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MFC PAPERS

## RESURRECTING BHORE

### RE-EMPHASIZING A UNIVERSAL HEALTH CARE SYSTEM

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Universal Health Care (UHC) is a human right. The Health Survey and Development Committee, popularly known as the Bhore Committee (after its Chairperson Joseph Bhore), underlined this fact while constructing the national health plan:

"..We feel we can safely assert that a nation's wealth, prosperity and achievement and advancement, whether in the economic or the intellectual sphere, are conditioned by the state of its physical well being."

"...Expenditure of money and effort on improving the nation's health is a giltedged investment which will yield not deferred dividends to be collected years later, but immediate and steady returns in substantially increased productive capacity. ...We need no further justification for attempting to evolve a comprehensive plan which must inevitably cover a very wide field and necessarily entail large expenditure, if it is to take into account all the more important factors which go to the building up of a healthy, virile and dynamic people." (II. 1-2).

The Bhore Committee made a global review of recent trends and developments in health care services. It looked at the developments in Britain, Australia, New Zealand, Canada, USSR and the USA and found an increased role of the state in providing health care. It concluded that the ferment of ideas arising out of the World War has resulted in an increasing awareness, on the part of governments and people, of the need for measures which will ensure social security.

'The idea that the state should assume full responsibility for all measures, curative and preventive, which are necessary for safeguarding the health of the nation, is developing as a logical sequence... The modern trend is towards the provision of as complete a health service as possible by the state and the inclusion, within its scope, of the largest possible proportion of the community. The need for assuring the distribution of medical benefits to all, irrespective of their ability to pay, has also received recognition.' (II. 7, 12).

Before the Committee proceeds to delineate its plan it discusses and clarifies three issues that emerge from the trend analysis in the context of India's political economy - whether the health services should be free, whether the service should be a salaried one and whether some measure of choice can be given to the patient as regards his doctor.

#### **1. Whether the medical service should be free or whether it should be paid for?**

"We feel that a very large section of the people are living below the normal subsistence level and cannot afford as yet even the small contribution that an insurance scheme will require. We therefore consider that medical benefits scheme will have, in any case, to be supplied free to this section of the population until at least its economic condition is materially improved. We are averse to drawing any line of distinction between sections of the community which are and are not in a position to pay for such benefits. The application of a 'means test' for this purpose is unsatisfactory and may often involve enquiries....."

< MFC is a group of socially conscious individuals interested in health >

Revamping a dying village health worker programme I have become a formidable task in the Nineties. A half hearted start in the seventies by the government, followed by a near total neglect and the conflicts between the VHW bodies and the state have nearly paralysed the VHW programme. In Maharashtra the 80-84 period was a complete undoing of the programme. Bureaucrats have no loyalty to any programme and the programme continues as a mere budgetary expenditure head. 'Yes! The programme is dying out.

Revamping such a program, could be .from anything like a daydreaming to a neatly carried out plan under some able leadership. But if there is to be a revamping-since there is no alternative to the VHW programme-what can be the possibilities? Firstly we must think and make fresh efforts in the technical scope of the VHW programme starting from what people need and want and stopping at what best a good VHW can do. We have to attend to the curative services,' herbal remedies in addition to other -systems and greater educational efforts expanding both the knowledge and the skills base. Secondly, we have to create a legal space for operating the VHW programme. The third aspect is the socio-economic aspect and administrative management of the VHW programme. How to decentralize the programme and generate financial support for the programme is really the crux of the matter. The conventional Zilla Parishad infrastructure has proven too bureaucratic and insensitive for the programme. So a new programme to be wedded to the govt. apparatus is nearly killing the former. Are Village Panchayats likely to fit the bill? The Karnataka experiment, though limited, should tell us more about this aspect. But anyone working at the village level will tell us that the present Village Panchayat system is also alien to the community. But then there is no other valid democratic large scale system that can take up such a programme. So a pertinent experiment with the Village Panchayat in wild conditions is due. Insurance programmes largely financed by the community members provide a 'lateral' dimension to this subject. But again this presupposes greater community organisation than is obtained today. Perhaps this insurance approach is possible today only the NGO sector. I feel that this third aspect is central to the task of revamping the VHW programme, others being important but marginal.

We consider, therefore, that for the present medical services should be free to all without distinction and that the contributions from those who can afford to pay should be through the channel of general and local taxation ' (II.14).

## **2. A salaried service as against a service of private practitioners.**

"The absence of certain amenities and services in the countryside has proved a deterrent to medical practitioners leaving the attraction of cities and towns and migrating to the villages. Various attempts have been made to solve the problem. One method, which has been tried in more than one province, has been the settling of medical practitioners in rural areas and giving them a subsidy which will enable them to start practice. This subsidy was intended to be supplemented by private practice among the richer sections of the community. We have had considerable evidence to show that this method has been far from being an unqualified success, partly because in many villages the income derived from private practice is too small to support the doctor in reasonable comfort. The result has been that, in many cases, the better type of such subsidised doctors has tended to gravitate back to the towns. In areas where, there are greater opportunities for private practice, the more prosperous sections of the community have, we are told, generally received greater attention than the poor. We have, therefore, come to the conclusion that the most satisfactory method of solving this problem would be to provide a whole time salaried service which will enable governments to ensure that number of representatives of medical associations, individuals and several responsible medical administrators lends strong support to this proposal". (11.14-15).

"Further, if the poor in the rural areas must receive equal attention and if preventive work must get done then private practice by whole time salaried doctors should be prohibited." (11.5).

## **3. Freedom of choice of a doctor**

"Theoretically the patient will be free to take treatment in any state institution. But in practice for his own convenience he would go to the nearest available. His choice would widen with the expansion of health care facilities. (11.16) Concluding the discussion the committee categorically states that we are satisfied that our requirements can only be met satisfactorily by the development and maintenance of a state health service. (11.13).

Thus we see that the concept of UHC was well entrenched on the eve of India's Independence. The National Health Plan Keeping in view the socio-economic and health conditions in India the Bhore Committee set itself the following objectives to be achieved through the plan they were formulating :

1. The services should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health;
2. These services should be placed as close to the people as possible, in order to ensure their maximum use by the community which they are meant to serve;
3. The health organisation should provide for the widest possible basis of co-operation between the health personnel and the people.
4. In order to promote the development of the health program on sound lines the support of the medical and auxiliary professions, such as those of dentists, pharmacists and nurses, is essential; provisions should, therefore, be made for enabling the representatives of these professions to influence the health policy of the country;
5. In view of the complexity of modern medical practice, from the stand-point of diagnosis and treatment, consultant, laboratory and institutional facilities of varied character, which together constitute 'group' practice should be made available;
6. Special provision will be required for certain sections of the population, e.g., mothers, children, the mentally deficient and others;
7. No individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it;
8. The creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement or recreation (11.17).

The Bhore Committee further recognised the vast rural-urban disparities in the existing health services and hence based its plan with specifically the rural population in mind. Its plan was for the district as a unit. 'Two requirements of the district health scheme are that the

peripheral of the (health) organisation should be brought as close to the people as possible and that the service rendered should be sufficiently comprehensive to satisfy modern standards of health administration.' (11.22).

The district health scheme, also called the three million plans, was to be organised in a 3-tier system'. In an ascending scale of efficiency from the point of view of staffing and equipment. At the periphery will be the primary unit, the smallest of these three types. A certain number of these primary units will be brought under a secondary unit, which will perform the dual function of providing a more efficient type of health service at its headquarters and of supervising the work of these primary units. The headquarters of the district will be provided with an organisation which will include, within its scope, all the facilities that are necessary for modern medical practice as well as supervisory staff who will be responsible for the health administration of the district in its various specialised types of service' (11.22).

This health organisation would provide integrated health services, curative, preventive and promotive"-- to the entire population. 'The health organisation is expected to produce a reasonably satisfactory service for rural and urban communities alike. It is based mainly on system of hospitals of varying size and of differing technical efficiency. The institutions will play the dual role of providing medical relief and of taking an active part in the preventive campaign' (11.30).

In this paper we will discuss only the long term programme which was to be realised within a period of 30 to 40 years (11.35). That is, by the early eighties the facets of the Bhore Committee should have been realised. We are now in the year 1992-93 and very well know (and it is very humiliating to know) that we are nowhere close to what the Bhore Committee had recommended in 1946 as the minimum requirements for a decent health care delivery system. This embarrassment is only enhanced when we discover that these recommendations of the Bhore Committee were far lower than the level most developed countries had reached on the eve of World War II!

## **RECOMMENDATIONS OF BHORE COMMITTEE.**

What was this level of health care envisaged by the Bhore Committee? Stated in terms of ratio to a standard unit of population the minimum requirement recommended was :

## **1. Minimum Required Ratios:**

567 hospital beds, 62 doctors, 151 nurses per 100,000 populations. As a contrast to this in 1942 in the United Kingdom these ratios were : 714 beds, 100 doctors, 333 nurses per 100,000 populations. And in India of 1988 these ratios lagged at : 76.3 beds, 42.9 doctors i per 100,000 population (100 per 100,000 if we include non-allopaths), 28.7 nurses per 100,000 population.

## **2. Organisation of Health Care Services:**

The three tier plan of health organisations was as follows: (11.17-34, ill.3, 4).

### **Primary Unit**

Every 10,000 to 20,000 population (depending on density from one area to another would have a 75 bedded hospital served by six medical officers including medical, surgical and obstetrical and gynecological specialists. This medical staff would be supported by 6 public health nurses, 2 sanitary inspectors, 2 health assistants and 6 midwives to provide domiciliary treatment. At the hospital there would be a complement of 20 nurses, 3 hospital social workers, 8 ward attendants, 3 compounders and other non-medical workers.

Two medical officers along with the public health nurses would engage in providing preventive health services and curative treatment at homes of patients. The sanitary inspectors and health assistants would aid the medical team in preventive and promotive work. Preferably at least three of the six doctors should be women.

