mechanisms of grievance redress for the users of these health systems. The current accountability deficit has to be addressed in the short term by social accountability, and answerability to the public.

Ways forward

Has the time comes for us to question the doctor of today? Do we need to question why doctors alone are considered to be the repositories of knowledge? How do we value the experiential learning of say a nurse or ANM working for two or three decades? Why are ANMs, nurses or paramedics not taught certain skills and why are these limited to doctors alone, why is there no task-shifting allowed? Is it possible that with de-specialization and task shifting, we might be able to overcome some of the human resource crunch in the health system? The presence of this hierarchial structure also prevents us from looking at the nurse or ANMs as partners or primary members of the team responsible for health delivery. It becomes important to not just train a good clinical doctor but rather train a doctor to work in a team, someone who would be accepting of other members in the team as partners and not just as assistants. We need to find creative and innovative ways in which IT can help in better understanding of health problems of local area and enable local providers to take informed decisions.

The MFC recognized there have been efforts to develop other fields more related to the social determinants of health, called by assorted names such as Family Medicine, Preventive and/or Social Medicine, Community Health and Public Health. There is an urgent need to re-imagine the existing public health system and think creatively of coping with the health workforce crisis. The HLEG Report had envisioned that the health sector could emerge as the single largest employer in the country providing employment opportunities to 50 lakh people, and engaging Rural Healthcare Practitioners with a three-year customized training as has already been tried in some states. Perhaps a less-doctor-centric model can indeed be the way forward, in which task-shifting and de-specialization can enable nurse-practitioners, rural medical cadres or AYUSH practitioners to assure quality services for the poor in under-resourced areas. The production of trained health workforce needs to be done at district level to the extent possible, in order to ensure the contextualized healthcare provision that is lacking at present (Planning Commission 2011).
Distribution needs to be examined across states (North-Eastern States versus Kerala), across rural-urban divide, across cadres (nurses versus doctors), across gender/ caste/ class/ religion, across systems of medicine (AYUSH versus Allopathy), across levels of specialization (general practitioners versus specialists), across types of specialization (Academic versus Clinical) and across sectors (private versus public). We also need to examine the role of social sciences in teaching so that the health workers can look beyond the structures of patriarchy or caste prevalent in the society. Medical education needs to weave in the ethical, cultural and social dimensions to produce better health workers.

In terms of ways forward it is important to consider that this is an election year and each one of us in our own capacities should ensure that people do not get carried away by populist election jumlas (empty promises). The proposed National Health Protection Scheme announced by the government promising a coverage of up to Rs 5 lakh per family per year will not address their real problem which is the OPD cost or the cost of medicines. Neither will it address privatisation and other crisis of the health workforce. This needs to be brought before the public and very clearly explained. At the same time, MFC as a platform also needs to get into the more political efforts to influence the election manifesto to ensure that Health for All as a right becomes part of the real election agenda for this country as well as for the political parties that are contesting in it.

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Notes

aThe paper acknowledges the contributions of SAHAYOG Lucknow, and the entire organizing team of the MFC Annual Meet 2018, including Mithun Som, Mohit P. Gandhi, Pankaj K Tiwari and Bijoy Roy.

bEmpowered Action Group, including the states that had poor health indicators like UP, Bihar-Jharkhand, MP and Chhattisgarh, Rajasthan, Odisha and Assam.

References:


Dave P. (1993): Community and Self-Financing in Voluntary Health Programmes in India; Health Policy and Planning, 6(1)


Ministry of Health and Family Welfare (2014), Contract Workers Employed in NRHM


Revisiting the ICMR-ICSSR Report ‘Health for All, an Alternative Strategy’

Anant Phadke

Since we are revisiting the 1978 Alma-Ata Declaration of 'Health for all', it will be interesting to recall/revisit the ICMR-ICSSR Report titled 'Health for All, an Alternative Strategy' which, one can say, is the Indian version of the Alma-Ata Declaration as regards the content. This 1981 publication - three years after the Alma-Ata Declaration - was the outcome of the work of the study group set up by Indian Council of Social Science Research (ICSSR) and jointly sponsored with Indian Council of Medical Research (ICMR). It is an important milestone in the history of health policy in post-independent India. This study group was chaired by Prof V. Ramalingaswamy and was comprised of eminent personalities in the field of health and social development like Raj Arole, Banoo Koyaji, and Prof N. S. Deodhar. The renowned Gandhian educationist, J. P. Naik, was the 'moving spirit' behind this Report and the main drafter of the Report. Dr. N.H. Antia was the member-secretary, while surprisingly, Dr. D. Banerjee was not part of this 'study-group'. This Report mentions Alma-Ata Declaration only once but the overall approach and content of this Report are very much in tune with the Alma-Ata Declaration. The Alma-Ata Declaration is of only 3 pages whereas this Report runs into 270 pages.

**Strengths of this Report**

It goes into all aspects of health policy in India and calls revolutionary changes across the health sector in India. Like the Alma-Ata declaration, it sees health as being dependent primarily on socio-economic development and calls for an integrated policy involving specific social, economic and cultural changes necessary to foster healthy living for the people; and calls as well for for universal availability of appropriate healthcare when needed. It argues for rapid socio-economic development to eliminate poverty, unemployment as well as elimination of marginalization of women, scheduled castes, scheduled tribes. Secondly, it calls for specific interventions to improve nutrition, sanitation, environment etc., social determinants of health, and emphasises democratic, decentralised, participatory form of government. Thirdly, it ask for radical changes in the existing model of healthcare because this "...imported and inappropriate model of health services is top heavy, over-centralised, heavily curative in its approach, urban and elite oriented, costly and dependency creating." (page 10)

It argues for a comprehensive approach which would take into account the philosophical, cultural, social, environmental dimensions of health and which would give primary importance to preventive, promotive aspects of health instead of primarily focussing on doctors and hospitals for curative care. It lays great emphasis on ability of the community and the Community Health Volunteer who lives in the community to deal with various health problems of the community and would be pivotal in providing important elements of primary health care to the common villager. The Report considers 'family planning' as an important objective but sees economic development, health education and women's empowerment as primary tools to achieve this objective rather than relying on technical measures and is clearly against 'camp approach' for providing any health service, leave aside family planning. I am not giving even a summarised account of what this Report says but I am merely mentioning some of the key issues deliberated by this Report to give an idea about its overall tenor, which is quite parallel to the 'Primary Health Care Approach' outlined in the Alma-Ata Declaration.

**Blind Spot**

The main limitation of this ICMR-ICSSR Report as I see it is its neglect of the political economy of health and healthcare - like the Alma-Ata declaration. It glosses over the fact that the ruling class in India, because of its profit oriented, costly and dependency policies would not be interested in radical improvement in the health-status of the people so long as it can get cheap labour without improving their health and without paying for their health care. The interests of the rich and better off in India demand that they pay less taxes in India compared to their counterparts in developed countries; and whatever taxes are collected, as little as possible to be spent on the health care of the rural and marginalised people. The developmental and health policy in India is shaped by the interests of the rich because there is little resistance from the exploited, marginalised. The overall policy will not change unless the balance of forces at the social level becomes favourable for the poor, or unless the interests of the ruling class themselves require a healthy population which can be more productive and hence would add more to their profits compared to the taxes to be paid for health and health care of the people. In India the ruling class continues to get cheap labour from whom adequate work can be extracted and which is replaced by younger new labourers if the older ones die early or are made to drop out of employment. Secondly, the interests of the health industry requires more and more health care expenses and the ruling parties have ensured that people will spend comparatively a great deal from their pockets for their health care, instead of the pool of tax collection being used to pay for the health care as has been the case in most of the developed countries. This political economy of health and health care, has not been even mentioned by this Report leave aside addressing it.
Given its overall perspective of less emphasis on curative care, it is no surprise that this Report does not give any specific recommendations about the pharma industry despite the fact that the unregulated pharma industry, both foreign and Indian, has been developing very rapidly since Independence and has been indulging in exorbitant profiteering as well as manufacturing and selling of irrational, medicines, irrational Fixed Dose Combinations, even harmful ones. At one place it says that “every effort must be made to see that the profit oriented private drug industry does not become a vested interest in ill-health” (page 92). But there are no specific recommendations towards it. In the late seventies, critique of the Indian pharma industry was being launched by MFC members and others and in 1982, the All India Drug Action Network was formed, which had outlined key elements of a pro-people, scientific pharma policy that is required. But there is no reflection of this in this Report.

The Health for All Report is also silent on private practitioners and private medical colleges. This is despite the fact that though most of the medical colleges in India till the writing of this Report were Government-run through tax-payer’s money, most of the doctors graduating from these colleges went into unregulated private practice. The Report is oblivious of the fact that in medical education, the uncontrolled private sector was growing; that the number of private medical colleges increased from 1 (4%) in 1950 to 14 (13%) in 1980 whereas the govt colleges increased from 27 to only 96. In 1980, in India, there were 70,000 and 170,000 doctors respectively in public and private sector. Yet there is no mention of the private health care in this Report; the private health sector being a kind of blind spot for this Report. Instead, what was needed was to take it on board to analyse its contradictions in order to see how to address these contradictions and to use these for public purpose. Modern health care is in reality based on modern science of clinical medicine and public health whose production and spread is primarily a socialised process. Long back gone were the days in which a ‘guru’ would share ‘his’ knowledge of medicine to only his chosen disciples. The content of medical education is a social process in all respects. Clinical practice is also now more and more based on Standard Treatment Guidelines, which emerge through consensus among experts, based on whatever published evidence and social knowledge that exists. There is hardly anything ‘private’ about it. Medicines, laboratory investigations and their indications etc., are all socially produced and guided by research findings, which is a social process. There should actually be very little difference in the process of clinical decision-making in regulated ‘private’ practice (as happens in many developed countries) compared to the decision making in the publicly owned clinics, hospitals. However, the profit making drive of the ‘private’ doctor can and does undermine the science of clinical medicine. There is thus a contradiction between the science of medicines, the ‘noble’ nature of the medical profession wedded to Hippocrates Oath and the ‘business-drive’ inherent in health care becoming a commodity. But this tendency of vitiating science and ethics of medicine by commerce can be mitigated if the private doctors’ fees are paid by a government/public agency through a policy of ‘standard rates for standard treatment’ (based on Standard Treatment Guidelines), as has been done in many developed countries. This experience tells us that making use of the contradictions of modern private medical care is not a mere wish but can be a reality. This is because in case of many doctors, the ‘business-drive’ has not been the main, dominant drive. At least this was the case in the first few decades after Independence, in case of traditional family physicians or individual consultants or those doctors who used to run small private hospitals. For them, being true to the science of medicine and to Hippocrates oath was an important value to be cherished and practised. Hence while many did violate both science and ethics of medicines, it was not the norm. However with the rise and domination of ‘money-making’ as the main drive of medical practice and especially with the rise and domination of the corporate sector, ‘business drive’ started becoming more and more important drive for doctors. But despite this if today doctors are given a chance, an option of earning well by using their professional knowledge, skills satisfactorily without indulging into unethical practices, at least some of them would opt for it. This of course is not the case for doctors wedded to the medico-industrial complex consisting of pharma industry, diagnostic industry and the hospital industry, especially the corporate sector. (These have to be nationalised, whenever social-political balance is favourable for this measure.) If the Public Health system is strengthened, and expanded, the ‘private’ practice of medicine would get more and more socialised and the ‘private nature’ of the medical practice would remain mainly for name’s sake. In about say 50 years, ‘private practice’ would start withering away and then the remaining would retire. All such considerations of the political economy of health and health care and the recommendations to address it are entirely absent from this Report. (One does not expect this Report to have a policy about the corporate hospitals as these did not exist in India then.)

