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Silver Jubilee

SOCIOLOGY AND POLITICS OF HEALTH FOR ALL IN INDIA

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SOCIOLOGY AND POLITICS OF HEALTH FOR ALL IN INDIA

Action for health and health services in India is rooted in the freedom struggle and in the privileged upper class value system of the leadership which came to power after Independence. This gave rise to a 'soft-state'. The leadership made many egalitarian pronouncements, but it did not pay attention to implementing them. The profound ideas behind HFA-2000/PHC contained in the Alma Ata Declaration were trivialized by the leadership for their narrow political gains. HFA-2000/PHC was the product of the joint action of the Soviet Bloc with the Non-Aligned Movement. When the global balance of power tilted dramatically in favour of the rich capitalist countries, they got the obviously radical concepts in the Alma Ata replaced by their own agendas and they used their power and influence to involve the national leadership in imposing ill-conceived, monolithic, technocentric and dependence producing programmes on the poor countries. They virtually managed the health services to subserve their own interests. Prior to that, class compulsions had led the national leadership in 1967 to hand over the family programme to bureaucrats who were more suited to the hatchet job of coercing hapless people into accepting sterilisation. That is spite of a colossal 10,000 times increase in the plan allocations, the population of the country shot up from 351m in 1951 to more than a billion at present, is a severe enough indictment of the bureaucrat-driven programme and their political mentors. Assigning of overriding priority to family planning and the international agenda on health has had devastating impact on the health services of the country. Further damage was inflicted on the already moribund health services with government's acceptance of the Structural Adjustment Programme dictated by IMF/World Bank. This has led to severe budgetary cuts, encouragement of the private medical care and cost-recovery for services from the government hospitals. WTO's patent regulations created further difficulties by raising the cost of drugs. Assessment of the state of the services in the Ninth Plan document, an extensive evaluation of CHCs by its Programme Evaluation Organisation, the report of the Independent Commission on Health in India which has observed that the health family planning programmes are in an advanced state of decay, paint a grim picture of gross neglect from the political leadership downwards.

SOCIOLOGY AND POLITICS OF HEALTH FOR ALL IN INDIA

A Review and A Perspective

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FOREWORD

Indian Academy of Social Sciences (ISSA) chose **Perspective of Development of India In the Twenty First Century** as the focal theme of the XXIV Indian Social Science Congress which was hosted by Panjab University from March 1 to 5, 2001 at Chandigarh. Essentially, three questions were raised: (1) What is India today? (2) What will be India tomorrow? (3) What India ought to be tomorrow? Scientists of all disciplines from all over India were invited to examine all facets of Nature-Man-Society complexity in the context of India and its peoples at the dawn of the third millennium. Peoples' quality of life and health was one of the major issues of deliberations at plenary and parallel sessions of the XXIV Indian Social Science Congress.

As we all know the framers of the Constitution of Democratic Republic of India had sought to rebuild a strong democratic and modern India where there will be no illiteracy, no disease, no unemployment and no poverty; where there will be no discrimination and exploitation of man by man and where rich will not become richer and poor poorer. Superior quality of life and good health of peoples was to be cornerstone of modern democratic India. Over five decades have passed since India became a free and sovereign democratic nation. Nine five-year Plans for India's development have been completed. India is supposed to have acquired huge and unprecedented wealth during this period. So hosts of questions arise in relation to peoples health. Some of these are: Are all Indian people healthy today? Is India disease free? Do all Indian people enjoy equal and better if not superior quality of life? Do all Indians eat nutritious and hygienic food every day? What is the nutritional status of Indian people? Is there any connection between nutrition and health? Is potable water available to all Indians? Is there any association between water and health? How does

environment affect ones health? What about hygiene? What about the health delivery system? Is India free from commercial health delivery system? What about infant morbidity? How has the health policy of India fared all these years? Is India free from drug lobby? Are safe and cheap drugs available to every Indian? Do those who cannot afford to buy drugs and doctors get drugs and doctors free of cost? What kind of linkages between population and. peoples' health exists? Has globalization improved peoples' quality of life and health? How do international organizations influence health policies and health administration in a country like India? Is there any overt or covert connection between WHO and other international agencies and Multi National Corporations manufacturing drugs? Is there any association between economy and health or between politics and health? How does the political economy of a nation influence its peoples' health? Is there a political economy of health? If yes, how to comprehend it? Professor Debabar Banerji has addressed to these and many more questions in his excellent paper **Sociology And Politics of Health For All In India: A Review And A Perspective** which formed the basis of his plenary lecture on "Perspective of Health For All In India" at the XXIV Indian Social Science Congress March 1-5, 2001, Panjab University, Chandigarh. The paper summates his over four decades of research in this field and puts forward an altogether new, appropriate, brilliant and valid social theory of peoples' health. It is hoped that the research scientists of diverse disciplines working on issues connected with health, medicine, quality of life, environment, food, nutrition, population, etc. will study this paper critically in order to discover, develop and enrich the social science theory of peoples' health. Policy planners, health administrators and health workers too will benefit by it. English-speaking people would get a better comprehension of and insight into the working of health policy and health administration in free democratic Republic of India. None-English speaking Indian

people who constitute 98% of the population shall, however, remain ignorant of Prof. Banerji's great contribution so long as it is not published in all Indian languages. Let us hope that the Indian Academy of Social Sciences will be able to publish it in all Indian languages soon. In fact, all the seminal works of Prof. Banerji need to be published in all Indian languages.