Of the 75 beds 25 would cater to medical problems, ten for surgical, ten for obstetrical and gynecological (ob. & gy.), twenty for infectious diseases, six for malaria and four for tuberculosis.

This primary unit would have adequate ambulatory support to link it to the secondary unit when the need arises for secondary level care.

Each province was given the autonomy to organise its primary units in the way it deemed most suitable for its population, but there was to be no compromise on quality and accessibility. Hence, a highly dense province like Bengal may have... a primary unit for every 20,000 population but a province like Sind (Now in Pakistan) or Central Provinces (now a part of Madhya Pradesh) which have a highly dispersed population may have a primary

unit for every 10,000 or even less population unit. The deciding factor should be easy access for that unit of population.

### **Secondary Unit**

About 30 primary units or less would be under a secondary unit. The secondary unit would be a 650 bedded hospital having all the major specialties; with a staff of 140 doctors, 180 nurses and 178 other staff including 15 hospital social workers, 50 ward attendants and 25 compounders. The secondary unit besides being a first level referral hospital would supervise both the preventive and curative work of the primary units.

The 650 beds of the secondary unit hospital would be distributed as follows : Medical: 150, Surgical: 200, Ob. & Gy.: 100, Infectious Diseases: 20, Malaria: 10, Tuberculosis: 120, Pediatrics: 50.

### **District Hospital**

Every district centre would have 2500 beds hospital providing largely tertiary care with 269 doctors, 625 nurses, 50 hospital social workers and 723 other workers. The Hospital would have 300 medical beds, 350 surgical beds, 300 ob. & gy. beds, 540 tuberculosis beds, 250 pediatric beds, 300 leprosy beds, 40 infectious diseases beds, 20 malaria beds and 400 beds for mental diseases. A large number these district hospitals would have medical colleges attached to them. However, each of the three levels would have functions related to medical education and training, including internship and refresher courses.

### **Special Services**

In addition to this basic infrastructure the Committee recommended a wide range of other health programmes, keeping in mind the special problems that India faced due to its economic and political conditions that would provide support and strength to this health organisation.

These included special attention to diseases like malaria, tuberculosis, small pox, leprosy, plague, cholera, venereal diseases, hookworm, filariasis, guinea worm, cancer, mental illness, diseases of the eye and blindness. Also, special programmes for health of mothers and children and environmental hygiene and an occupational health service for industrial workers were indicated. We must point out here that this special consideration were not to be independent programmes but a part of the general health service.

## **BHORE COMMITTEE NEGLECTED : A MISSED OPPORTUNITY FOR A COMPREHENSIVE HEALTH CARE SYSTEM**

The above review of the Bhore Committee Plan -has been done with the purpose of showing at we missed the opportunity of establishing a comprehensive health care system. At that point of time the capital cost for Bhore's plan was only one percent of GDP and the recurring cost (including amortization of capital expenditure) a mere 1.33% of GDP.. This level of spending was about three times less (as % of GDP) than what many developed countries were spending during those years.

Instead, the private sector, then very small in the hospital sector, was allowed to grow rapidly - rapid expansion of drug industry, private medical practice and private hospitals supported by an ever increasing supply of trained doctors and pharmacists mainly from public institutions. Though private practitioners were a fairly large number then, they were a vulnerable profession and could have been institutionalised into a state controlled health care system.

Today, with increased commoditisation of health care, the private health sector has developed strong vested interests which, especially in the present climate of privatisation and liberalisation, has now become a major barrier to developing UHC system.

### **MODIFYING THE SHORE PLAN**

The recommendations of the Bhore Committee make sense even today, 46 years later. If, implemented over the present decade they could transform radically health and health care in the country. However, the last four decades have seen the kind of changes which now make the Bhore recommendations, as they stand, very difficult to implement.

Hence, given the basic idea, a modified system now needs to be evolved for achieving the objective of UHC.

A state run salaried health care service, as recommended by Bhore, is no longer possible or feasible because of the manner in which health care services have grown in India, as well as due to the prevailing global economic scenario. There are also lessons to learn from the experience of the welfare approach of western capitalism and 'right to health care' approach of socialism.

In India's case of British experience is most relevant.

When the British NHS was started the situation of private health care was similar to what it is in India today.

However, the difference lies in the ability of the state; to undertake the task of organising the myriad health care services under a universalised umbrella. It is not that the Indian State cannot do what its British counterpart did over four decades ago. The problem lies in the unenviable position of the Indian State the total lack of any professional or statutory regulations and controls over medical practice, the multiplicity of systems of practice (alongwith rabid cross practice), the current structural adjustment requirements which reduce resource availability for social sectors, and, of course, the past health -policies and programmes which have created a dual system of health care services (rural and urban differences).

Given this scenario what are the possibilities of setting up an UHC system, given a basic political will and the pressures exerted by widespread poverty?

Where the basic model of health care delivery is concerned the one delineated by the Bhore Committee is the basic requirement. There should be no dispute about this because this minimum decent standard is absolutely necessary for any worthwhile, effective and egalitarian system. The area of modification that is necessitated by the historical experience is the mechanism of financing and the provision of routine curative care.

### **Modifications at the Primary Level**

The structure recommended by the Bhore Committee at the primary level is also institution based and it is here that the major modification is required.

Given the vast number of individual practitioners of all varieties (over 7 lakhs in numbers) existing today, routine care cannot be institutionalised as envisaged by the Bhore Committee.

We are here not discounting the primary unit hospital which is recommended at the 20,000 population level. That is a must, along with its preventive and promotive infrastructure. However, the primary unit must be a referral unit for first level hospitalisation, including: maternity cases. Routine medical care must be: decentralised by involving the existing general practitioners into some contract or insurance based system. Efforts must be made to assure that undeserved areas get general practitioners to serve the population.

We have enough doctors to spread across the population on the basis of one GP per 150 to 200 families. The GP, or more appropriately the family physician, will be the first level for any medical attention, except an emergency which needs a higher level care.

Here, we will not go into the details of the structure to be evolved. It will suffice to say that each family physician should have a fixed number of families to; 100k after and s/he will be reimbursed a contracted amount for providing such care. This also implies universal enrollment; redistribution of medical practitioners to cover the absolute minimum requirement; regulation, standardisation and audit of medical care; and price fixing. In other words, the State has to play an even more significant role in organising and monitoring health services.

Whether such a reorganisation is feasible both organizationally and financially. Our answer is Yes. The State regulates myriad activities in the public and private spheres and hence creation of a regulation mechanism for medical care and practice should not be difficult. Whenever a new area is regulated vested interests, usually a dominant group opposes it. However, historical experience shows that if the State exerts its political will, the dominant forces can be overcome because the State can generate easily a mass support for its actions. One needn't give examples of such actions by the Indian State in various spheres. They are well known.

We are fortunate today in having lessons from various countries which have implemented systems of UHC. One can use these experiences to organise a system of UHC most suitable and appropriate to our own socio-economic setting.

Financially today UHC is feasible. India is today spending about 6% of its GDP on the health sector, i.e. about Rs.36,000 crores (about one-third by the State). Because of the disorganised and market oriented system there is a lot of wastage of resources. A properly organised, regulated and a monopoly buyer system of health care delivery can cut this wastage and reduce the burden on many households"

especially the poor ones.

The essence of such a system should be that no direct payment is involved. Tax revenue will remain one important source of financing. Segments of population which can afford to pay must be charged on their income / production. Thus employers, organised sector employees, middle and upper levels of self employed (including farmers) and professionals etc. can make contributions either as insurance or as a health protection tax. Those who fall into the 'cannot-afford' category (about three-fourth of the population) will have the same rights as those who contribute. If health becomes a right and adequate and quality services are easily available then those who can afford to pay will most willingly contribute to any prepayment scheme.

The intention of this paper has been to only present an idea and hence we will not go into any detailed plans and modeling of organisational and fiscal structures.

## CONCLUSION

To conclude we would like to indicate important issues which need to be thrashed out in designing an UHC system.

1. Integration of multiple systems of medicine and creation of a single family physician cadre.
2. Restructuring medical education in, the above context.
3. Policies regarding redistribution of medical human power to meet the populations and the new system's requirements.
4. Creation of mechanisms for regulation, monitoring and audit of health care provision and providers.
5. In the Context of the above evolving various standards of medical practice.
6. Stronger regulation of drug production and pricing.
7. Setting up a fiscal mechanism for raising resources as suggested in the above discussion social insurance, health protection tax etc...
8. Organising a system of compensation for providers of services.

NOTE: All references refer to Bhore Committee Report Volumes and page no. (e. g. II.6.means Vol. II page 6)

## HEALTH CARE UNDER PANCHAYAT RAJ

N. H. Antia and Kavita Bhatia

The existing model for providing health care to the rural population is based on the Primary Health Care

concept of the Bhore Committee (1946), reiterated by the WHO at Alma Ata (1976) and by ICSSR/ICMR

report Health For All : An Alternative Strategy (1981). Unfortunately instead of the envisaged people based and people involved system the existing PHC, the sole vehicle of the government for providing health services to the 70% rural population of India, has become a top-down bureaucratic exercise for 'delivery' of services. It now has Family Planning as its prime objective. The Community Health Centre (also known as the upgraded PHC or Rural Hospital) has been converted into a mini district hospital of a purely curative nature and not the apex body of all the health services for 100,000 populations as originally envisaged in the ICSSR/ICMR report.

This has not only created dependency among the people but the coercive Family Planning programme has alienated them from their health services. The single-minded interest in this programme has not only demolished the Health component but has also failed to achieve even the Family Planning 'target'. The present expenditure on the rural PHC programme is about Rs.25/- per capita per annum as compared to about Rs.150/- per 'capita for the 30% of the population which is urban. There is hence not only a need to reallocate resources but more important to devise a rural health service in keeping with the epidemiologic profile and the people's needs, and involving them in their own health and its care to the extent that this is possible. The joint ICSSR/ICMR Committee had "analysed the health problems of the country in its widest perspective and had clearly stated that health care is basically the peoples own problem. Contrary to common belief health lends itself admirably both technologically, economically as well as culturally to a decentralised small scale people based approach. The recommendations of this report have to a considerable extent been reflected in the National Health Policy of 1983.