Other issues

There are other secondary issues with the recommendations of this Report. As regards financing of health care, it appropriately recommended that both health and education should receive top priority in development and argued that public expense on health care should be equal to that on education. Since the Kothari commission had recommended 6% of National Income to be spent on education, the Report recommended the same amount be spent on health when
the govt expense on health in 1980 was around 1% of GDP. Compared to this recommendation of six fold increase in health expense, this Report estimates that the per capita annual public health expense needed to achieve health care for all would be a mere Rs. 30!(page 101)

To me, this is a gross underestimate. The budget for medicines alone would be quite substantial. Ten years later I had estimated the rational drug budget with rational use of drugs to be around Rs. 90/- per capita. (Drug Supply and Use, Sage Publications) The Report argues why and how the strong community base envisaged by it would mean huge saving of unnecessary expenses and hence how an annual budget of Rs. 30 per capita would be sufficient. It envisages that out of this budget, Rs. 6 per capita is to be spent in the community itself with the help of the Community Health Volunteer, Rs. 7 in the sub-centre and Rs. 6 at the Community Health Centre located for a population of 10,000. There is no specific reference given for this estimate and we would require some evidence based discussion on this. We should of course keep away from the consumerist, drug dependent model of health care but the huge morbidity load of infectious diseases cannot be wished away. (Now we have a huge increase in the morbidity load due to non-communicable, chronic diseases.)

One of the reasons for this very low estimated budget for health is based on the questionable assumption of the Report that “The community component which comprises over 90 per cent of all health care does not require skilled personnel or expensive medicines which are chiefly required in the referral part of the curative service.” (page 101)

These and such assumptions that “over 90 per cent of all health care does not require skilled personnel” need to be assessed based on the experience of various community based projects that have been undertaken by various groups in the last 40 years.

Many things have changed in last 40 years a great deal, and level of urbanization has advanced a great deal. Yet to me, the perspective of the role of Community Health Worker is still valid though I have been doubtful about the claim that 90% of the health problems can be solved in the community. In MFC we had discussed this changing role of the CHW with less emphasis on curative symptomatic care in urban, peri-urban areas and more emphasis on his/her role as community mobiliser, educator, counsellor, patient/citizen advocate.

The Report gives welcome emphasis on traditional, indigenous systems of medicine and argues for synthesis of different systems of medicine, which means health facilities would make available both allopathic and non-allopathic systems of care for patients to choose and for coordination among these systems. This is more realistic than expecting an integration which means the same health personnel uses different systems of medicines in an integrated way as per need of the patients. This is indeed very ambitious to produce such human power to a large extent all over India with integrated knowledge of different health care systems. However the Report does not deal with Unani system and does not mention homeopathy presumably because it is not an indigenous system. But there have been thousands of homeopaths, millions of patients seeking care from these homeopaths and it is not wrong to expect that this Report of 1981 would have some policy about these practitioners.

**Contemporary Relevance**

As regards the contemporary value of this Report, the same observations that have been made regarding the Alma-Ata Declaration apply to this Report also. I am not repeating this discussion here. I would only point out that none of the subsequent health policy documents have sharply posed the key importance of the social determinants of health as this Report has done, most of the discussion being confined to provisioning of health-care. Thus for example, Report of the High Level Expert Group (HLEG), circa 2011) on 'Universal Health Coverage', which is otherwise a very good, balanced, comprehensive report on providing health care for all, does not address the issue of social determinants of health but only makes a mention about it. It says “It is imperative to pay attention to the social determinants of health by sufficiently investing in non-health related sectors that have a direct bearing on health outcomes. It is equally important to focus on the cross-cutting issues of gender and health that we have articulated upfront in the Report.” That’s all! This is not to belittle the recommendations of the HLEG Report. We need to note that the HLEG Report recommends keeping two thirds of health budget for Primary Health Care, gives a lot of importance to Community Health Workers, recommends two well trained community health workers per thousand population in both urban and rural areas, gives due role for other paramedics and their training, career path. Thus this report does not subscribe to the domination of secondary/tertiary care and doctors. Secondly, it specifies enhanced role for elected representatives, Panchayat institutions, Civil Society Organizations, NGOs, and argues for Peoples Health Assemblies from local to national level to which the health care system would be accountable. Thus the HLEG Report takes a break from the dominant model of health care. But still it is certainly short of the comprehensive approach in the ICMR-ICSSR Report and the Alma-Ata declaration. In this sense also this 1981 Report is still relevant!

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The world over public finance for healthcare is at the core, if universal access and equity in healthcare has to be delivered. Not only developed capitalist countries but even many developing and low- and middle-income countries have secured universal access to healthcare for its population. Then why is India struggling to realize this goal?

The recently launched Ayushman Bharat National Health Protection Mission (NHPM) by the incumbent government is an attempt to move in that direction but it has failed before it could take off because of its flawed design. The NHPM is a hospitalization only cover for the bottom 50% of the population and it is being framed within the insurance model. Both the Union government through RSBY and many state governments through its state specific schemes have gone down that road and have seen more failures than success. Despite huge investments by states in such schemes the out-of-pocket burden of households has not reduced as revealed by the 71st Round of NSSO. Ignoring this history the union government still opted for such a model led by the wisdom of the NITI Aayog – a model that does not benefit the patient but the insurance company and the private hospital. Such a model has not worked anywhere else in the World so why will it work in India. Further the second axis of Ayushman Bharat – the health and wellness centres – which were to strengthen primary healthcare at the sub centre level has been completely side-lined and no significant budgetary allocations have been made for it.

Why this will not work is because it is selective and targeted and uses a flawed financial model. It leaves out the rest 50% population, it ignores primary healthcare which is the foundation for any UHC approach and above all it fails to bring in the minimum resources needed – atleast 2.5% of GDP or Rs. 3600 per capita.

Public finance for healthcare in India is one of the lowest in the World, even lower than most least-developed countries. For 2018-19 health ministries committed Rs 191060 crores or Rs 1470 per capita or a mere 1.02% of GDP. The Centre’s contribution net of grants to states and UTs was only 11% (27% including grants disbursed). If we net the CGHS from the above then the budget for the general population comes down to Rs 1448 per capita. Of course there is wide variation across states with quite a few states spending more than the national average. In Arunachal it is Rs 6706 per capita, in Sikkim it is Rs.5575 per capita, in Mizoram Rs 4304 per capita, in Goa Rs 2536 per capita and at the bottom we have West Bengal at Rs 806 per capita, UP Rs 892 per capita, Bihar Rs. 898 per capita and Maharashtra at Rs. 975 per capita. The states which spend above the national average are also on the average better performers in healthcare outcomes and have more robust public healthcare delivery.

Reengineering Social Health Insurance for UHC

Ravi Duggal

Social Health Insurance in India

That apart there are also examples in India where we see universal access to comprehensive healthcare for the more privileged communities from the organised sector workforce. These are basically social health insurance models which tell us that to provide reasonably good healthcare the resources needed are definitely more than Rs. 3000 per capita. The CGHS, ESIS, CHSS, ECHS and armed forces, and Railways are good examples which could be upscaled to the general population. We discuss these examples below:

**CGHS** covers a large part of the Central government workforce, including Parliamentarians, Judges and other Central government agencies. The total cardholders (families) under CGHS are 1,131,902, including pensioners. The total beneficiaries are 3,370,176. For these privileged families the Union government allocated in 2018-19 Rs. 2863.55 crores from the Ministry of Health budget. This translates into a whopping Rs. 8497 per capita (Rs. 5303 for serving employees and Rs. 17149 per capita for pensioners) or Rs. 25341 per family (Rs.19215 and Rs.34412 per family for serving and pensioners respectively). This is
nearly six times more than what governments spend on healthcare for the general population. The CGHS coverage is comprehensive for life and there is no discrimination as regards the quantum of services that can be accessed, except for access to types of rooms during hospitalization which is based on pay bands. However in contribution there is regressive discrimination with those in the higher pay bands contributing the lowest in terms of proportion of their income. Overall the employee contribution is less than 1% and this is in sharp contrast to ESIS where 6.5% of wages (1.75% from employee and 4.75% from employer) constitutes the contribution from a sector of employees whose monthly wages are less than Rs. 21,000 per month.

Given the assured access to healthcare at no direct cost to patients, the utilisation of these services is huge. The daily outpatient attendance is more than 1.5% of the beneficiary population in contrast to the daily attendance to seek healthcare in the general population as recorded by NSSO which is less than 1%. In case of hospitalization and specialist consultations there is an increasing trend of referrals to private empanelled hospitals and consultants and this has contributed to the walloping cost of CGHS which has doubled since 2012-13. Despite being financed by tax payer’s money the CGHS is very non-transparent and does not publish its data. The little data that is available is largely from questions asked in Parliament. If the amount spent on serving CGHS beneficiaries is used as a benchmark then upscaling of this to the general population would require a budget of Rs 689,000 crores or 3.6% of GDP. Maybe with economies of scale the cost could be reduced to between 2.5 to 3 percent of GDP.