Non-English speaking suffering peoples of India will discover to their great joy that Prof. Debabar Banerji is their great friend if they happen to read it and his other works. Prof. Banerji is the true voice of the voiceless.

The undersigned expresses his gratitude to Prof. Banerji for accepting our invitation and permitting the Indian Academy of Social Sciences to publish it as a part of its Silver Jubilee Millennium publications. It is a matter of great pleasure to all of us that the Indian Academy of Social Sciences has resolved to confer Prof. P.V. Sukhatme ISSA Silver Jubilee Gold Medal Award to him on January 28, 2002 for his seminal works on peoples health and quality of life and his life long championing the cause of the voiceless suffering peoples who have often been described by their elected representatives as 'dumb and deaf'

January 7, 2002
Allahabad

N.P. Chaubey
General Secretary

SOCIOLOGY AND POLITICS OF HEALTH FOR ALL IN INDIA

Debabar Banerji

ABSTRACT

The promise to provide 'Health' and `For all' has wide interdisciplinary dimensions. Implementation of HFA is a socio-cultural, economic and political process, which lead to technological considerations with their own managerial, sociological and epidemiological dimensions. Action for health and health services in India is rooted in the freedom struggle and in the privileged upper class value system of the leadership which came to power after Independence. This gave rise to a `soft-state'. The leadership made many egalitarian pronouncements, but it did not pay attention to implementing them. The profound ideas behind HFA-2000/PHC contained in the Alma Ata Declaration were trivialised by the leadership for their narrow political gains. HFA-2000/PHC was the product of the joint action of the Soviet Bloc with the Non-Aligned Movement. When the global balance of power tilted dramatically in favour of the rich capitalist countries, they got the obviously radical concepts in the Alma Ata replaced by their own agendas and they used their power and influence to involve the national leadership in imposing ill-conceived, monolithic, technocentric and dependence producing programmes on the poor countries. They virtually managed the health services to subserve their own interests. Prior to that, class compulsions had led the national leadership in 1967 to hand over the family programme to bureaucrats who were more suited to the hatchet job of coercing hapless people into accepting sterilisation. That is spite of a colossal 10,000 times increase in the plan allocations, the population of the country shot up from 351m in 1951 to more than a billion at present, is a severe enough indictment of the bureaucrat-driven programme and their political mentors. Assigning of overriding priority to family planning and the international agenda on health has had devastating impact on the health services of the country. Further damage was inflicted on the already moribund health services with government's

acceptance of the Structural Adjustment Programme dictated by IMF/World Bank. This has led to severe budgetary cuts, encouragement of the private medical care and cost-recovery for services from the government hospitals. WTO's patent regulations created further difficulties by raising the cost of drugs. Assessment of the state of the services in the Ninth Plan document, an extensive evaluation of CHCs by its Programme Evaluation Organisation, the report of the Independent Commission on Health in India which has observed that the health family planning programmes are in an advanced state of decay, paint a grim picture of gross neglect from the political leadership downwards. A quantitative dimension to the advanced state of the decay is available from the National Family Health Survey-II. The perspective for the coming years depends on the political turn of events. People have to fight to wrest their rights from the ruling class. A very faint echo of the restiveness among the people is discernible in the convening of the Jan Swasthya Sabha, where people's representatives from village level upwards gathered to draw up a National Charter of Health, which included a strong condemnation of the existing global system and demanding Health For All Now! Very long grinding struggles lie ahead for the people for wresting their rights from the usurpers.

DODGING THE FORMIDABLE TASK OF IMPLEMENTING 'HEALTH FOR ALL'

The concept of 'Health For All' (HFA)(1), as will be pointed out below, is embedded in a new, much more 'public' oriented thinking on the discipline of public health that had emerged some quarter of a century ago. The term, 'health' in the phrase HFA embodies an area which is much more extensive than the even the widest definition of the conventional public health which embraces curative, preventive, promotive and rehabilitative aspects; it includes, among many others, areas such as food and nutrition, safe water, the enormous area of environmental sanitation, education, housing, employment and social and economic justice. The component of the phrase, 'For All', has a powerful democratic resonance, focusing on

the unserved and the undeserved, on equity. Implementation of HFA is thus a complex process; it is a socio-cultural, political and economic and a technological process, the latter, in turn, has managerial, epidemiological and sociological dimensions.