Several health projects like Jamkhed, Banwasi Seva Ashram and our own 10 year experience at Mandwa have demonstrated the feasibility of such an approach. With the passing of the Panchayati Raj bill in Parliament in 1989 for reactivating a decentralised form of government, health will also become a decentralised activity controlled and operated by local bodies from the village Gram Panchayat to the Panchayat Samiti and District level. This will entail increased inputs at this level and transfer of the rural health infrastructure namely the PHCs and CHCs and manpower to the local bodies. It is therefore imperative at this stage to propose a model of health care encompassing the technical, sociological, cultural and economic aspects of this bottom-up approach for a people based health service and its implication on health problems and programmes.

The Community Health Care System (CHC: System) is presented as a model for health services: based on Indian experiences in decentralised health care. 'This model proposes to decentralise the health system and services upto the one lakh population level where about 95% to 98% of all health needs, preventive, promotive: as well as curative will be met; about 85% to 90%' of this being eventually undertaken at village and PHC level.

This model does not depart to any significant, extent from the existing rural infrastructure except for modest augmentation at the village level and hence should be acceptable and usable on a national scale. While the recurring cost of such a health system is envisaged at about Rs.80/- per capita per annum, the major increase will be for non salary recurring expenditure which at present consists only 15% of the existing PMC budget.

If such a system can demonstrate that the vast majority, of health care can be undertaken at this level including all National Disease Programmes as well as Family Planning, except for the relatively few cases requiring specialised attention, such increased cost would be justifiable and acceptable.

Table 1

### **COST OF COMMUNITY HEALTH CARE SYSTEM**

(Per Capita per Annum)

Population Level	Health Care Unit	Per Capita Expenditure
2,500	Village Health Center	30
20,000	Primary Health Center	27
1,00,000	Community Health Centers	23
Total CHC System		80

The cost of such a System, which will provide appropriate health care for most of our country's population which of lives in the rural areas, is well within reach but calls for a better balance of available resources from the current lopsided pattern of expenditure which is biased towards the urban population.

Table 2

**ANNUAL INCREASE IN HEALTH EXPENDITURE  
(Per Capita per Annum)**

Expenditure	Rural	Urban
Current*	25	150
Proposed by CHC System	80	150

\* Broad Estimate

At present that local private practitioner or the distant district hospital are the chief health resources for the rural population despite the availability of the PHC. The aim of this System is to rectify this anomaly and ensure that 'no individual should be unable to secure adequate medical care because of inability to pay for it with integration of the preventive; promotive and curative services and make them available as close to the people as possible in an acceptable manner and within the available resources of the country.

Table 3

**ANNUAL INCREASE IN HEALTH EXPENDITURE  
(1990-92)**

State Expenditure	(Rs. in crores)		
	Rural	Urban	Total
Proposed	5,200	4,400	9,600
Current (1990-91)	1,600	4,400	6,000
Increase	3,600	-	3,600

Note: All figures are broad estimates.

In sum we proposed to increase the expenditure on rural population to a reasonable level while freezing the expenditure on the urban population at the current level. If all the sources of expenditure in the country are included, we find that country is already spending more than double the proposed expenditure. Besides the Rs. 6, 00 crores expenditure by the Ministry of Health and Family Welfare,

other Ministries (Railway, Defence, P & T etc.) the corporate sector, the Municipal bodies, and the ESIS expenditure is in the urban areas. If we add to this personal household expenditure, we find that about 6% of the GNP is already being spent. Most of this expenditure is concentrated solely on the urban population. Our model proposes to reorient this bias. It must be carefully considered whether the mix of the sources of finance should include the Government. Foreign aid, Charity, insurance - both private and voluntary and public and compulsory or by user charges. This would vary from urban to rural situations.

### AN OVERVIEW OF THE MODEL

The essence of this model is the Village Health Unit comprising of a full-time Community Health Worker and a day for every 500 population supported at the 2,500 population (an average Gram Panchayat) level by an Auxiliary Nurse Midwife. Eight such units covering a population of 20,000 (as recommended by the Bhole Committee) being provided supportive services by a PHC. The present PHC covering 30,000 populations cannot provide adequate access nor intensive cover to the population. At the 100,000 population level this system envisages a Community Health Center (CHC). The most important aspect of such a system will comprise in evolving and operating an entirely different community based approach with specific training and reorientation of all health personnel for the specific tasks at each level. Also in activating and involving the community in its own health and its care and eventually assuming charge of all the health service at the above mentioned levels through the Panchayati system.

### RE-ORIENT A TION OF PRIORITIES IN THE CHC SYSTEM

A major cause for the failure to address the health of our people as also of the health system itself is the lack of appreciation of the dominant role of the people in such an intensely personalised human activity. The existing rural public health system has converted health into a techno-managerial bureaucratic exercise dictated from a distant Capital where the people are visualised as 'targets' for achievement of national goals. On the other hand the private sector though providing personalised service has also lost the welfare of the individual and community in its desire to maximise profits.

The elite, of which the medical profession is a part, has confused education with intelligence and hence feels

that the illiterate or even semiliterate poor are incapable of understanding, leave aside looking after their own health and welfare. Having secured control of the power and decision making process they have feathered their own nest utilising the Western model they seek to imitate. This has inevitably resulted in expensive curative services and hospitals catering primarily to their own requirements in urban enclaves. This has become the first choice not only of the private medical sector but also of the public sector. As a result of the influence they exert because of the personalised rapport with the decision makers such as politicians and bureaucrats who they treat, they are in command of decision making even in the public sector. This has resulted in the diversion of the limited resources of the public sector to urban medical colleges and hospitals where the majority of the private doctors receive their professional training. The training is based not on the pattern of diseases which affect the majority of our people but on that of the West which is also the disease pattern of our elite. Sophisticated expensive equipment is purchased at public cost to train the specialists in medical colleges and hospitals to deal with such diseases. This inversion of priorities as demonstrated by the distribution of resources, manpower and health facilities between urban and rural areas is partly intentional, but is also partly the result of almost total lack of awareness by the medical profession of the medical health problems that affect the majority of our people as also the socio-economic and cultural conditions under which the available technology has to be utilised for their benefit.

The Community Health Care System aims to correct this imbalance of health priorities where the decision making and implementation of most health activities will be from village upwards and not top-down as at present. Only then can technological and social relevance be brought into the health system. The reality of the cultural and social distance between the medical professionals and the masses has also to be considered in evolving such a system especially at the CHC and PHC levels.

A graded referral service is a key element of the CHC system. Each level will refer cases to the next level and there will be no bypassing of lower level to reach the hospital directly. The adequate services at the village level and the PHC attached to the CHC should ensure that the rural hospital is utilised only as a referral center as per actual medical and Public Health requirements. The essence of the model is that the people must not only be actively involved in their own health care but that the

health services upto the 100,000 population (Block / Panchayat Samiti level) should be under their administrative and as well as financial control. Adequate funds should be provided to these bodies to ensure this.

Only this can ensure people's participation and active involvement as well as ensure accountability unto those who are paid to serve them. Without this precondition no model can hope to succeed. Much fear has been expressed about the misuse of power at the lower levels but misuse of power and corruption is not the prerogative of any level and is more visible at the smaller levels where interpersonal interaction is far easier and misuse can be checked.

The dissemination of power to the lower levels must be associated with widespread detailed information about all facilities and services and monetary resources provided for public use. This would prevent monopolizing and diversion of resources by local leaders and lack of accountability by the service personnel. Secrecy is an important mode for avoiding accountability and appropriation of resources.

Panchayat Raj if implemented in its true spirit of democratic decentralisation with delegation of financial and administrative responsibility to the people will provide this basic requirement as well as the frame-work for the implementation of health care at the community" level where the majority of the health problems are found. At each level the people have to be provided the resource and powers as well as latitude to modify the model to suit their local requirements e.g. use a mix of the indigenous and allopathic systems in the purchase of medicines and supplies and selection of personnel.

No targets will be imposed from above but technical information and broad guidelines will be provided for e, implementation of National Programmes for Special Disease Control and also for Family Planning.

The responsibility for operation of such a Community Health Care System at each level will be vested in the people and their Panchayati institutions. The Panchayat its bodies, especially at the Gram Panchayat level, will be supported by People's Committees. These bodies will be free to consult their health personnel or any other source to facilitate decision making and functioning. The health functionaries will report at each level to the respective Panchayat body.

The financial/technical planning of the Community Health Care System will be undertaken by the Panchayats in consultation with the available technical personnel at the Primary Health Center (PHC) and Community Health Center (CHC). The disbursement of salaries and other expenditures will be through the Panchayats and the ratio of salaries to supplies at all levels will be in a minimum ratio of 60:40 and 85:15 as at present. The maximum expenditure declining at higher levels. Power will not be vested only in the elected members of the Panchayat but will be shared by Representative People's Committee which will function with the health workers and the Gram Panchayats. The majority of the members of the People's Committees should be women, as well as be the health workers of this village system.

This Community Health Care model does not provide rigid directives but only broad guidelines. The ratio of population to personnel is flexible at each level and can be modified to local needs. However, there will

be no transfers of staff so inimical to continuity of operation and for purposes of building rapport and ensuring accountability. Inefficient staff may be warned or dismissed by the Panchayat bodies, but not imposed on another Panchayat through transfers.

Since the majority of the population consists of women and children and most of the health problems affect them, all health workers at the village level must be women when they will live and work as an integral part of the community which will pay their salary and to whom alone they will be finally accountable. They will work towards a common purposeful goal collaborating not only between themselves but also with the Anganwadi (ICDS) worker and the teachers of the village school. They will receive support from the PHC and CHC both of which will also be under the control of the community through the Gram Panchayats and Panchayat Samiti, and the People's Committees at each level.