CHSS is another liberal Central Government health scheme which is for employees of Dept. of Atomic Energy, specifically the BARC in Mumbai and its other centres across the country. Again information on this is not available in public domain. Recently TISS conducted a study of CHSS and here is what we gather about the scheme. This scheme covers about 175,000 population including pensioners and the average cost across the centres was Rs. 16000 per beneficiary in 2013-14 (about Rs. 280 crores). This is indeed a very expensive model and the TISS study revealed that nearly two-thirds of inpatient care were referrals to private hospitals. Also it revealed that the hospitalization rate was 17% in Mumbai and 25% in Kalpakkam. This is extremely high because the expected rate of hospitalisation is around 6% to 8%. Infact in the Kolkata centre of DAE which follows CGHS pattern the hospitalization rate was only 6% but surprisingly here too the cost was high at Rs. 15000 per beneficiary. In Mumbai the study found that 7% of the hospitalizations were unnecessary as they could have been treated as out patients. Another reason for the high cost could be due to a higher incidence of cancer amongst DAE employees but such analysis is not available (anecdotally of the 11 families I know who have worked at BARC 6 employees succumbed to cancer and 2 spouses also had cancer). My hunch is that the higher cost is due to inadequate regulation and control of their facilities and referrals and because it is a small and elite community of scientists who have to be well looked after.

The Armed Forces perhaps offer the best healthcare facilities to its employees and families and most of it is through self-provision. So in some sense it is like a state run healthcare system. Unfortunately obtaining data on these is difficult as armed forces budgets are only available in abstract form. However, occasionally one does get some information through CAG audit reports. The CAG report for 2010-11 reveals that the armed forces spent Rs.5913 crores which worked out to Rs 5973 per beneficiary, including pensioners (Rs. 2939 per beneficiary for pensioners and a whopping Rs.7708 for serving personnel). Whether you are a soldier or officer you get access to the same services with reasonable equity. Unlike CGHS, CHSS and ESIS this is not contributory. These health services provide evidence of what a good healthcare service that is comprehensive and equitable would cost, albeit on a very liberal scale. It must also be noted that for tertiary care the armed forces are also increasingly using private hospitals, especially for retired personnel under the ECHS. The ECHS for retired employees is now made contributory and provides access to consultations and hospitalizations where armed forces own facilities are not available. In 2014-15 the ECHS expenditure was Rs. 2236.17 crores at a cost of Rs. 4738 per
beneficiary, a huge increase from 2010-11 because of increase in external referrals which were 72% for inpatient care.

The Railways is another public agency with robust health infrastructure and a well managed Health Directorate which runs the health services providing both medical care to employees and pensioners as well as dealing with public health issues in railway colonies. In 2015-16 the railways spent Rs 2015 crores on medical services and Rs. 644 crores on public health measures. For the 64 lakh beneficiaries in that year medical care works out to Rs. 3148 per capita which seems like a reasonable healthcare system (Rs.4155 including public health). The Railways mirrors the public healthcare system in most ways and is the closest model that the public health system could emulate. The railway medical services in 2016-17 handled over 2 crore OPDs and 469293 inpatients which gives a hospitalisation rate of 7% and OPD rate of 3 per person per year both very close to the normal rate as found in NSSO surveys. So in that sense the Railways healthcare model, again a largely self-provisioned model appears to be best suited for the larger public health system. Its unit costs of various components also shows that it is a rational model, even though recently its reliance for tertiary care on the private sector has increased considerably.

The ESIS is a huge social health insurance program for the organized sector working classes who earn less than Rs 21,000 per month. With that income ceiling it hence covers only a small proportion of the workforce. Presently it covers 3.53 crore persons and with family members included this provides coverage for 13.73 crore population. Its total expenditure for 2018-19 is estimated at Rs. 19,048 crores (Revenue + Capital) and its total receipts Rs. 25077 crores with contributions from employees and employers amounting to 87% and this being a whopping Rs.6806 per capita. So unlike the CGHS this worker’s social health insurance is financed mostly through workers contributions and this is a contradiction because the workers covered under this scheme are the low paid workers unlike CGHS or CHSS or armed forces who are a mix of mostly middle and high wage earners. Even the general reserves of the ESIC exceed Rs. 30,000 crores (Total Reserves over Rs.55,000 crores). With 32,349 hospital beds, 20,346 medical personnel and 18,501 other staff which manage 39 lakh inpatients and 286 lakh outpatients annually in house (additionally similar amounts through external referrals) it is a huge establishment and its spend on medical care for 2018-19 is projected at Rs. 12642.96 or Rs. 4052 per employee.

The ESIS is not an ideally functioning social health insurance program. It looks huge in numbers with a per capita expenditure of Rs.2667 in 2016-17 which is 2 times of general government health expenditure for the same year. But it is not universal access even for the organized sector employees; infact it covers less than 40% of the organized sector employment and by design it is largely targeted at blue collar workers thus fragmenting social security even in the organized sector. While huge investments have been made in ESIS as evidenced by the infrastructure and human resources for healthcare, all this is poorly structured and managed. Despite having a robust hospital and clinic network the utilization and occupancy rates are very low (below 50%). One reason could be poor quality of services (vacant positions of doctors and specialists are huge) and the other a growing reliance on outsourcing to private practitioners and private hospitals, especially the latter.

The current government under the advice of the NITI Aayog is being pressured to “reform” ESIS by bringing in Health insurance for secondary and tertiary care. Infact in their 2018-19 budget a provision of Rs. 1000 crores (subject to approval) has been made for buying health insurance for the ESIS covered employees which will divert all hospitalization to the private sector. The workers should realize the danger in this because private health insurance will have limits on their healthcare cover unlike the present mechanism where there are no limits for healthcare expenditures.

Conclusions

The above review of some of the main social health insurance programs in India brings out the wide range of assured healthcare access for a small privileged population which is estimated at around 15% of the country’s population (the above discussed schemes itself covering 12% of
the population). Those covered under these schemes get unlimited comprehensive coverage for their healthcare needs and both out-patient and inpatient. What is important to note that all these schemes have a strong foundation in primary healthcare through dispensaries, health centres and out-sourced empanelled practitioners and on which they have built varied forms of delivery mechanisms for secondary and tertiary care. This is the kind of healthcare that should be made available to the rest of the population also. But the country’s health policy driven by NITI Aayog wants to steer both general healthcare as well as social health insurance into a private health insurance supported mechanism, especially for secondary and tertiary care. This must be resisted.

What we need to do is to reengineer social health insurance by pooling all such schemes, and increasing its base by bringing in as much of the unorganised sector into its fold. Yes social health insurance in India needs to be reformed but not in the way the NITI Aayog thinks. All employees already covered under different schemes as discussed above and some smaller ones that we have not included in the review should be merged into a National Social Health Insurance (NSHI) scheme after pooling all their resources. Innovations would be needed to bring in the various unorganised sector worker groups. For example all those who own farmlands and pay land revenues could be included as one very large group and those registered as marginal and small farmers could be enrolled as part of NSHI but without making any contributions – for the middle and rich peasantry a proportion of their land revenue or a slab based amount could be fixed as a contribution. All non-land owning daily wagers similarly should be enrolled without contribution (which to some extent is already being done under the NHPM) into the NSHI. Similarly other unorganised occupation/profession groups could be enrolled and an income criterion could be fixed below which it would be non-contributory and above which contributory slabs could be fixed. Of course this won’t be an easy task but this is the direction that we need to push the health financing strategy which would converge both tax revenues for healthcare and social health insurance contributions into a single pool for universal health care. And for service delivery there is a clear learning that primary healthcare foundation has to be strong whether it is publicly provided like CGHS, CHSS, Railways and armed forces or a mix of public provision and contracted in providers as under ESIS. As regards the secondary and tertiary care the deficits in public provision in the long run can be built up and in the short run a regulated empanelment system could help rein in provisioning from the private sector. However, insurance as a mechanism of financing should not be used in developing such a strategy.

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Notes

2 Ravi Duggal, 2018: Health Budgets 2017-18, Mfc bulletin No.379, July 2018
3 https://cghs.nic.in/
4 Ministry of Finance, 2018: op cit
5 Rakesh Sarwal, 2015: Reforming CGHS into Universal Health Coverage model, NMJI, Vol 28:1
7 CAG, 2013: Performance of Medical Establishments in Defence Services, Report No.18 of 2012-13, CAG New Delhi
10 Indian Railways Annual Report and Accounts 2016-17, Ministry of Railways, GoI, 2018
11 ESIC Financial Estimates and Performance Budget for 2018-19, ESIC, New Delhi, 2018
12 ESIC Annual Report 2016-17, ESIC, New Delhi, 20
International processes have long been influencing governments and their actions the world over and nowhere is this seen more clearly than in the field of health, especially maternal health and now adolescent health. Myriad partnerships, collaborations have been formed which in turn have identified global ‘truths’. One such truth was pushing institutional delivery the world over. Institutional delivery was equated to delivery assisted by experts the consequences of which would be a reduction of maternal deaths. While this certainly has its merits, it is worth our while to critically examine the ways in which global partnerships play out. Take for instance, the recently concluded Partnership for Maternal, Newborn and Child Health (PMNCH) Forum meeting held in New Delhi on 12th - 13th December 2018. Started in 2005, the Partnership, as it is referred to, was formed to support the achievement of the MDGs (especially MDG 4 & 5) and to focus on the critical role of a continuum of care approach for sexual and reproductive health and rights of women and adolescents in particular. The Partnership seeks to create a multi-stakeholder platform to support the implementation of the Global Strategy for Women’s, Children and Adolescent’s health. The pathway to this would be achieving more through the power of the collective through promoting the engagement, alignment and accountability of the constituent partners.

One of the critical themes of this partnership is putting people at the centre, cross sectoral action to bend the curve for women’s, children’s and adolescent’s health and the power of the Partnership as an accelerator for action. The Delhi meeting saw the successful participation of all 10 PMNCH constituencies which shared the programmes and schemes that they had undertaken to improve sexual and reproductive health of women, children and adolescents. But where were the people, especially marginalised people in all these discussions? Only a few presentations discussed the lacunae in data on marginalised populations such as indigenous people, the fact that such data was not factored into programmes, as they were not collected in the first place. It was also pointed out that the ‘country aggregate approach’ to data overlooked the need of identifying marginalized and excluded groups to ensure that all women, children and adolescents are reached and their rights realised.