Table 4  
COMMUNITY HEALTH CARE SYSTEM

Population Level	Panchayat Unit	Health Unit	Estimated Percentage Care
2,500	Gram Panchayat [GP]	VILLAGE HEALTH UNIT 1 Village Health Worker (F) 1 Dai (F) 1 Female Multipurpose Worker (F)	50%
500 509 2,500			
20,000	Group of GPs	PRIMARY HEALTH CENTER 2 Doctors 2 Nurses 10 Beds Ancillary staff	13
100,00	Samiti or Block	Panchayat <i>i/c</i> Senior Medical Officer [PSM]  [Preventive] 1 PSM doctor 4 Health assistants  [Curative] Rural Hospital 60-100 beds + dharmshala with 5 basic specialists and 4 general practitioners.	5
1 Million 5 Million	(District) (City)	District Hospital Tertiary Care Hospital	1.75 0.25

That the illiterate or even semiliterate poor are incapable of understanding leaves aside looking after their own health and welfare. Having secured control of the power and decision making process they have feathered their own nest utilising the Western model they seek to imitate. This has inevitably resulted in expensive curative services and hospitals catering primarily to their own requirements in urban enclaves. This has become the first choice not only of the private medical sector but also of the public sector. As a result of the influence they exert because of the personalised rapport with the decision makers such as politicians and bureaucrats who they treat, they are in command of decision making even in the public sector. This has resulted in the diversion of the limited resources of the public sector to urban medical colleges and hospitals where the majority of the private doctors receive their professional training. The training is based not on the pattern of diseases which affect the majority of our people but on that of the West which is also the disease pattern of our elite. Sophisticated expensive equipment is purchased at public cost to train the specialists in medical colleges and hospitals to deal with such diseases. This inversion of priorities as demonstrated by the distribution of resources, manpower and health facilities between urban and rural areas is partly intentional, but is also partly the result of almost total lack of awareness by the medical profession of the medical health problems that affect the majority of our people as also the socio-economic and cultural conditions under which the available technology has to be utilised for their benefit.

The Community Health Care System aims to correct this imbalance of health priorities where the decision making and implementation of most health activities will be from village upwards and not top-down as at present. Only then can technological and social relevance be brought into the health system. The reality of the cultural and social distance between the medical professionals and the masses has also to be considered in evolving such a system especially at the CHC and PHC levels.

A graded referral service is a key element of the CHC system. Each level will refer cases to the next level and there will be no bypassing of lower level to reach the hospital directly. The adequate services at the village level and the PHC attached to the CHC should ensure that the rural hospital is utilised only as a referral center as per actual medical and Public Health requirements.

The essence of the model is that the people must not only be actively involved in their own health care but

that the health services upto the 100,000 population ( Block/ Panchayat Samiti level) should be under their administrative and as well as financial control. Adequate funds should be provided to these bodies to ensure this.

Only this can ensure people's participation and active involvement as well as ensure accountability unto those who are paid to serve them. Without this precondition no model can hope to succeed. Much fear has been expressed about the misuse of power at the lower levels but misuse of power and corruption is not the prerogative of any level and is more visible at the smaller levels where interpersonal interaction is far easier and misuse can be checked.

The dissemination of power to the lower levels must be associated with widespread detailed information about all facilities and services and monetary resources provided for public use. This would prevent monopolising and diversion of resources by local leaders and lack of accountability by the service personnel. Secrecy is an important mode for avoiding accountability and appropriation of resources.

Panchayat Raj if implemented in its true spirit of democratic decentralisation with delegation of financial and administrative responsibility to the people will provide this basic requirement as well as the frame-work for the implementation of health care at the community level where the majority of the health problems are found. At each level the people have to be provided the resource and powers as well as latitude to modify the model to suit their local requirements e.g. use a mix of the indigenous and allopathic systems in the purchase of medicines and supplies and selection of personnel.

No targets will be imposed from above but technical information and broad guidelines will be provided for implementation of National Programmes for Special Disease Control and also for Family Planning.

The responsibility for operation of such a Community Health Care System at each level will be vested in the people and their Panchayati institutions. The Panchayat bodies, especially at the Gram Panchayat level, will be supported by People's Committees. These bodies will be free to consult their health personnel or any other source to facilitate decision making and functioning. The health functionaries will report at each level to the respective Panchayat body. The financial/technical

Each of the levels of the CHC System are components of a single comprehensive people's health unit for only when all levels function in concert can the CHC System be truly effective. Should anyone of the units be isolated, the entire system will be dysfunctional. We have seen this happen to be present day Community Health Worker, PHCs and Community Health Centers (Rural Hospitals).

### **BROADER IMPLICATIONS OF THE MODEL**

If the model is operated nationwide, it will have far reaching implications on health related issues in areas like medical education, training of supportive non-medical personnel, selection and evaluation of technology, production of drugs and instruments, status of non-allopathic systems in the health structure and appropriate medical research. It will encourage widespread experimentation in designing alternative systems like the CHC system, perhaps in collaboration with NGOs. It will require more sociological, economic and technological inputs at higher levels of decision making, rather than

leaving it entirely to non-medical general administrators. Other sectors particularly sanitation, water supply, infrastructure and education will have to be simultaneously developed on similar lines. The CHC System is set within a decentralised framework and operationalising the model ultimately implies decentralisation to the extent possible in all areas, not only in health and related areas.

In the ultimate, the operation of the health system will be determined by the political will either to look after the basic needs of all, as decided at Independence, or exotic needs of a few which has resulted in the present model. In a democracy it is for the people to decide this if provided with adequate and appropriate information.

[This paper is an extract from a forthcoming book : People's Health in People's Hands by Dr. N. H. Antia and Kavita Bhatia (Eds.), F.R.C.H., Bombay.]

## **ECONOMICS AND HEALTH**

### **NEW ECONOMIC POLICY - A PERSPECTIVE**

**Vrijendra**

(A paper presented at the MFC Meet: Wardha, September 1992)

**I**

On July 24, 1991 a new Industrial Policy was announced by the Finance Minister Dr. Manmohan Singh. The new Industrial Policy has deregulated the economy in a substantial manner. The new policy has abolished all industrial licensing irrespective of the level of investment, except for a few specific industries. The number of industries reserved for the public sector has been reduced from 17 to 8. These units are primarily in defence related areas. The government also announced that all public sector units (PSUs) would be reviewed and a part of its shareholding in these enterprises would be offered to the mutual funds, public financial institutions, the general public and the workers.

The govt. has also decided to reduce budgetary support for the PSUs, to expose them to competitive forces and to force them to improve their productivity and profitability. The govt. is also in the process of formulating an exit policy for the PSUs to reduce their labour force. The MRTP Act has been virtually scrapped for the big business which means that effectively the big business

has been exempted from any significant regulation. The investment limit for the small-scale and ancillary units has been further enhanced. Also the small scale units are for the first time, allowed the option to offer upto 24% of their shareholding to large industrial units. These changes effectively mean that large units can control small units to further their own interests in the economy.

The new Industrial Policy has removed locational restrictions on industrial units to a large extent. In fact, henceforth, industrial projects involving foreign loans from agencies like the WB, ADB etc. may be located in environmentally 'problem areas' without any clearance. The new policy also provides that from now onwards public financial institutions and banks would not exercise the option of converting part of their loans into equity in industrial enterprises. The liberalisation of the economy for the private sector on such a large scale is based on the assumption that a sudden burst of entrepreneurial energy would take place with deregulation- and public disinvestment. However, in practice, these policies have adversely affected demand and employment.

The cuts in social and development expenditures to reduce the fiscal deficit- as insisted by the IMF, are likely to adversely affect both the growth prospects of the economy as well 'IS the welfare of the vast poor and working people.

In fact, in 1991-92, investment declined compared to the previous year though precise data are not yet available. Industrial production declined by 2%, yet there is no evidence of either domestic or foreign entrepreneurs seizing the opportunities offered by delicensing to go in for major new investment or additional production.

In a way it is not surprising because of the specific character of private industrial investment and output in India such as : the demand driven nature of investment and capacity utilisation in industry and heavy dependence on public investment for demand and 'for widespread infrastructure and access to energy. Thus, substantial reduction in public investment has had a negative impact on industry, with other deflationary policies, the net effect has been a significant slow-down in industrial growth. Besides, in some areas, "expenditure cuts have led to supply shortages adding to 'inflationary pressures in the economy along with recession.

In fact, the price rise in last one and half years has been so persistent that it has become a political problem for the govt. as the price increase has savagely reduced the real income of the working people, especially the large majority in the urban unorganised sector and the agricultural landless labourers.

## II

Simultaneously, there has been an increase in unemployment with declining employment opportunities coupled with increasing layoffs' and lockouts in the industrial sector.

In July 1991, the rupee was devalued to the extent of 20%, on the advice of the IMF, primarily to increase the amount and the competitiveness of Indian exports. However, the available evidence does not suggest that devaluation automatically increases competitiveness of exports and enlarges the market for them. For instance, in the 1980s the rupee depreciated significantly against major international currencies like dollar, yen, pound but the export performance failed to improve. Instead, India's share in the world trade declined during the same period.

Now, when the domestic economy and the world trade are forecast, to deflate, the current devaluation is unlikely to improve export performance. But it has enormously increased the price of imports, the amount of foreign debt and its servicing. Even before devaluation, imports had become much more expensive than exports and

yet they increased in dollar terms during 1982-90 on account of increase in imports of capital goods, luxury goods, export-related imports and other intermediate goods. Similarly, the nature of India's exports-primary products and low-technology items-means that the demand for them is not likely to increase in response to price reduction.

On the other hand, devaluation with liberalisation benefits the MNCs from the developed countries. It shifts the terms of trade in their favour while liberalising measures improve the market for their products and services.

## III

As a part of the measures to correct the BoP crisis in the economy, in the new Industrial Policy, major concessions were announced to attract foreign direct investment (FDI) to the country. It specified 34 industries with high-technology and high-investment, wherein' automatic permission would be available to FDI upto 51 % equity. Foreign investment would also be allowed in service areas. The govt. also announced that there would be no bottlenecks in clearance of proposals for foreign equity participation. Companies with upto 51% equity would be encouraged to act as trading houses primarily engaged in export business.