In this global trend of partnering with the private sector, which is visualized as filling in the gaps and addressing what governments have missed out on, corporations like GAVI are being upheld for being equity “role models” as they purportedly play a critical role in reducing the immunisation gap between rich and poor nations. And when one of our Ministers finally did talk about girls in villages and about the steps that were being taken to influence the adverse sex ratio, she mentioned that planting a tree and offering it as a gift to each girl born is a positive step, as it will ensure that the girl is no longer a burden, as resources for her dowry are already being collected! Thus the ultimate goal that the Minister highlighted was getting girls married with a dowry to ensure that she is wanted by her natal as well as her marital family, rather than ensuring that she is empowered to chart the course of her life and future.

Are such international events and conferences ways in which we are collectively deluding ourselves? For in highlighting our successes, our failures are brushed under the carpet and voices that raise uncomfortable questions are ignored as are demands for transparency and accountability. Who in these international gatherings and conferences are questioning why voluntary reporting is being promoted instead of mandatory reporting? And who while setting up targets and indicators are asking the poor and the marginalised women and girls what they really want? By agreeing to the setting up of ‘voluntary reporting agreements’ a deliberate move is being made to undermine accountability, which by its very natures implies the binding nature of ‘answerability’, enforcement and the promise of non-repetition. Thus although mouthing the right
words, these processes are undermining human rights. The accountability in these international forums feels more like a global donor-led, technocratic accountability system. In such a system no duty bearer is held accountable to uphold the entitlements of the marginalised and to provide remedy and redress. The systematic promotion of public-private partnerships (including for-profit players and private donors) and the phenomenal increase in funding of selected health interventions (seen as quick fixes) has diverted attention from basic primary health care provision. Areas which need urgent intervention in sexual reproductive health are being identified by global agencies. So suddenly, in India, there is increasing talk about how essential cervical cancer screening is; but there is very limited noise is being raised on the need to have safe abortion services in place. With such lopsided funding priorities will the goal of health for all ever be met?

Notes

1. The Partnership for Maternal, Newborn & Child Health (The Partnership, PMNCH) is an alliance of more than 1000 organizations in 192 countries from the sexual, reproductive, maternal, newborn, child and adolescent health communities, as well as health influencing sectors. The Partnership provides a platform for organizations to align objectives, strategies and resources, and agree on interventions to improve maternal, newborn, child and adolescent health.

2. The partners include governments of partner countries; donors and foundations; intergovernmental organisations; non-governmental organizations; academic, research and training institutions; adolescents and youth; healthcare professional associations; private sector partners, UN agencies and global financing mechanisms.

3. The fact that GAVI is making available cheap vaccines on a large scale in Africa was highlighted as one of the ways in which the equity gap is being closed.

The following links are to articles in EPW 2008 issue on Alma Ata:
Vol. 43, No. 39 (Sep. 27 - Oct. 3, 2008)
Reflections on Alma-Ata C Sathyamala : https://www.epw.in/author/c-sathyamala
The Complex Truth George Thomas : https://www.epw.in/author/george-thomas
Thoughts on Alma-Ata and Beyond Binayak Sen : https://www.epw.in/journal/2008/47/commentary/thoughts-alma-ata-and-beyond.html
and a rejoinder by D. Banerji:
Vol. 43, Issue No. 52, 27 Dec, 2008
Another False Promise Letters Debabar Banerji: https://www.epw.in/journal/2008/52/letters/another-false-promise.html
Introduction

A healthcare worker is one who delivers care and services to the sick and ailing either directly as doctors & nurses or indirectly as aides, helpers, laboratory technicians, or even medical waste handlers. Data suggests that there are around 59 million healthcare workers worldwide.

Do these millions of workers who toil every day to provide healthcare to the ailing population enjoy good health themselves? In other words, are the healthcare workers healthier than their patients? As those who care daily for the sick and injured, healthcare workers are often viewed to be immune to injury or illness. Ideally, the very fact that the health facility is within their reach would make one believe so. However, the picture is not as rosy as it seems.

India is having a gross deficit of doctors, nurses and paramedics. Such shortage is not a new realisation. Since decades, lots of discussions have taken place already on the same and also to overcome this workforce crisis by adapting better strategies. To this date, India is struggling to achieve WHO prescribed doctor-population ratio and doctor-nurse ratio. A plethora of factors existent before and after the 1978 declaration have resulted in a scenario that is most unhealthy for healthcare providers, being a big obstacle in providing optimum care which the declaration was aimed at. Here the word healthcare provider is used to talk about doctors.

Much concern has been expressed about doctors, their working conditions and health. This concern has centred not only on the long hours that they endure, but also on other reportedly stressful aspects of work, e.g. the high workload, exposure to pathogens and related hazards and the emotional demands of patients in quality of care. However, there is great paucity of literature regarding health problems faced by healthcare providers; with nurses and paramedics being especially ignored over this.

Although stress and workload are measured by the way one defines them subjectively, a raw understanding exists about the multiple factors affecting health of doctors & their fellow healthcare workers, mainly including the hazards they face at the workplace with respect to the exposure to diseases. The article is an attempt to give a general account of factors affecting the health of healthcare workers, who has serious implications in attaining broad goal of ‘Health for all’.

Abuse at workplace

Verbal abuse is not uncommon in Indian healthcare setup. Irrespective of working setup, whether its government or private, junior doctors are often abused by senior doctors and hospital managers. Similarly nurses and other allied healthcare workers are abused by junior and senior doctors. In a cross-sectional study in high-risk medical wards in UK, 83% of staff reported verbal aggression, 50% reported being threatened and 63% had been physically assaulted. In Australia, 58% of GPs in a cross-sectional national survey conducted between February-May 2010 reported experiencing verbal abuse in the last one year of their practice; 18% also reported theft and damage to property. There is no such data available for Indian setup. Reason for this could be profit seeking private health players who does not want to disclose data regarding workplace quality and also patient centered government healthcare setup which care very less about their health workforce.

Safety at the workplace

The standardized mortality rate of doctors is less than the general population but doctors have similar rates of chronic illness. Doctors and nurses work in an atmosphere that is potentially hazardous in many ways. They are exposed to harmful chemicals and instruments far more than any other class of employees. More than 2 million incidences of needle prick injuries are being reported every year, with evidences of lesser seeking of proper pre and post exposure prophylaxis.

A north India base study in 2017 reported 73% doctors to be at risk of exposure to blood transmitted diseases through injuries like HIV,
Hepatitis etc. Among them, resident doctors were the highest in number (91.4%), followed by interns (7.4%), and faculty members (5.19%). 19.1% nurses were found to be at risk and so was the 3.2% of the staff involved in handling hospital waste.

**Stress**

Right from the days in medical college to the days of residency, doctors spend significant time under stress, earlier due to the studies and later with multitasking work along with studies. The unavoidable load of patients mismatched to the number of care-givers has unarguably increased their stress. It is reported that 71% of residents and 62% of nurses in India have not been getting the adequate sleep as advised. An increasing number of doctors have come up with complaints of depression, somatoform disorders, anxiety, unexplained headache and other lifestyle disorders of which stress and inadequate sleep is an associated factor. Burnouts and depression are fairly common in residents and nurses. As reported by Smith and Goldcare, 44% of doctors reported adverse effects on their health due to increased workload. A relatable data for India could not be retrieved. Burnouts and depression being fairly common in residents and nurses. The prevalence of depression has been found much higher in psychiatrists, who are actually intending to treat depression. This suggests the neglect of the public health providers, to maintain optimal health of health workforce, in order to maintain their work efficiency.

**Substance abuse**

Many doctors have been reported to consume alcohol, cigarettes and occasionally drugs as coping mechanism to the stress their workplace brings to them. Higher than average rates in the incidence of alcoholic cirrhosis among doctors, suggests that doctors are abusing alcohol, more than other profession.

The medical culture is slow to own up to the psychological stress we face and therefore we hesitate to constructively support, or confront, others. The high prevalence of the biggest health risk factors among the health care givers is not only paradoxical, but alarming as it indicates poor tolerance and escapist behaviour, often leading to reduced work efficiency and many a times, work absenteeism.

**Violence at workplace**

The alarming increase in the incidences of violence at medical settings has created a gross fear among the medical fraternity. It has been stated that 80% of serious violent incidents reported in healthcare settings were caused by interactions with patients. The remainder were caused by visitors, family members or co-workers. Violence is a universal problem and it occurs in developed countries also. According to figures compiled by NHS Protect, the incidents of workplace violence in the United Kingdom (UK) increased by 24% from 2009-10 to 2016. While there were 56,718 incidents in 2009-10, 70,555 incidents were recorded in 2016.

In a retrospective survey of all ER employees of a tertiary care centre in Vancouver, Canada, 68% of the health care workers (doctors, nurses) reported increased frequency of violence and 60% also reported an increased severity. Seventy percent of doctors employed in the emergency room (ER) faced violence in a hospital in Israel.

India is no longer an exception to the violence incidence. Being a country with minimal health resources and sparsely situated health facilities and uneducated population, violence against health care workers is a daily news here. Exposure to workplace violence in the past one year in a tertiary hospital in the capital of India (Delhi) is 40.8%. No gender-wise difference in the exposure to violence has been reported in this particular study.

A report from the University of Iowa Injury Prevention Research Center (UIIPRC) in 2001 has categorised workplace violence into four major types.

- **Type 1 (Criminal intent):** Such acts of violence have no “legitimate relationship to the workplace”, for example, robbery, etc.
- **Type 2 (Customer/client):** The perpetrator is a customer or client at the workplace and commits an act of violence during service by the worker. Violence against doctors and other healthcare workers falls in this category.
- **Type 3 (Worker-on-Worker):** The acts of violence are done by the employees or past employees of the workplace.
- **Type 4 (Personal relationship):** The perpetrator usually has a personal relationship with an employee (e.g., domestic violence in the workplace)
In India, type 2 workplace violence is more common. The factors contributing to violence are unnecessary investigations, delay in attending to the patient, staff shortages, poor infrastructure. Violence against hospital authorities are also often triggered by requests of advance payments or withholding the body of the deceased patient until the final bill is settled.