A special board would be constituted to negotiate with a "number of world's largest international manufacturing and marketing firms". Investment by these firms would, be "considered in totality, free from pre-determined parameters or procedures." Automatic permission would be available to foreign technology agreements in high priority areas with certain restrictions.

These changes were announced to bring about structural transformation of the economy and to integrate it in the - international capitalist economy. Once again, the measures announced to correct the BoP crisis with the help of the MNCs fail to incorporate India's and other LDCs' experience with the MNCs and the foreign capital.

These changes hide the fact that that MNCS plan their allocation of resources to only further the interests of their parent company. They are not concerned with benefiting the economy of any country in which and particular investment is located. Various branches of the MNCs in different countries export and import among themselves at arbitrary prices called transfer prices. They apply a variety of threats and pressures on a particular country to minimise restrictions and hindrances) for foreign capital in that country.

They also wish to minimise difficulties encountered in getting out of a country other countries offer greater investment and profit opportunities or if their needs change with changes in resources, technology, problems an account of labour and other regulations in the domestic economy with regard to, say, technology transfer and remittances abroad.

Available evidence suggests that the MNCs, in fact, add to the trade deficits of a country because they are consistently import-intensive. For instance, RBI and other agencies have repeatedly documented that the foreign controlled companies are a net spender of foreign exchange. At the same time, they adopt a variety of measures to prevent exports from the host company to protect their foreign markets. They also maintain a colonial pattern of trade in commodities and thereby reinforce the backwardness of the economy and its vulnerability to the worsening of the international terms of trade for primary products and low-technology items. In this context it needs to be recalled that the roots of the current BoP crisis can be traced to the 1985 export-import policy of the Rajiv Gandhi govt. This policy liberalised imports on a large scale. It was based on the theory of import-led exports which, in turn, would lead to export-led growth in the economy. The policy also permitted a heavy dose of import liberalisation, supposedly to remove bottlenecks in domestic production, especially in export goods industry.

Further, from 1987-88, India's independence an external savings began to increase dramatically with increase in trade deficits. Large-scale borrowings from the foreign commercial banks on the advice of the WB soon led to BoP crises and a sharp decline in additional debts from these banks. The credit rating of India was sharply lowered and India was forced to approach the IMF for a 'Structural adjustment loan' on the condition of liberalising the economy for the private sector and for FDI on a large scale.

#### IV

To understand the larger mechanics of the global market economy and the pressure on India on a variety of policy issues related to the participation of the MNCs, it is interesting and relevant to look at the changing global context of the FDI. By the end of 1990, FDI in manufacturing, real estate, raw material extraction, financial investment etc. made in other countries was over \$ 1.5 trillions. Though it is a gross under-estimation because data are based on the book value of assets, it indicates that FDI tripled in the 1980s alone. Besides, the area of FDI has extended beyond manufacturing and

extraction of raw materials to finance, real estate, insurance, advertising and the media. This upsurge and diversification of FDI has been introducing new economic and political features both in DCs and LDCs without reducing contradictions between the rich and the poor countries. There has been a general slowing down of economies of the DCs in the last two decades. This has induced capital to create and seek new profitable opportunities along with rise in protectionist measures in these economies. Although the sharp increase in FDI after the recession of the 1980s has been remarkable, its growing importance has been apparent for a long time now, almost since the end of the Second World War.

Yet, of late, there has been an important shift to investment in services from manufacturing and raw material. New forms of economic penetration have occurred in finance and insurance, communications, advertising and the media. For example, for the USA, while investment overseas remains important (40% of all investment during 1966-90), there has been an extra-ordinary rise in investment in banking, finance and insurance after 1966 (30% of total US FDI in 1990). The amount of investment in banking, finance and insurance in LDCs at \$43 billion is 1/3rd more than investment in manufacturing. Also, the US investment in the third world is more heavily in banking, finance and insurance (40%) than in DCs (25. %).

This is not an isolated case. It reflects, even with reservations, how deeply the globalisation of finance has penetrated the daily economic lives of people in the LDCs. Despite this striking transformation in the world capitalist system since the mid-40s, the dependence of the third world on the first world remains in a fundamental sense. Also the gap between the rich and the poor countries continues to widen in prosperous as well as in stagnating periods.

When the BoP statistics are analysed for the LDCs, one finds that BoP on all current transactions is positive for all the years between 1986 and 1990 if payments abroad of interest, dividends and fees to foreigners are excluded but as soon as these payments are included in BoP data, the balance turns negative for each year on a large scale. As the deficit for a LDC becomes unmanageable, the IMF and WB come forward as rescuers to 'rescue' not the indebted countries but primarily the foreign lending banks of the DCs whose profits and stability depend on continuous servicing of their loans.

As BoP crisis of a country becomes acute, international

lenders become more restrictive in their lending and more heavy-handed in their restraints imposed on the borrowers. Loans are made available on the condition that borrowers adopt policies aimed at resulting in large positive balance between exports and imports. In practice, these policies mean fewer social benefits, squeeze on wages and a drastic reduction in imports. As a large proportion of imports is needed for domestic production the import cutback adversely affects goods required to meet basic needs of the people. Thus, the result of these restraints, compounded by sharp decline in prices of many primary products exported by the LDCs, leads to a serious decline in income and employment in these economies as happened in many Latin American and African countries in the 1980s.

Though public and private lenders continue to lend to indebted countries to make it possible for them to continue servicing past debts and to prevent a wholesale collapse of banks in the DCs, the emphasis shifts more and more to discipline the borrowers, imposed chiefly through the IMF. As interest and principal liabilities continue to increase, the net debt continues to decrease and debt servitude becomes dominant. The net result is:

- (a) a transfer of economic surplus from LDCs to DCs, and
- (b) an entrenchment of dependence from weaker to stronger nations.

Thus, the third world as a whole, paves the way for capital accumulation and profit-making by giant corporations and financial institutions of DCs. The policy framework in India is being made attractive to the MNCs in this larger global context. It also puts in perspective the attempts by the USA to make India agree to the GAIT proposals (Dunkel Draft) modify the Indian Patents Act, opening the services sector and even agriculture to the MNCs and so on.

## V

The thrust of the new package consists of devaluation delicensing and decontrol of industrial activities; globalisation of the Indian economy; removal of fiscal and other impediments to foreign trade and FDI and other related issues. This tendency reflects almost total concentration on the industrial sector as yet especially the modernized part of it and the implicit concentration of economic decisions with regard to macroeconomic, monetary, trade and exchange policies.

It is based on the premise that, one way or the other agriculture and other sectors of the economy will automatically adjust to these changes on their own.

It, thus, ignores the nature of agriculture in India and how its production relations have changed in last 40 years with its illusion of 'self-sufficiency' even as conflicts in rural areas have sharply increased. It also ignores the consequences of a market-friendly state on agriculture, policies and issues its structure of support and subsidies such as fertilisers taxation policy and the PDS and its bias in favour of large farmers with marketable surplus; and against the large majority of small farmers and the landless labourers.

The liberalisation measures may be virtually identified with dismantling of control in areas of the industrial private sector and foreign trade. Changes in the other activities of the govt. are subordinate to this basic policy framework. The social and political consequences of these changes on the already highly vulnerable democratic polity are being deliberately overlooked. The policy package blissfully ignores that a large proportion of the poor population still depends vitally on the capacity of the state to transform and improve their social, economic and political prospects. The redefinition of the role of the state in the new emerging framework raises a variety of crucial issues beyond the task of economic adjustment. The govt. seems to have abdicated its role as guardian of social interest and its accountability to people, except in a purely formal sense.

At the same time, the state is increasingly being identified with the Central govt. further straining the already fragile and centre-state relations in India. There has been a consistent and notable intrusion of the centre in area of state government with centrally sponsored schemes and assistance. The centre has extended its role to even micro-level planning for allocation of technical and financial resources Apart from agriculture, areas of public health and education are perhaps, the most important areas of accessibility for the poor sections. Yet, it is precisely these areas that have received much more lip-sympathy than resources warranted in accordance with their high priority.

The proponents of liberalisation in their zeal to globalisation the economy have turned a blind eye to the basic questions of social justice and unemployment because the market cannot handle them. The policy framework seems to have been designed solely to regain credibility in the eyes of the foreign lenders and investors without any consideration of its disastrous consequences on domestic economy and socio-political perceptions and institutions. The selective resoluteness of the govt. is evident on various issues.

For example, while it has firmly food and fertilizer subsidies to reduce fiscal deficit, the same firmness is conspicuous by its absence when it comes to reducing the privileges of the rich and the powerful

In the present state of the Country, the ruler-ruled divide, so characteristic of the colonial regime, is more than ever visible. The policies and programmes are, accordingly, being formulated to subservise the interests of the rich after the powerful. Whether they also serve the long-term interests of the nation and its people seems to be only a minor consideration, if at all, while the rich are increasingly being integrated in the 'global civilization of capitalism' in their life-style and consumption levels, the poor majority is increasingly being denied even scarce access to resources and commodities.

Thus, there is little doubt that the liberalising measures and the advice of the IMP-WB would not harm the interest of the ruling minority who have been responsible for the present crisis in the first place. Instead, as the experience of the Latin American and African countries shows, the poor, who benefited the least from the past policies would bear the burden of readjustment.

The new package of policies also reflects the inability and unwillingness of state to ensure that the costs of readjustments are equitably distributed and the basic infrastructural facilities are created in the areas of health and education so that the poor can at least increase their efficiency and productivity. Instead, the groups which have systematically manipulated the state in the past are likely to manipulate the market as well to serve their private interests.

## VI

Within the framework of the mixed economy in India after independence, the health planning was declared to be an integral part of socio-economic planning. The Bhoré committee report provided the blueprint for a national Health policy. It recommended free provision of health care services with heavy emphasis on the preventive and rural services. However, in practice, about 55% of public expenditure on health services is spent on curative health care and medical education. The share of the public health expenditure which is directly relevant for the health of the majority is about one-third of the total expenditure.

The family welfare programmes claim the rest. In medical education, the actual emphasis has been on producing well-trained but highly specialised doctors in curative

services despite the repeated emphasis on social and preventive medicines and paramedical personnel in policy documents. Similarly, medical research is concentrated on diseases like cancer, heart diseases, neurosurgery etc. which enjoy international glamour rather than on diseases like leprosy and filariasis, more relevant to the needs of the people.

There are glaring disparities in urban-rural accessibility to health care system. These disparities are further compounded by disparities in regional distribution. Such vast disparities have taken place despite the fact that the Govt. owns about 75% of total hospital and dispensary beds. Thus, despite its welfare pretensions, the state in India has been subsidizing health needs of the rich and the middle classes who constitute the most vocal sections of the population and monopolies benefit from public services.

While the state in India has ignored the real basis of disease and ill-health of the people in their working and living conditions, it has played a very active role in creating and widening opportunities for private capital accumulation in health sector. The nature of state intervention is also evident from its policy towards private sector in medical care and pharmaceutical industry. The growing liberalisation and privatisation in economic policies has only added to the progress of monopolistic tendencies in the supply of health care services. The big business houses like Tatas, Birlas, Hindujas etc. have been entering the health care market with the active cooperation from the Indian state in the form of reduced custom duties and the imposts of medical equipments, tax concessions, subsidies and other charges for services like water, power, financial assistance and same times even direct collaboration in establishing high-technology hospitals in the joint sector.

Multiplication of diagnostic centres, nursing homes and hospitals in the corporate sector represents a radical transformation of health care system in India. As a result, the cost of medical care has been increasing at an exorbitant rate. Similarly, in the drug industry, the Indian state is subservient to the interests of foreign MNCs. These MNCs manage to manipulate the political leadership and the bureaucracy in their favour. The result is that the Indian drug market is flooded with a large number of formulations and combinations which are either useless or positively harmful to the health of the people.

The new policy package will further accentuate these distortions in the availability of the health care in India.

With proposals to almost handover the entire medical system to the private sector, it seems likely that in near future, the public health system in India will be dismantled. For instance, the increasing tendency to impose graded charges on different types of services available in govt. and municipal hospitals to people, the privatisation of medical education and other attempts to hand over established hospitals in the state sector to private medical colleges and

trusts in different parts of the country are symptomatic of the kind of health care system that is increasingly being shaped in the country by the state in collaboration with the private sector. In such an emerging scenario, while the health needs of the people, especially the vast poor majority, will increase, their accessibility to the health care system is likely to further decline in future in the absence of suitable public provisions to meet their health requirements.

## ABOUT THE BULLETIN

### SPOT SURVEY OF MFC BULLETIN AT WARDHA MID-ANNUAL MEETING 1992

As our editor was bemoaning the lack of enthusiasm and support for the bulletin for the nth time, and some members began to sport the usual comments, criticisms and platitudes, the idea of this spot survey at the mid-annual meet itself cropped up. Perhaps we should assess how bleak the situation really is. That is exactly what we did.

First, to give a profile of the 39 MFC members at the meet, 35 of whom responded by completing the brief questionnaire. About 60% (23) were doctors two had a background in biochemistry and microbiology respectively.) There were no paramedical professionals, such as nurses or technicians. In the non-medical category the professional range was from social researcher to teacher of college economics and computing. Four of the doctors also taught in medical colleges. Six persons were based in rural areas, 12 in urban centres, and the rest all had about equally mixed rural-urban involvement. Three of the doctors were homeopathic physicians. Those were no practitioners of ISM (indigenous systems of medicine). Incidentally, of the 23 doctors, only three were women.

To give the score for years of contact with, or knowledge of MFC through the bulletin, 15 were old members since ten or more years, and 8 had learned of MFC within the last three years. The remaining 16 had known of MFC for more than three but less than ten years. About half of the latter had become active only since the last two to four years. The 36 respondents listed their special fields of interest (usually more than one) and these could be grouped as follows:

1. Primary Health Care including control of, malaria, Kala Azar etc., and MCH : 12 persons.
2. Women and Health, including sexuality and violence against women: 8 persons.

3. Child and School Health: 4 persons.
4. Mental Health: 3 persons.
5. Health Education and science writing: 8 persons
6. Medical Education and Health worker training: 4 persons.
7. Health Economics, Regularization of the private Health Sector, Govt. Policy: 8 persons.
8. Development and Health, Environment, S & T, Occupational Health, Tribal Health, Reforestation: 14 persons.
9. Human Rights, Medical Ethics, Malpractice Health-related protests movement: 6 persons
10. Drugs and Medicare: 7 persons.
11. Indigenous Medical Systems, Herbal Medicines, etc., 7 persons
12. Philosophy of Science: 1 person.
13. MFC organizational Matters: 5 persons.

About the strong points of the MFC, the respondent had the following to list. The articles are relevant, interesting thought provoking, usual (of a type hard to find anywhere else, or unique to MFC), field based, sincere and earnest; they document changes in, the health and medical field with a social perspective, and highlight the effects of issues on economically deprived sections; they provide a good mix of field experience and theory; the analysis of experimental data is good ((but interpretation is poor); there focused issues of the bulletin allow concentration on particular problems and development of "critique", a new way of thinking.

Also, the MFCB is an important medium for communication among friends, and a forum for thought and action on issues decided by MFC members, new of MFC meetings gets conveyed. Through the bulletin, MFC can get across to non-MFC groups and institutions.

The best articles latter get collected and published as MFC 'anthologies' which are like<.l by many. These are helpful references for researchers in the health field and others. "Writing in the bulletin is not difficult" subscription rates are comparatively low. Last, but not the least, the MFC bulletin has survived for eighteen years.

The following weak points were perceived and listed:

There is growing superficiality, stagnation, and lack of direction. Many articles are too amateur and/or individualistic, and after statements lack validation by data. Too many articles are technical and narrow in focus. There are not among personal' observations about "our career our profession" (from a medical student). Single-topic or "Theme" issues leave our uninterested persons. The former healthy tradition of reader response has been allowed to die out in recent years.

Regarding format, it changes too often there are many typing errors and layout flaws, articles are too long, and the format lack variety and attractive design. Concerning subscriptions and readership, irregularity of printing and postal delays are annoying. Weak subscriber Contact is the main cause of falling subscriptions. Too few readers respond or otherwise contribute to the MFCB.

However, neither does the editor give clear indications about editorial policy or hints of how to contribute. There is also no compact statement pealing about MFC for new readers.

Suggested changes in the bulletin are therefore : add more variety in the share of regular columns (of special interest, letters to the editor, short pieces, especially experimental account and reflection from local MFC members or groups, book and journal article reviews, diagrams, flow charts, cartoons, extracts from other sources or from past bulletins, correct news (e.g. reports of doctors agitations, etc. The length should be increased to more than the present eight or twelve pages. "Theme" issues should not focus only on the theme topic, but leave space for other interests and regular features. However, theme issues are desirable, as they help MFC's position to develop and get clearly revealed. A balance should always be struck between the medical and non-medical aspects of health. A member asked for specifically for more articles on 'Medicare'.

Further, balance is required between academic debates, experiential reports and discussions, interpretation of emerging trends, case studies & idea exchange. Articles should occasionally include practical information, responding to readers' needs.

The format, layout and proofreading should improve. The MFCB should be published monthly and on time. There should be a small note on MFC in every issue.

Editorially, the focus of each issue should sharpen with accent on current trends and events. The editor and other MFC members should be willing to entertain "absurd" opinions, as long as they are sincere. Above all, the editor should cultivate a thought and action process related to health. Editorial policy is to be clarified, crystallized and communicated explicitly-to the readership. Also, the editor should regularly communicate "how we can act" on the issues raised in the bulletin, and "motivate us more"! (Other words used were "persuade", "pressurise", "attract"...) Furthermore, the editorship "should be an enjoyable chore, not a burden" (take note, Sham!). The editorship should continue for a longer time - upto five years rather than the present two-year rotation: A full-time editor is preferable, or at least a more active support team, part-time office support and a professional approach.

**Subscription-wise the rates should be increased:**

Students	Rs. 15/
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Presently	Rs. 30/
(But Rs. 25/- concessional rate for activists with less support).	
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Presently	Rs. 300/-

One person should manage subscriptions. All possible tricks to increase subscription should be tried and / or retried. Routine subscription management can be streamlined according to modern practices and a marketing approach adopted. "Subscriber Meets" can be held in localities. Cost-sharing of means, copy orders can be tried by willing regional members, e.g. medical students and interns, MSW colleges, university staff, paramedical persons, PHD doctors etc, and follow-up done. Finally, the wrapper should be made secure.

Answers to the question, "Why have you not written for or responded in the bulletin are revealing? The most common reason was laziness or inaction, but a few said "lack of habits". One called it "disinterest in writing".

Several wrote that they have been too busy. One said he "came close to it several times". One squarely; blamed a lack of stimulus' from the editor's side. One wrote, "I just didn't feel like it, but I'll write now". An old member said she doesn't respond so much nowadays because "few articles raise debatable issues". Some hesitated because they were uncertain of MFCB editorial policy.

A set of other comments about writing revolved around feeling of inhibition and lack of confidence : "I thought my pieces would be rejected or criticised..." a feeling that the MFC level of argument and debate is too high" and "I felt incompetent for real and imaginary reasons". A few members said they had a language problem with English, and would like to write in Gujarati or Marathi if it could be translated. Encouragingly many comments were appended with words like "will be writing", "will write in future", "surely can send something", "I wish to write about my experience very soon", "I hope to write", "I shall try",

One wrote currently, "I write." Another added, "will love to continue." Well, going through the questionnaire responses and writing this report, although it was not an easy task was at times even exhilarating. From it I personally feel that the long wooed (and often ruled) "revitalisation process" in MFC is willy-nilly underway.