The most usual places in hospitals prone to violence are ERs. Intensive care units (ICUs), admissions, patient transportation, billing are other areas where workplace violence are common. The security of health personnel and facilities in civil contexts requires urgent attention. Furthermore, a better legal protection for medical and other health professionals would be advisable, the same as many countries already do for law-enforcement officers. Whoever attacks a nurse, physician or another health worker, regardless whether this is a verbal or physical attack, must know that he or she will be severely punished for it.

This not only adds to the stress but often leads to disappointment from one’s job, further adding to the psychological sufferings of a healthcare provider. The incidences may have been happened to the smaller fraction of the community, but have been highlighted enough to create a generalized sense of insecurity at the workplace. This has led to a trend of defensive handling of patients, with the hospital staff keeping their safety before patient care along with unnecessary referrals.

Workplace bullying

The Oxford English Dictionary defines a bully as a person who uses strength or power to coerce others by fear. Swedish researchers have defined bullying at work as harassing, offending or socially excluding someone or negatively affecting their work.

There is a growing, worldwide evidence base on workplace bullying. A combination of economic rationalism, increasing competition, downsizing and the current fashion for tough, dynamic, ‘macho’ management styles have created a culture in which bullying can thrive, producing an atmosphere of oppression and stress in many workplaces.

Raynor and Hoel defined five bullying behaviours. These are:

1. belittling someone in public, professional humiliation, accusation of lack of effort
2. spreading rumours and gossip about someone, name calling and teasing
3. ignoring someone’s presence, withholding information, preventing access to opportunities such as leave or training
4. applying undue pressure to produce work, setting impossible deadlines, unnecessary disruptions
5. failure to give credit when due, giving meaningless tasks, removal of responsibility, shifting of goalposts, repeated reminders of error

The UK National Workplace Bullying Advice Line says at least 12% of healthcare professionals face workplace bullying and 10% among workers from social services background face workplace bullying. Over 90% of these enquiries involve a serial bully. Although bullying is not a gender issue, approximately 75% of callers are women, probably because women are more willing to admit they are being bullied and more likely to be motivated to do something about it.

Workplace bullying and mistreatment of medical students have been linked to many adverse effects on the health and wellbeing of those who experience it, including depression, anxiety, lowered job satisfaction, increased sickness absence, a higher propensity to leave and reduced effectiveness at work. Increased smoking and escape drinking have also been reported.

In India, the following measures has to be taken at hospital level, administrative zonal level to reduce workplace bullying:

The following can be helpful:

1. ensuring that personal development in includes working on
2. self-awareness
3. reflecting on unpleasant or suboptimal interactions with other people
4. organising anonymous multi-source feedback, including from colleagues with whom one does not have a good relationship
5. attending a workshop on management of bullying and harassment in the workplace
6. encouraging team development training tackling excessive workload and staff shortages.

Imbalanced personal life

In a study conducted in UK among junior and senior doctors, Almost half of senior doctors said that working as a doctor had had adverse
effects on their own health or wellbeing. More GPs than hospital doctors believed this to be the case. The most frequently mentioned adverse effect in text comments was ‘Stress/work–life balance/workload’ followed by illness. Almost half of senior doctors did not agree that the NHS is a good employer when doctors become ill themselves. More women than men, and more GPs than hospital doctors disagreed that the NHS is a good employer when doctors become ill themselves.6

Many doctors expressed regret that they had lost so much time with their family, particularly with their children. Duty hours that are not fixed and obligations to be at the workplace causing postponement of important affairs, as a common reporting by many of the professional, has led to considerable distress in their lives. A grave lack of ‘me’ time and time for their partners has resulted in broken marriages/relationships, negligence in child care and a feeling of dissatisfaction among health care providers.

**Financial problems**

It is a common scenario at especially under public health setup. Despite working for and average of 80 hours a week the health care workers aren’t paid what they think they deserve, considering the values and risks associated with their profession. The case is worse with the nurses, paramedics and the staff involved in the hospital management.

United kingdom is one of the richest nation. It has a well-established healthcare service. In 2015, junior doctors in England’s National Health Service (NHS) voted overwhelmingly in favour of strike action for 3 days in December.23 27 741 doctors voted in favour of taking strike action whereas only 564 voted against, in a ballot organised by the British Medical Association (BMA). According to Mark Porter, BMA Council chair, “junior doctors have clearly been left with no alternative but to consider strike action due to the Government’s continued threat to impose a contract that is unsafe for patients and unfair for doctors”. Thus its evident that junior doctors and health care workers are neglected much while devising the pay scale for their work.

Due to such irresponsible behaviour in pay scale setting, Many a times they themselves do not have enough money to get the kind of medical services they need. In recent years, few places in Madhya Pradesh, UP, West Bengal and Maharashtra have witnessed mass strikes demanding for a hike in payments but no notable steps have been taken. Such strikes are further worsening patient care and increases morbidity & mortality.

**An ignorance?**

To reduce workspace bullying, violence and abuse improvement in communication skills pays the central role. Realizing that, Medical council of India developed ATCOM (attitude and communication module) in their faculty development programme designed for full time faculties of medical colleges. Integration of communication skills in the medical curriculum is also need of time, to overcome the communication gap. MCI Vision 2015 document which was published in 2011 emphasized on early integration of communication skills in medical curriculum. However, three years already crossed after the VISION 2015 deadline and no such step was taken to include communication skills in undergraduate medical curriculum. Informed consent also plays a vital role in minimizing workplace violence and it also helps in protecting the doctor as well as patient from legal punishment & mental trauma.

All the health policies in the previous decades have focused on maximizing patient care, but none has talked about the health of the people who provide it. The policies, at their core, lack a humane consideration of health care providers & health workers hardly have spaces for their release. In that case, it is hard to expect a system run by distressed people, filled with huge numbers of people having health issues, to provide optimum health that our health policies talk of. While talking about health for all, and planning alternative strategies for health care, health of the health workforce must not be ignored.

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Introduction

The health sector is one of the largest labour-intensive sectors and in many countries, women constitute around 75% of the workforce in the health sector. Women are mainly concentrated in para-medical cadre of the health workforce hierarchy such as in ‘nursing and midwifery’ and community health workforce. On the contrary, other cadres of the health workforce such as physicians, dentists, pharmacists and managers have a poor representation of women. (WHO, 2008).

In India, women healthcare workers, both in the public as well as the private health sector, work in the lower levels of the health workforce hierarchy and constitute a range of paid, unpaid and underpaid cadre. As a result of privatization, cuts in government expenditures and other global forces, there has been an increase in the informalization of the public sector workforce, including that of the health sector. In the context of reforms such as ‘flexibility’ initiated and advocated by the World Bank, even though gender should be perceived/considered as an integral aspect/part of such discussions, very little headway has been made in this regard (Standing, 2000). Human resources in the health sector has been part of manifold discussions at the international and national levels, however the basic and ideological fact that the division of labour in this sector is structured by gender has been ignored (Kuhlman, 2012). Following the overall pattern, in India too, women comprise a large proportion of the informal labour workforce within the health sector despite reforms.

Women Health Workforce as Contractual Work to Volunteers

At the community level, the new and emerging trend of formal voluntarism has been observed first among the Accredited Social Health Activists (ASHAs) or the Mitans, as they’re known in Chhattisgarh. In spite of having devoted much of their life to being health workers, with low wages, low social status and less power, they continue to remain informal workers (Nair, 2011). These are the group of women health workers who are working as volunteers and subsidising health services. They are not recognised as formal health workers up till now. Along with these in mid-nineties, one of the components of the health sector reforms was that of public health sector workforce restructuring. In 1996, the World Bank-funded SHSDP (State Health System Development Project II) through International Development Assistance (IDA) to Government of India pushed it to develop the district health system. It recommended third-party recruitment of personnel for supportive services like diet, solid waste management, and security. In this process, the health care institutions were deemed no longer responsible for these workers. It also stated that wherever the direct recruitment of medical, para-medical and technical staff by the state government will be slow, required staff would be recruited on contract (World Bank, 1996). Secondly, post-reforms transformation of Indian public sector hospitals, has introduced contractual workers besides regular and permanent workers. The term contract worker can cover wide varieties of the employment relationship in the sector. It includes short-term workers with direct contract, part-time workers with a direct contract, and workers on a short-term commercial contract (full time, part-time), agency workers, day labourers, informal workers and workers in any employment relationship with contractor or subcontractor (ILO, 2006).

Currently, within the organized health sector increasingly one finds the presence of contract workers within different categories of the workforce such as ANMs, lab technicians, doctors and nurses. This has accelerated the informalisation process within the formal institutional spaces like public sector hospitals. There is some estimates available in relation to contractual staff employed through NRHM at the level of Primary Health Centres and Community Health Centres. By March 2011 there were 148361 skilled contractual service providers including 33667 staff nurses and 60268 ANMs (GoI, 2011). These estimates show that around 63 per cent of women were employed in nurse categories and on a contract basis with low wages. This also shows that within workforce restructuring,
women professionals in the health system are marginalized. It has been stated that post-NRHM government relies more on contract staffs at the primary health care level. However, its experience shows that the attrition level is high as there is the huge difference in pay between the permanent and contractual workers (ibid). Over the past few years, a similar trend is visible in the secondary level public sector hospitals of West Bengal where for ancillary services workers were employed through the third-party agency which is a non-standard form of employment (Roy, 2010). These workers are mainly Group IV/D workers who are coming from lower caste and class backgrounds. It was found that in the tendering process even when minimum wages were considered ancillary service providers were paid less than minimum wages. They were also not entitled to any health benefit from the government hospitals where they were working. Hospital authority has no role in securing for these workers’ rights or stability of work (ibid).

**Increasing Informalization: Is it creating newer hierarchies at work?**

The findings of my MPhil study of “Changing Working Condition and Employment arrangements of nurses in medical college and hospital of Patiala, Punjab” (The fieldwork was done between October 2016 and February 2017) gives the detailed socio-economic background of staff nurses working in a hospital. The data from the study shows that in all the government hospitals in Punjab during the period of 2016-2017 contractual nurses are employed and range from as high as 86 per cent to as low as 7 per cent of the total nurses employed. Only one district hospital has less than 10 per cent of contract staff nurses. Of all the government hospitals Rajindra Hospital / Government Medical College Patiala has largest share (86.5%) of contract staff nurses. Contract posts are found more amongst nurses and Group IV staffs. As like any other organization hospital is also a hierarchical organization which is governed by the imbalance of power and knowledge. So, data of the study shows how informalization is creating new hierarchies which are multiple in nature.

**Informal (Contract-based workers) and permanent workers**

There are two groups of staff nurses one is permanent and the other is contract staff nurses. Also with them nursing students share the work load of the wards as interns. The data shows that on salary of 1 permanent staff nurse almost 4 contract staff nurses are working in this hospital. Even permanent nurses had their own union. Contract staff nurses didn’t have any independent nursing union till 2010. Contract staff nurses joined permanent nurses’ union in 2006. The non-fulfilment of all contract nurse’s demands led to the erosion of trust between both the groups. Contract nurses developed their own independent union in 2011. They felt being used by permanent nurses to full fill their own demands as contract staff nurses were greater in number. Besides differences between the PSNs and CSNs, work atmosphere in the hospital is also changing since the other permanent staffs like Group D staffs do not take orders from CSNs particularly when bio-medical waste has to be cleaned from the wards. Eighteen CSNs who were interviewed shared this fact. CSNs feel that even when they work hard Group D staffs do not accept their seniority.

Data also shows that hatred and disrespect is deep rooted towards contract-based nursing community as well as towards other contractual employees in this hospital. Most often regular staff nurse and also senior resident doctors call all contract staff nurses as ‘bacche’. PSNs think that CSNs are not properly trained and are incapable of taking nursing related responsibilities on their own. This irritates the CSNs. Regular nurses feel this contract staff nurses trained in private institute have not received proper training.

**Based on Social Backgrounds**

In this hospital CSNs who were working on contract felt being given lower status and respect and were thought to be ‘kacchaa mulajeem’ (temporary workers) in the hospital. The word ‘Theka’ is used to refer liquor shop in Hindi and Punjabi. This parallel is often drawn and mentioned to the CSNs. There is stigma attached to word of theka. My study shows total there are 343 contract staff nurses working in the study hospital. Around 220 staff nurse’s women from scheduled caste category with training in nursing have entered into contractual employment in this hospital. This was corroborated by the hospital administration. One of the administrative personnel at the hospital explained that substantial numbers of the scheduled caste women are employed as staff nurses on contract.
There are lower castes people in Punjab too... Even among staff nurses of total 343, there are around 230 or 220 are from lower castes only (Admin employee of the hospital)

The demographic profile of 40 staff nurses 20 permanent and 20 contract staff nurses shows among permanent staff nurses (PSN) majority of staff nurses (17) follow Sikh religion, and rest of (3) follow Hindu religion. It has found that the majority of permanent staff nurses (17) are from upper caste categories such as Jat Sikh, Baniya, Khatri and rest of (3) are from scheduled castes such as Ramdasiya Sikh and Mazbi Sikh. In comparisons to permanent staff nurses, a large number of contract staff nurses (16) are from scheduled castes such as Ramdasiya Sikh, Mazbi Sikh and only 4 of them are from Jat Sikh, Baniya.

Nurses have shared their experience of being humiliated by relatives and family members who said things like "tum toh theke par ho... hulladbaji karate hogi" (You are on contract based work. You must be doing crazy stuff). One of the senior nurses shared how this term theka is also associated with lower castes women and how Punjabi communities see this.

In Punjab contract workers are mainly from Ramdasiya community. I guess others think they are not very good women. Whenever you talk, you are thekewala banda (contract-based person). Then they would possibly think you are “galat banda” (a bad person). They think these people do not have kabeeliyat (abilities). They even think that such people (contract-based) are not women who conduct themselves appropriately because they are so much into strikes. See even people also say, “Who comes to such work? women from good class and nice families will not accept such jobs”. See, in Punjab there is a huge community of pechadehue log (lower caste and class background people). (A permanent staff nurse in an interview)

Such health reform (occurring since the 1990s and advocated by multilateral agencies like WHO and the World Bank) also impacts the horizontal and vertical gendered division of labour within the workforce. This entire aspect of “who does what” is structured and influenced by gender. So, the actual location of men and women health workers in the hospital is actually influenced by the socio-cultural arrangements of men and women in society. This reinforces the classification of men and women into caring and curing work, as well as informal and formal work, part-time work and a career path (Kuhlmann, et al., 2012). The segmentation and division of labour are not only layered by gender. Because all working women do not share ‘common social identity’ or don’t come from the same background. They are associated with different religion and caste and class.

These glimpses into the reality at the field level raises issues that need to be explored further and relate to a) How different layers of hierarchies are getting created due to the restructuring of the health workforce? b) On one hand, a large number of these group of women are the first generation of workers to gain a job within the formal organization (tertiary government medical college and hospital). On the other hand, these jobs come with poor working condition with increasing precarity.

**Conclusion**

This paper shows that how different range of health workforce so as women health workforce has been informalised over the period of time. My MPhil study shows that nurses who are breaking the gender ‘cage’ and joining the workforce remain trapped in hierarchical structures that use their various identities to force them into slots and into fighting with each other. New managerial arrangements are using gender constraints of women to trap them into low paid, hard work where they are not free to protest, thus deepening the discrimination against women workers in the health system. The relationships between the processes of informalisation and development of newer internal hierarchies beyond gender identity and layers of discrimination also is a reality and needs to be explored further if one is to understand the negative effects of human resources reform in the health sector. What has been observed through the study is that discrimination is not just rooted in gender but also caste, class and other social identities like religion as well as how reforms tend to replicate and intensify discrimination against women workers rather than actually provide a space for empowerment of women workers.

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I Thankfully Acknowledge

All the nurses who shared their experiences, time and emotions; Dr. Bijoya Roy, Dr. Mira Sadgopal and Prof. Imrana Qadeer, (Retd.) for reading the draft paper and providing inputs.

Notes

1 MPhil Research Scholar from Ambedkar University (In collaboration with Centre Women’s for Development Studies)
2 During 1990’s in the period of reform international donors put forward the new public management theory and policy recommendation. This has created many questions on the state capacities and its direct role provisioning. There were some variations in context of different countries. But it was based on some common themes such as shifting direct role of state in provision of public services by involving the private sector for efficient services and accountability (Shaw, 1990).
3 Nursing, Public Sector Hospitals and Changing Working Condition: An Exploratory Study of a Medical College and Hospital, Punjab
4 Permanent Staff Nurses
5 Contract Staff Nurses
6 The most of permanent nurses are from upper caste and after getting higher education such as B.Sc and M.Sc they prefer outmigration to North America.
7 In relation to gender equality horizontal segregation means women and men in different sections and occupations.
8 Vertical segregation means men’s domination of the highest status of jobs in both traditionally male and traditionally female occupations.

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Some time back, Safdar Hashmi introduced me a young Students’ Federation of India (SFI) comrade Dr. Amit Sengupta who little later became inseparable comrade in movement and in my life too. Now I have lost both of them and that has created a real vacuum in my life.

Amit’s coming in the realm of health movement was little later than some of us. Formation of Bhopal Jnan Vigyan Jatha emanated from a casual discussion sitting in Delhi Science Forum’s office at Local Shopping Centre, Saket. Beyond our expectation, Ashok Jain, Director of Department of Science and Technology (DST) agreed to our proposal to the extent that beyond our any conjecture asked us to make it a much large event. Raghunandan returned from DST with a large block of ice-cream, according to Amit’s analysis, looking at his body language (like Dr. Watson) that Raghu has come with success for a big deal. Well, then we sat to draw a large architecture which became largest ever campaign for science popularization. The rest is known: five Jathas travelling from five extremities of the country assembled at Bhopal giving rise to All India Peoples Science Network (AIPSN). In this process few of us, then available, produced campaign materials for the Jatha. Amit along with Safdar created a 20-minute video film on health situation of the country. To our knowledge, that was the first film on this topic. I have projected the film in a number of villages where the message was more pronounced than our speeches (which were usually delivered before projection). In fact, this led us to change our pattern by showing the film only—no ‘bhashan’!

Gradually, Amit was drawn on the issues of medicine where he perfected in no time; not because being a doctor but an ardent health activist. He started using data on pharmaceuticals which was at that time quite difficult to find for the purpose to build up data store. Amit had selected number of slots where data is to be complied. He used to drive us to collect information from difficult sources like industry’s own data banks. Our initial target was monitoring foreign multinational pharmaceutical companies. Amit started using them with his usual satirical overtone writing for media. Although very few of us then were working in this area and sources were quite limited yet Amit’s write up was enough for enraging the multinational companies. This was reflected in a meeting of Chemicals and Fertilisers Ministry though rarely used to call us for meetings: industry persons in the meeting refused to respond the exposures made by Amit.

For the first time, a legal battle on banning of an injurious medicine EP (estrogen-progesterone) was launched by All India Drug Action Network (AIDAN). Following direction of Supreme Court, the Drugs Controller was organizing public hearing. In the Delhi hearing, pharmaceutical companies brought a large number of well known gynecologists who spoke very high about efficacy of the drug. Mira Shiva was placing the evidence and explained how the evidence put forward by the doctors was false. Enraged professor Dr. C.S. Dawn demanded apology from Mira, claiming that she had abused doctors. Amit stood up and started reading from a text book which attributed number of harms that this drug can cause. Then he said that let me read out the name of the author of this text book- none other than Dr. C.S. Dawn. This eminent doctor had no other way but to leave the meeting. Amit rushed behind him outside the meeting room and said aloud “Dr. Dawn, your air ticket is paid by Organon Company and we have a copy of the receipt from their travel agent”. Dr. Dawn was dumbfounded and stripped of his honour.

When Amit became General Secretary of AIPSN, the first ever full plenary followed by several workshops were arranged in All India Peoples Science Congress that provided cohesive discussion of health activists. This was a precursor of a larger health movement that would follow. Sometime later, international health activists in a meeting held at Cape Town while preparing for an international assembly by the end
of year 2000 called nations to consolidate movement at local level. This inspired health activists to organize large event on health in the country. It was felt that the success of Jan Vigyan Jatha could be adopted for mobilization culminating in an assembly. Accordingly, Amit convened several meetings and proposed that all who are involved in health movement would be contacted for participation. Amit started meeting many organizations hitherto not connected with others and not specifically involved in movement per se. Many groups doing simple philanthropic work with commitment to the health need of people were contacted. The result was spectacular in the sense that all agreed to participate to such event. It was a great opportunity in bringing people for common cause of peoples need for healthcare. Meanwhile, international movement decided to hold an Assembly at Dhaka.