I agree to write about one of the newest members I that" the bulletin is very necessary and SHOULD NEVER ~ BE GIVEN UP". But, I sympathize with the poor editor and feel the next step is to see how we all can help in whatever way possible.

To be fair, however, we must keep it in mind that the persons collected at this meet were a selected lot, enthusiastic or dedicated enough to travel the distance and attend at personal expense. What about the rest of the MFC bulletin readership? Do not hesitate to respond in the coming bulletins.

Meera Sadgopal

BY THE WAY

## COLD STATISTICS IN MEDICINE

B. M. Hegde,

"I welcome criticism, even when for convenience sake, it deviates, for the time being from truth." said Sir Winston Churchill, A wise man once said that "truth will influence only half a score of men at any time or age, while mystery will attract millions of followers". Unfortunately medicine is suffering the same fate.

"Statistics have not added even an iota of new knowledge to medicine", was the emphatic statement of Myre Syme in 1990.

"Sciences do not explain, they do not even interpret, they merely make models - mathematical constructs, which with a few verbal explanations are supposed to work", said John Von Newmann.

Newton's laws of determinative predictability were proved wrong by the theory of relativity. Laplace's hypothesis that "given the accurate position of every particle in this world and the capability to calculate, can trace' the history of this planet from its beginning to its end" has had two major flaws.

Both the prerequisites were impossible to achieve and as such the hypothesis remained only a conjecture. Lorenz credited to have initiated' scientific weather prediction, very soon realised that weather can never be predicted accurately.

Medicine has gone through all these in the past, indeed Proust once wrote: " To believe in medicine would be the height of folly, if not to believe in it were not greater folly still, for from this mass of errors there have emerged in the course of time many truths".

Shaw's lively preface to "The Doctors Dilemma" had less influence on the public. Whatever the explanation, until now medicine's "contribution to prevention of sickness, disability and premature death was taken essentially at its own evaluation"

I recommend the serious reader to a beautiful book written by Sir Macfarlane Burnet entitled "Genes, Dreams and Realities" (Aylesbury, Bucks: Medical and Technical Publishing Co. Ltd 1971) Where he concludes that "the

Contribution of laboratory science has virtually come of an end and almost none of the modern basic research in the medical sciences has any direct bearing on the prevention of disease or on the improvement of medical phase". Now look at the criticism of this in the press. Burnet was accused 'not merely of scientific error, but even more seriously, of lacking faith in the potential of Science. Many of us are influenced by the Cartesian model in concluding that improvements in health are derived from understanding of the structure and function of the body and of the disease processes that affect it. We are carrying over to living things principles which have been applied successfully to inanimate matter. Human body is a dynamic organism and the laws of linear Euclidean mathematics do not hold good in human affairs.

Many of us believe that control 'of infectious diseases has based on the knowledge derived from basic research and applied largely through immunisation and antibiotic therapy. Thomas McKeown in his classic treatise "The Role of Medicine" (The Nuffield Provincial Hospitals Trust 1976 has clearly shown "that basic research and antibiotic therapy had little effect on the death rate before 1935 and since that time have been less important than other influences!"

A good look at Figure 1. would convince anyone, more so the ones who believe in cold statistics, (I cannot give these figures for India as we did not and do not have. such documents) that medical methods had little influence on death rates over the years. The look at Figure 2 should convince even the converts that therapy had very little effect on a disease the death rate has mounted steadily after the advent of Sulpha and antibiotics. In non-linear mathematics initial condition may have catastrophic final outcomes, beautifully bought out in this stanza:

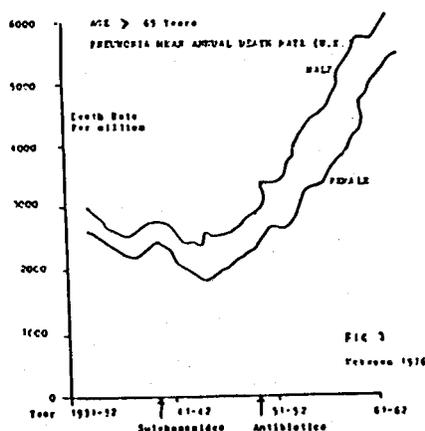
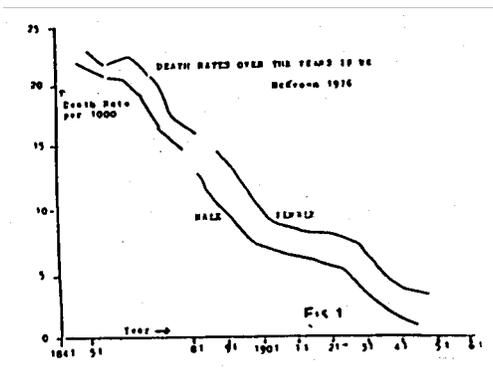
For want of a nail, the shoe was lost,  
 For want of a shoe, the horse was lost,  
 For want of a horse, the soldier was lost,  
 For want of a soldier, the king was lost,  
 For want of a small nail, the kingdom was lost.

This kind of mathematics, called Chaos, applies to medicine and human beings.

It should not be understood that immunisation or treatment were of no value, on the contrary they were probably effective, but their impact on mortality and morbidity was small in relation to other influences. The effect of immunisation and therapy on a population which it's underfed and heavily exposed to infection is doubtful. The WHO's experience in developing countries suggests that "it is questionable if infectious diseases could be controlled by vaccination in a malnourished population at all." The story of smallpox is an exception to this rule. Experience of the last two centuries indicates that infectious deaths fell to a small fraction of their earlier level without medical intervention.

Until 10,000 years ago, the main restraint on population growth was a high level of mortality determined directly or indirectly by lack of food. First agricultural revolution lowered mortality. We see the cycle again in Africa now where mortality is directly related to starvation. Increase in population is another prerequisite for micro-organisms to invade their human host. Overcrowding and urbanisation are other factors. Coupled with under-nutrition, the ground is prepared for the germs to have an upper hand in the battle with their human host. Infant mortality is also associated with nutrition and lack of hygiene. If we do not wake up now, by the year 2040, the global population will mount to 10 billion and the total food output an only feed about half that number. The population bomb has exploded already and we should not be complacent about our health only through medical sciences. We must wake up and try to bring down the population.

Death Rates over The



Be that as it may, we will now look at the "lifesaving advances" in cardiovascular and pulmonary diseases. The advances such as open-heart surgery, blood vessel surgery, treatment of high blood pressure, management of coronary heart disease, prevention of poliomyelitis, Chemotherapy of TB, and acute, rheumatic fever, cardiac resuscitation and pacemakers, diuretics in the treatment of heart failure, intensive care units, and the new diagnostic tools, were reviewed by Comroe J, H, and Dripps R.D. (Scientific basis for the support of biomedical science, Science 1976: 192: 105). They were able to show these advances relied largely on work which was not clinically oriented at the time it was done. Apart from poliomyelitis where a large contribution was made to a relatively small problem and tuberculosis and rheumatic fever where a small contribution was made to a large problem, the rest are all examples of halfway technology... the kinds of things that must be done after the fact, in efforts to compensate for the incapacitating effects of certain diseases whose course one is unable to do very much about". Such measures may prolong life for a few years, but they do not prevent diseases, nor do they restore the patient to a life of normal duration and quality. The last statement may be better explained with reference to diabetes. The discovery of insulin was regarded as a great landmark in the history of medical science. It is true that insulin has prolonged many lives, but it is doubtful if treatment can control the secondary complications like cataract, neuropathy or blood vessel diseases. Although many of the problems of diabetes have been alleviated by insulin, they have by no means been an "effort to look with high power glasses at a very small segment of the very large field". Multiple factors determine health and disease.

The decline of infectious diseases deaths preceded by more than hundred years the discovery of micro-organisms. The withdrawal of thalidomide and avoiding rubella during pregnancy prevented congenital malformations without any knowledge of teratogenicity. Cessation of smoking by doctors lowered the incidence of cancer of lungs before detailed knowledge of carcinogenesis. Fortunately there are other alternative approaches for the solution of health problems.

We should try to understand conditions determined at fertilisation to minimise the problems of congenital diseases. Efforts must be made to exploit our resources to study environmental influences on human health better.

Mental illnesses present a formidable challenge. Freudian psychology has been disappointing. Apart from "conferring a secular blessing on the practice of confession and on with its emphasis on therapy, it has had little impact and the miserable lives of many who are mentally ill," Even the therapeutic paradigm of one gene, one enzyme, one transmitter, one receptor, one behaviour, one clinical syndrome one drug has not worked. The working of millions of brain cells in tandem does not follow this paradigm. Really profound observations on human conditions were made by Christ, When He said, "he that shall findeth his life shall lose it" and by La. Rochefoucauld when he said that "it is easier to generalise' about mankind than to understand any one man".

Physical illnesses depend mainly on environmental influences. Exceptions are conditions determined irreversibly at fertilization; the small number associated with gene or chromosome abnormalities and the large number which result from genetic programmed wear and tear of organs at the end of life.

For the post-natal life one should aim at transforming the health of infants and young people, essentially by improved feeding and modification of the environment in which they live. It is now also clear that even most cancers are due to environmental influences where we have to take into consideration the change in reproductive behaviour. It is naive to suggest that these will be easy to identify and modify for the benefit of mankind, but an attempt must be made in this direction. We have been barking up the wrong tree going headlong after laboratory research to find solutions to all health's problems.

In medicine there is confusion. It is not because there is a lack of effort at explaining things. On the contrary there is a surfeit of opinions in medicine. For an earnest seeker of truth they are not consistent and in fact, most of them are contradictory. It is like the "It was the best of times, it was the worst of times, it was then time of wisdom, it was the time of foolishness (A tale, of Two Cities)

Do you not agree with me now that medicine is also of a social philosophy? It is said in lighter vein that "Twentieth century medicine would do much to restore nineteenth century faith in prayer". "The Doctor is 11: described as a man of principle devoted to the advancement of science and the welfare of his patients and also as a charlatan who can be counted on to look after nothing but his own interests". The time-honored doctor patient relationship has taken a beating because of large scale commercialisation of medicine.