It was then planned that a national health assembly would be held at Kolkata from where participants would go to Dhaka. A unique plan of attending the Kolkata assembly was prepared that participants coming in trains through main routes where people from different towns would join the stream. Amit took initiative to co-ordinate and develop campaign materials. Six campaign booklets were published, of which Amit authored at least two. Participants from Punjab started travelling in the train and others started joining in different stations till Howrah rail station. Throughout the journey, participants campaigned through songs, small speeches, recitations campaign among the other passengers. In a similar manner, participants from south and central India also traveled in trains.

Amit led planning of the national assembly programme for three days through different events. The plenary was inaugurated by former Director General of WHO, Dr. Halfdan Mahler who frankly said that slogan of ‘Health for All by 2000 AD’ was a mistake since he did not feel at that time that health had become a political issue. The Kolkata Assembly discussed a vast area of health which became precursor of Dhaka international assembly. Immediately after national assembly, 200 delegates started for Dhaka journey. At that time organizing visa and crossing border with immigration formality was not easy. Amit formed a team to take care of all kinds of unforeseen eventualities.

The first international assembly held at Savar, Dhaka had reflected true spirit of movement through fervent participation of Indian delegates. It reached to a classic moment when Indian delegates started singing in the assembly in protest to the presence of the Deputy Chief of the International Monetary Fund (IMF). In subsequent workshops and discussions, Indian delegates participation generated prime importance. Thus, the first Peoples’ Health Assembly was marked with pronounce presence of Indian delegates; some credit can be attributed to Amit’s tireless organizing and leadership.

Of many other activities of I would mention our involvement with Health Action International-Asia Pacific (HAI-AP) led by our most respected friend Dr. Balasubhramanium. Amit had attended all the meetings of HAI-AP where he made most impressive presentations. Dr. Bala had special affinity to Amit since like Amit he was also a political person. It was always our task to brief him about political situation of India. He also expected that Amit and his friends in India should take up responsibility to run HAI-AP.

Amit was a welcome person in informal gatherings, charming one always with his wit and puns in conversation and of course laughing aloud. In case of all difficulties, troubles or disasters, Amit was the first to take up challenges. In the Peoples Health Assembly-4 held last at Savar we found an almost insurmountable situation which compelled us to almost abandon the meeting. But Amit was determined that at any cost this should be held. That helped us to pursue all possibilities and approaching all sources that finally yielded results. We had to cancel one day of the assembly, but Amit worked meticulously in redesigning the programme, accommodating all five days -worth of activities in four days. It still reverberates in our mind when conducting the concluding session of PHA4 Amit gave the last slogan “Awaz do…”

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It is indeed hard to believe that I am writing my tributes to my dear friend Amit, who for over two decades played crucial and multiple roles in my life as mentor, hand-holder and colleague. What makes it more unbelievable is that we were together for almost 20 days in Savar, Dhaka in November 2018 – barely till a week before he left us forever – working closely on organising the International People’s Health University (IPHU) and the 4th People’s Health Assembly (PHA) of the People’s Health Movement (PHM).

I can still vividly remember when I first met Amit at the Delhi Science Forum (DSF) office in 1994. That was the period when women’s groups were actively involved in the campaign against population control policies, injectable contraceptives and coercive sterilisations. I was working with Jagori, a feminist organisation, those days. We were planning to come up with a strategy to stop the introduction of the injectable contraceptive Depo-Provera in the Family Welfare Programme. Chinu Srinivasan and Gopal Dabade from All India Drug Action Network (AIDAN) asked me to become involved in a Public Interest Litigation (PIL) suit on bannable drugs that was being filed by DSF. A friend, Kalpana Mehta from Saheli, suggested I should meet a certain Dr. Amit Sengupta at his office in Saket J Block Market and consult him about the prayers for the intervention.

I was new in Delhi those days. I took the bus number 500 from South Extension to Saket and walked into his office. The room was full of papers, files and books. I noticed someone sitting behind a table piled up with papers in a corner, barely visible. I asked him very politely that I wanted to meet Dr. Amit Sengupta. He looked up with a rather serious look and said, “I am Amit… yes, what is it about?” I was extremely nervous in the beginning, but slowly managed to have a conversation. He was very supportive and explained the process with great patience. Over time, Jagori along with Saheli, AIDS Awareness Group (AAG) and other individuals intervened in the DSF case in the Supreme Court against Depo-Provera, asking for it to be included as a bannable drug.

Over the years we met far more frequently and we both became a part of Jan Swasthya Abhiyan (JSA) and PHM. Amit was a founding member of the PHM and was instrumental in building PHM as a global people’s health network bringing together movements, organisations, academics and activists committed to the struggle for health for all. He was instrumental in organising, the IPHU, a capacity building program for young health activists; and the WHO-Watch in Geneva which intervenes with its own statements in to the debates at the World Health Assembly. Amit was the editor of the Global Health Watch (GHW), the civil society’s alternative report to the WHO’s World Health Report, which covers almost every aspect of the state of global health within the social-economic and political realities. He brought his enormous political, organisational and leadership capacity to both PHM and JSA. He could easily relate complex analytical information in a very simple manner to the grassroots health activists in JSA through his speeches, workshops and discussions. He also wrote extensively and he had an amazing ability to address complex issues related to health policies, IPR and patents, and issues around the pharmaceutical industry, to name a few.

Amit had very clear views on many issues related to health care, role of pharma, the role international NGOs and the UN. I still recall the heated, discussions on Universal Health Coverage (UHC) a few years ago after the release of the Report of the High-Level Expert Group on Universal Health Coverage (HLEG) and also the shifts from global health organisations towards coverage. Amit had very clear thoughts on this. He never accepted the term Coverage; he believed in Care. According to him, “UHC is essentially designed to universalize ‘coverage’ rather than ‘care’ which is built on, and lends itself to, standard neoliberal policies, steering policy-makers
away from universal health options based on public systems. He argued that, in glossing over the importance of public provisioning of services, many proponents of UHC are actually interested in the creation of health markets that can be exploited by capital.

Similar concerns were expressed by Amit again at the recently concluded fourth PHA in Dhaka where more than 1400 health activists from almost 73 countries came together. Amit was instrumental in bringing together voices from various corners of the globe with common as well as unique stories about their struggles and experiences of working with issues related with health and justice.

Interestingly, Amit never became a part of Medico Friend Circle (MFC). When I was the Convenor, I used to often ask him about his reservations and reasons for not associating with MFC. He would simply laugh and say, “I am not invited.” I would ask him why did he need an invitation, it is an open forum. He would say many in MFC may not like his strong opinions on certain issues.

When we had the 40 years of MFC celebrations in Delhi, I asked him again. Amit came for the evening celebration and spoke so well about the great respect and admiration he had for MFC’s sustained contribution to the politics of health. He was quite keen to know the story behind the big red circle of MFC’s logo. He was quite keen to attend the annual meet in 2016 held at Jan Swasthya Sahayog (JSS) in Ganiyari, for the first time, but changed plans in the last minute as he had to be in Geneva for the WHO Watch-related work.

His respect for MFC’s politics and steadfastness as a friend stood out when he was resolute in his support to me and MFC in the process of the post-2002 MFC fact finding report “Carnage in Gujarat, A public Health Crisis” and in the complaint to the Medical Council of India (MCI) against certain doctor involved in the riots. When I was facing constant harassment and threats as the convenor of MFC, Amit was the first person who reached out to help. He would simply pick up the phone and respond to those who were bothering me, in his acerbic best. He even offered his office space and suggested that in case any of them tried to meet me, it would be better in a larger group rather than me alone. This was at a time when very few came forward and were willing to be become involved.

The untimely and unexpected demise of Amit is an irreparable loss to the community of national and global health movement. JSA/PHM remembers him with a heavy heart and fondest of memories for being a long-standing friend, colleague, and fellow comrade in the struggle for health for all.

At a personal level, I feel you are still around, just stepped out of town for a meeting and will be back in a few days. You will call any moment and ask in your typical style, “Kya chal raha hai? Let’s meet.” Going through old mails, I think of you, your constant support, guidance and inspiration while working together, and our wonderful friendship. Adieu my dear friend, till our next meeting.

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Note
Universal Health Coverage: Beyond Rhetoric, Amit Sengupta
(http://www.municipalservicesproject.org/publication/universal-health-coverage-beyond-rhetoric)
Declaration of Alma-Ata
International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

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

Declaration:

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

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

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

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

V  Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

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

VII Primary health care:

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

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

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

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

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

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

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

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

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

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

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental 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.
The term corruption embodies a strong negative moral connotation. More so in the healthcare, perhaps even more in medical practice and in relation to doctors, for the ethics are supposed to traditionally be fundamental to the medicine. So not surprisingly when during the tenure of the UPA-II there was an upsurge of the campaign on corruption, the health sector also witnessed increased attention to corruption. From the TV Talk Show like Saytameva Jayate to the British Medical Journal (BMJ) having high prestige in India and South Asia intensified that debate in healthcare. The publication in the BMJ in 2014, the experiential account of corruption in medical practice in India by the Australian doctor David Berger (1), followed by an editorial co-authored by one of the editors of this volume with two editors of the BMJ (2), seem to form a backdrop to the conceptualisation of this volume.

In 657 pages the volume packs 41 essays divided in to eight sections, and in addition, a brief introduction of 9 pages by authors, topped by Prof. Amartya Sen’s Foreword of five pages. The Foreword and Introduction at the onset make very clear that the corruption is chosen by the editors as a vehicle or entry-point for a wider discussion on the failures, and some optimistic happenings in the healthcare system. As I read the essays in the volume I realised that this was perhaps done in order to provide space to a wide variety to perspectives, including those which do not deal much with the issue of corruption in the volume.

The first section titled Background, opens with the longest essay of the volume by Ritu Priya and Prachinkumar Ghodajkar explaining “The Structural basis of corruption in healthcare in India”. Both its length and lack of novelty in the analysis make it a tedious reading, but it poses three questions, essential to fix the system as well as corruption. The first and most important is how to overcome the alienation of the system from people by bringing people’s participation and control in it; the second, there is no way but to have healthy financing in order to achieve universal access and good standards and lastly, it argues strongly for making the regulations serious public and professional concerns. The second essay by Shiv Visvanathan brings out the anthropology of corruption in a very lucid way. The corruption in different systems manifest in different ways and serve different purposes, and he describes breathtakingly wider arrays of them. He argues that corruption is a distinct form of exchange that can happen in all systems, warranting a distinct anthropology and should not be reduced to a simple pathology that could be easily treated. Two other essay in this section focus on the political economy. One by Kaveri Gill, uses the framework based on four conditions developed by Colin Leys in the context of the NHS in the UK to understand the extent of commodification of healthcare services in India. The essay by Amit Sengupta uses the framework of globalisation and neoliberalism that promote “illegitimate use of public power to benefit a private interest” to delineate three pathways of neoliberal corruption: (a) ideological redefinition of role of state in favour of provision of benefits to private sector; (b) providing critical space to the private corporates and foundations in the governance structure; and (c) the capture of the regulatory structure of the state by the private interests.

The second section titled “Corruption in Practice” has the most number of essays, twelve, and they are written as case studies or as experiences, by some of the best known practitioners in healthcare and commentators. This section is highly readable, though lots of information in those essays is already known. The domains of corruption covered are medical councils (Sunil Pandya), Medical Education (Avinash Supe,
Third section, titled Moral, Politics, Legal issues and consequences has four different kinds of essays and seems the title of the section was derived from the essays rather than prior planning. The essays of VI Mathan and Abhijit Chowdhury express moral outrage at the lost good traditions and the caring at the service of market. George Thomas describes several types of corrupt practices which result into the further impoverishment of the poor people. The last essay by Arghya Sengupta and Dhvani Mehta explains the types and reasons for preponderance of corruption cases in the courts on public sector as the law does not cover other sectors but they provide recommendation for the legislative changes needed for comprehensive struggle against the corruption.

The fourth section titled “We Are Not Alone” contains four essays on corruption elsewhere. David Berger’s essay opens with his experiences in India but soon describes situation at other places and then focuses on the World Medical Association and its coronation of Ketan Desai from India as its president. There other essays are from our neighbourhood – Bangladesh, Sri Lanka and Pakistan.

The sequence of sections five to eight is perplexing – the sections five and eight are providing a range of alternative strategies and experiments, the section six provides personal views of three prominent senior doctors and the section seven consist of two major scandals; one old and one current. To take the seventh section on scandals first, Rupa Chinai’s recollection of the 1980s Lentin Commission’s inquiry into the glycerol tragedy at the government’s JJ Hospital Mumbai is written in a very engaging style. Since these were the events that shaped my activism in healthcare, I was interested in the story she has told here and would have liked her to expand on the last section where she says that two similar scandals were later on uncovered in two leading private hospitals in Mumbai in 1988 and 1991. While scandals in the government system hit the front page very often and stay there for long, the same does not happen for the similar scandals in the private sector. The differences in the media coverage, the approach, the selective outrage by the profession and people and of course government on the scandals in two different sector would be interesting to understand. The second essay on the scandal, so well-known at present, is of Vyapam by Sandhya Srinivasan. This is the biggest scandal to date in the medical education with over 2500 arrests, 200 criminal cases and number of deaths or murders allegedly attributed to it.

The section six is titled “Personal Views” with an essay each by Kunal Saha, Farokh Udwadia and Ratna Magotra. Saha’s personal tragedy is covered well in media, and in this essay, he takes off from there to narrate how, while battling with that tragedy, layer by layer, the corruption in the medical associations and regulatory bodies revealed to him. Udwadia reflects about different ways by which the profession could be made responsible and accountable. Mangotra, partly in line with the essay by George Thomas, talks about various ills – particularly gifts and commissions and their consequences. Seems the editors could have easily accommodated these essays in the thirds section.

The two sections that discuss alternative strategies and experiments are five and eight.

The Section Five is on the governance with five papers advancing different strategies to combat corruption. Meeta and Rajilochan, and Rakhal Gaitonde talks about the role of protocols and evidence-based interventions (clinical and others) respectively. Sunil Nandraj takes up issue of constructing regulatory mechanism by the Clinical Establishment Act. Samiran Nundy explores the potential of digital technology in the governance. And Abhay Shukla deals with several strategies propounded by his group – from building movement for patient rights, clinical establishment regulations, public system monitoring by people to the dissenting doctors coordinating their efforts for upholding healthcare ethics.
The last, the eighth section is titled “Beacons of hope” and contains seven essays on a variety of experiments. Unlike the essays in section five, these essays do not seem to have direct connection to the fight against corruption or anti-corruption movement. They are of course very exciting experiments, such as, Banyan in Tamil Nadu (Lakshmi Narsimhan et al), CMC, Vellore (Sunil Chandy), St. John’s Bangalore (GD Ravindran), MGIMS Sevagram (SP Kalantri, Anshu), Shaheed Hospital (Binayak Sen), Pramukhsawami Medical College, Karamsad (Amrita Patel) and Pain and Palliative Care Society, Calicut and Pallium India (MR Rajagopal). Since most of these experiments are known to me, I enjoyed reading them.

Complexity of corruption

I must confess that despite several lucidly written essays by authors whose work I regard highly, I found this volume very difficult to read. The length was the first major problem so I kept putting it off. I would have like the to see it in two volumes – one describing and analysing corruption and the systemic roots of it; and another describing typologies and strength and limitations of recommendations, work, campaigns and movements to eradicate corruption or to reorganise system to reduce it. Another problem is absence of rigorous editing to weed out overlaps, which are too many as the same issues are discussed again and again in different essays. And some essays did not seem to make good efforts to connect to the theme of the volume. While conceptual work on the history and evolution of system is important, it needs to be aligned with the theme. Same is true for the essays describing experiences, narrating case studies and experiments. Establishment of such connection to the theme would have reduced the length of the volume and improved its readability.

The last section describing the non-profit and NGO experiments of wide variety – political activism and ideologies, academic excellence, religious commitment etc – as Beacons of Hope do not seem to provide the kind of alternative for new system as well as ground to combat corruption. There are two reasons for that. The first is the perplexing problem we have faced with the idea of scaling up micro-level experiments and models at the national level. Are they exceptions which escaped the vagaries of the system due to heroism of some individuals and institutions or are they allowed to survive to distract our attention from the large scale rot? The second is the misconception that in the non-profit and even genuinely voluntary institutions there is no financial and non-financial corruption. Here I will go by what Shiv Viswnathan has suggested in this volume, that we need to use anthropological gaze to explore each context to uncover different nature of corruption, not only whose consequences are negative but also those that may be providing immediate benefits to many.

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When the plague broke out in London in 1665, and the Cambridge University closed down, Isaac Newton shifted to Woolsthorpe (150 km north of London), where he spent some very productive years while the theory of gravitation gravitated to him, and the laws of optics unraveled. The writer of this piece has information that Newton, though not much of a traveler ever, was very keen to visit India and its neighborhood during the plague in London, after reading Sir Thomas Roe’s accounts. (1) Unreliable archival sources also suggest that he knew of Ibn Batuta’s accounts of the 14th century where Batuta spoke of the islands of Maldives as one of the wonders of the world. (2) After learning of the long duration of the journey to India (about six months), and the considerable death rates of those on ship, Newton allegedly backed out. He however made handsome profits later from India without traveling there, with his considerable investments in the East India Company. (3)

At the Regional hospital in Kulhudhuffushi, at the northern tip of Maldives, where I worked as a physician some years ago, I saw this middle-aged lady from a neighboring island. “Since when have you had this headache?”, I asked politely. “Since around 10 years ago…”, replied the lady “when a coconut fell on my head”. I was slightly taken aback at this new cause of headache and head injury but soon regained composure and continued my enquiry about whether she had lost consciousness…etc. I mentally added a falling coconut to my list of causes of headache, when that very day another patient implicated a coconut falling on her back as the cause of her backache of many years duration. I had no reason to disbelieve their complaints as a 1.5-2 kg object falling from the height of a coconut tree can surely cause of lot of injury. To me, falling coconuts now started assuming the shape of a public health problem. When I narrated these accidents later at home, my son added tongue in cheek, “Papa, in Chhattisgarh in India, you said the problem for the farmers there was the irregular rainfall, while for some islanders here it seems to be unexpected coconut fall.”

It is not only coconuts which fall off the trees, but tragically, also sometimes the boys and men who go up to get them. The manner in which people climb trees seems less safe than the mode they use in Kerala, for instance. In the span of a month, I saw a patient with paralysis of both lower limbs and incontinence, and a young boy with paralysis of all 4 limbs, both of whom had their spines injured by falls off coconut trees. The boy’s story is especially poignant. He was known as one of the naughtiest children in the neighborhood, and fond of stealing coconuts from other people’s trees. Once when he was up on a neighbor’s tree, and had already made a few strokes with his knife, his father came shouting, asking him to get off. In a hurry he tried to scamper down, when a large bunch of coconuts fell down, dragging him along. He has never walked or used his hands since then.

To return to Newton, one can only speculate on the outcome of his visit to the Maldives, had it happened. One can imagine him standing beneath a 50-foot coconut tree, while gazing at the Indian Ocean and speculating on the nature of light, being either a witness or a victim to a falling coconut. If he had witnessed a falling coconut, this tropical fruit would have been immortalized in the discussions around discovery of gravity. If he had been victim, he would have been knocked out for a fair amount of time, and perhaps left with a niggling headache of tropical origin, later. In either case, I suspect however that this incident might have advanced science by a few centuries. He would have marveled at the immense power of a relatively small object falling with a great velocity, and
might have arrived at not only the laws of gravitation, but also the equation \( E=mc^2 \) (where \( E \) = energy of a falling coconut, \( m \) = mass of a coconut and \( c \) = coconut’s velocity during fall!) which he otherwise left for Einstein to discover. Alternatively, a coconut could have also injured him enough to render him incapacitated to pursue further scientific enquiry, thus slowing down scientific progress!

Finally, in this nutty yarn, there are some dreaded creatures which join the dots of the sojourn of Newton in the vicinity of apple trees during the plague, falling coconuts in Maldives and the patients in the hospital. Rats. I had never before seen rats climbing coconut trees to eat coconuts, but they do so in Maldives. The Maldivians try to keep them away by tying a tin sheet around the trunk of the tree to make it too slippery for the rats to climb. I suspect that rats who surmount this obstacle, gnaw at the bunches of coconuts, often in acts of revenge, making them fall like missiles on the heads and backs of unsuspecting men and women.

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