Time might come very soon when patients may question "If we are disabled, what is the role of medicine?!"

I am a strong believer in the positive role doctors could lay in society if they followed the Hippocratic adage in its entirety "cure rarely, comfort mostly but, console always" : even if it becomes clear in the future, many tinkers like Thomas McKeown believe so, that the determinants of health are largely put side the medical :are system."

Burnet suggested "that future historians may speak of an age of scientific discovery that started with Galileo in 1586 and ended something less than four hundred years later." In spite all over claims the only doctors who "have been effective are the fracture doctors dealing with accients, dental surgeons and to a lesser extent obstetricians. Interestingly all these deal with normal healthy human beings. When human beings are unhealthy the doctor effect has been negligible.

Future scenario would be "intrinsic diseases like degenerative diseases, cancer, old-age and auto-immune diseases, diseases of civilisations like lung cancer, road

accidents, alcoholism and drug addiction and the general problems of society which infringe on health like limitation of population growth, disarmament, and control of environment". Medicine has a role to play in this set up; the major actors in the drama will be observational sciences, ecology and ethnology. "Because of their rather direct bearing on contemporary human problems" said Sir Macfarlane Burnet, in his book-Genes, Dreams and Realities.

It is a pity that in India even informed opinion of the elite seems to be far from realities. A friend of mine suggested that "accident treatment requires high-tech gadgets and modem ambulances and we in India should gear up to meet the challenge". In reality what we should be doing is to avoid accidents by designing better roads, safer vehicles and stricter control of licensing drivers and avoiding drunken driving and not trying to use all our resources only to treat accident victims, although the latter is important.

I am still optimistic that this world will not perish on Friday, the 11th November 2026 AD at 1.23 p.m. The Domsday equation is based on linear mathematics and is bound to go wrong when applied to this dynamic universe.

LAW

## THE SUPREME COURT RULING - IMPLICATIONS FOR US

Sham Ashtekar

The landmark ruling given by supreme court in the petition filed against the Kerala high court decision has created a panic among non-allopathic practitioners through out the' country. In Maharashtra state, fake practitioners are already on the run because of police actions. With this decision unauthorised use of allopathy by non-allopaths also comes under fire. This has far reaching implications, both negative and positive as far as public interest is concerned.

In summary the case is like this. Kerala state had started diploma course in homeopathy, just like any other state. The diploma holders could practice allopathy after due registration with their own boards of regulation. Subsequently diploma holders from Bihar University also were treated on par with the Kerala state diplomas and allopaths. The petitioner challenged the use of allopathy by these diploma holders in Kerala high court. High Court ruling upheld Slate Govt.'s decision to permit use of allopathy by these diploma holders since medicare is a subject on the concurrent list. The Supreme Court considered the matter and ruled that there are separate boards for regulations of each pathy and separate course tend to recognition by registration council.

So allopathy can be used only by degree holders of Modern Medicine and not by any other categories of doctors.

Subsequently, at least in Maharashtra, there have been a few proceedings against non allopaths indulging in Modern Medicine. Anything like storage, use, prescription of Modern Medicine by the other categories is against law. Non-allopath Association are slowly waking upto this fact and there are protests.

Let us now analyse the implication in the context of public interest.

1) The ruling should wipe out misuse/abuse of modern medicine drugs by untrained persons, and to this extent it is a great instrument if properly enforced. 2) Looking at the rural urban doctor distribution scenes, nearly 90% of the rural 'doctors' are non-allopaths. Over 70% of the curative medicine is offered by the private sector. Allopathic doctors are very few. So, ns far as the rural scene is concerned, this ruling will nearly deny 'Modem Medicare' to the majority of the population. Modem Medicines are especially useful in  
a) Infections and infestations b) Emergencies.

In both these areas other pathies have no substitutes. In general of the bulk of drugs used in rural sector, nearly 90% is from modern medicine category. So this presents a 'Socially impossible' situation; for the ruling. 3) In the general practitioner category which consists of MBBS, graduates as well as non-allopaths (Homeopaths and Ayurvedics to a great extent; the recruitment of the former (MBBS) is fast 'dwindling. Since majority' of them prefer to do some post graduation. A situation is imminent wherein MBBS will merely be a pre-post graduation qualification rather "than a thing by itself. So the general practitioners category will largely consist of non-allopaths hereafter. 4) The state government and rural NGOs are engaged in the 'Paramedics program' (indulging the health guide) in the rural health care. Use of allopathy/Modern Medicines by the paramedic category stands prohibited as per this ruling, though the state govt. categories might get same temporary (flimsy in the court of law) immunity with GRSc Government resolutions) supporting them. The NGO progr3mmes indulging in health care by paramedics comes in jeopardy with this ruling, with immediate effect, though most of them would prefer to operate closing their eyes to the law. Enforcement agencies also might turn a blind eye since the total sense of NGO operation is negligible both in quantity 3ntl seriousness. But this C3nnot go on for long.'

So, what will be our position on this situation? I propose the following. 1) The Supreme Court ruling is wholesome and welcome anti should be made use of to cleanse the land of abuse of medicines by non-allopathic doctors (rather by Vaidyas und homeopaths). We have to propose measures to bring the ruling into effect. I strongly feel that regulating medical stores vigorously is in the realm of possibilities. It should be a practice to turn down prescription of modern medicines by non-allopaths, and even punish the guilt store-keepers and practioners.

I request a larger sharing on this matter.

### INVITATION TO ATTEND The MFC MEET, TO BE HELD IN CALCUITA ON JANUARY 23, 24, AND 25 1993.

Dear Friends,

The forthcoming MFC theme-oriented meet will be held in Calcutta. The theme, "National Medical Care Policy" has been carefully planned for a rearatory meeting was held in Wardha this September.

A detailed circular letter about the Calcutta meet will soon follow. The next newsletter (December, 1992) will also carry relevant announcements. This tentative circular is being sent to all of you, to specifically request you to attend the Calcutta meet. You are aware as to how much effort goes into organising a full17edged MFC meet. The Calcutta MFC groups are really striving very hard. Poor attendance demoralizes the entire organising team.

It also adversely affects the quality and depth of discussions.

The present depressing atmosphere of privatisation of health services and the impending doom of the new economic policy on public (and private) health care services we all must discuss alternatives that are pro-people and those which, groups like ours should rightfully demand. To think of a universal National Medical Care Policy is one such alternative. During the XVII Annual Meet in Bombay (Sept. 1991) we had discussed the need to regulate private practice in medicine.

2) But these has to be a provision of crash courses in Modern Medicine (say six months) for non-allopaths which will enable them to effectively anti rationally use a decided range of modern medicine - drugs & skills. Mechanism for evaluation, disqualification and continuing education should be created. 3) As a long term measure, a 'general practitioner' course should be introduced to use the major healing systems in the context of our realities. This will be a very important institution in health care in our country. 4) There should be short courses for village level health workers with both academic and legal recognition. It should be made compulsory for both Govt infrastructures, NGOs, or volunteers to qualify through this mechanism. 5) The above categories. (Village level health workers and general practitioners) should be made to operate in the context of a frame of regulations that pertain, to tasks to be carried out, duties & responsibilities, do's and don'ts, fees to be levied, zones for working etc. We can perhaps begin regulatory mechanism here at the rural scene first. 6) The only way to bring these reforms is through legislation by Parliament and not by State assemblies.

When I consulted a senior legal expert on this matter, he suggested that the best possible way to start action on this track is to file writ petition to High Court/Supreme Court requesting an order to direct the State to realise the situation and effect legislation changes to bring these reforms. The non-allopaths bodies in Maharashtra arc already in process in order to earn them access to modern medical technology. We can slip in this (a) A properly trained and regulated general practitioner category. (b) A properly trained and regulated village level health functionary.

Sham Ashtekar

How do we view the Consumer Protection Act? How will the new economic policy affect the health status of the Indian people? How will women be affected? What did the Bhore Committee have to say about medicare? How to work out costs of medicare (load of morbidity, drug and personnel costs, etc) and ho have health movements had seen the issue of Nation medicare? Can we think of a universal medicare structure and identify the hurdles that such a policy will have in its formulation and implementation? These and man others will be the questions raised in the theme me in Calcutta in Jan. 1993.

Please motivate your colleagues and friends to attend this important meet. Please write to Dr. Sujit Das to Dr. Sarkar immediately [or return reservations. Please also drop a line of continuing your participation me. Please keep a lookout for further announcement (like exact venue) in the December bulletin.

Hoping to see you in Calcutta then, and with warm regards,

*Yours sincere*  
Manisha Gupte  
Convenor,

Have you renewed your bulletin subscription? Are you getting the bimonthly bulletin regularly? Are you membership dues paid? Is it possible for you to pay your life subscription to the bulletin (*Rs.300/-*)? That will ensure the financial viability of the bulletin. It /Will save the energy and time of repeated renewals both for MFC as well as you. (Incase the bulletin closes down, all life subscriptions will be returned!)

**Convener**

PLEASE SEND ALL CORRESPONDENCE AND DEMAND DRAFTS (FOR RETURN RESERVATION) TO Next MFC meet will discuss National Medicare Policy Calcutta Meet (23, 24, 25th Jan. '93)

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700091.

**IN THIS ISSUE .....**

	Author	Page No.
—MFC Papers		
Resurrecting Bhore	Ravi Duggal	1
Health Care under Panchayat Raj	Ravi Duggal	6
—Economics & Health		
New Economic Policy – A	Vrijendra	12
Perspective		
—About the Bulletin		
Spot Survey of MFC Bulletin	Meera Sadgopal	17
—By the Way		
Cold Statistics in Medicine	B.M. Hegde	19
—Law		
The Supreme Court Ruling -	Sham Ashtekar	23
Implications to us	Manisha Gupte	23
—Invitation to Calcutta MFC Meet		

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Editor

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