Indeed, HFA calls for elaborate interdisciplinary action. The great German physician-philosopher had observed as early as in 1848 that 'health is nothing but practice of politics on a larger scale'. The relatively recent improvement in the health status of people in countries like Japan, South Korea, Taiwan, Hong Kong and Singapore can be attributed more to socio-economic development than to specific actions of the health service systems. In fact, compulsions for involving the people in the economic and social development processes has impelled the political leadership in these countries to promise - and then fulfil that promise - to offer health services, mostly using public funds, to cover at least large sections of the populations. A classic instance of such action by governments can be found in the setting up of the National Health Service in the United Kingdom, more as a *quid pro quo* to mobilisation of all sections of the people of that country to fight during the World War II. In a seminal study of the history of public health Thomas McKeown (2) has presented convincing evidence to assert that the health status of the populations in European countries had improved more due to the profound socio-economic changes that had taken place there than due to interventions through public health organisations.

Spectacular improvements in health status of populations were also noticed in the aftermath of the bloody revolutions in almost all the socialist countries. Indeed, China's use of 'Barefoot Doctors' was hailed in other developing countries as a model (3). It is also noteworthy that when China plunged headlong into the liberalization process by giving a free reign to what it has called the 'socialist market', there was almost a total collapse of the system of the Barefoot Doctors serving in rural health cooperatives. It is a profound irony that when this created extreme suffering among the poor sections of the population, the government sought the assistance of the World Bank to help it in reviving the rural

health cooperatives among the 20 million of its people, whom they called as `abjectly poor'!(4) Cuba presents a more encouraging instance among the socialist countries which has maintained a very high health status for its people along with a steadfast commitment to its socialist convictions.

The anti-colonial struggle in India gave a somewhat different complexion to the political economy of health and health service development. In India too the political leadership of the struggle promised the unserved and the underserved many egalitarian actions to mobilise them. This was reflected in the very contemporary tenor of the resolution adopted in 1940 by the National Health (Sokhey) Sub-committee of the National Planning Committee of the Indian National Congress (5). Among many recommendations, it categorically stated that `the maintenance of the health of the people was the responsibility of the state'. It long anticipated the Chinese pattern of Barefoot Doctors by recommending training of community health workers in large numbers `in practical community and personal hygiene, first aid and simple medical treatment, with stress on social aspect and its implication for public health work', to meet the immediate situation; they emphasised that `the cornerstone of the scheme we recommend is a `Community Health Worker'. These ideas of the Sub-committee were considerably expanded and elaborated by the recommendations of the Health Survey and Development (Bhore) Committee in 1946 (6). Among many other guiding principles, the Bhore Committee mentioned that `no individual should be denied adequate medical care for his inability to pay for it'; `health programmes, from the beginning lay special emphasis on preventive work'; `medical services must be urgently provided as soon as possible to the vast rural population of the country'.

However, after India gained independence, such lofty pronouncements, which incidentally contains many of the postulates of HFA referred to in the foregoing, suffered severe neglect. In his monumental work *Asian Drama*, Guannar Myrdal (7, p.20) had been prophetic in analysing the causes of such neglect. He called India a `Soft State'. He had observed that when India became independent, a new ruling elite took over power

from the British. These new rulers continued to make lofty egalitarian pronouncements but depended essentially on the machinery bequeathed to them by the British to ensure that the fruits of independence would fall mainly on the laps of the new ruling elite and their hold on the government will be perpetuated. He went on to observe that the national political leaders in India were all members of the privileged upper class. Their new responsibility and power rapidly invested them with still greater privileges. Many who had borne heavy burdens or undergone personal sacrifices in the independence struggle saw in their own advancement a symbol of political revolution. Also as politics became increasingly concerned with practical issues and the pressure of vested interests on them grew stronger, a new type of politician with few inhibitions for working for special interests, invaded the political scene.

Myrdal's depiction of the class character of the national leadership, their solemn promises to tend to the problems of the unserved and the underserved and their almost invariable failure to fulfil their promises are vividly manifested in an account of the many decisions taken by the leadership in the field of public health. Starting from their warm endorsement of the recommendations of the Sokhey and Bhore Committees and committing themselves to implementing them, there have been numerous other such endorsements and commitments to improve and strengthen public health services. The slogan of Health For All by 2000AD, coined by a resolution of the World Health Assembly in 1977 (1) was found very catchy to the national leaders as it not only created a glorious vision for a bright outlook for health to the long suffering deprived sections of the people, but it also gave them a virtual 23-year `lease' to perpetuate the lop-sided policies they have been following since Independence. So patent have been their actions to mislead the masses that the officials involved did not care even to fathom the implications of `Health' and of `For All'; the hollow slogan dazzled the people to the extent of temporarily blinding them even to question the sincerity of the national leaders in making the latest in the chain of the promises.

This game of betrayal of such vital interests of large masses of the people of the country was taken to an almost absurd position when the Prime Minister of the country declared in his Independence Day speech of 2000AD from the ramparts of the Red Fort that his government will provide Health For All without even caring to give any explanation of what his government and its many predecessors had done to move towards the promise that was made 23 years ago. The privileged ruling class thus successfully managed to dodge the task of making HFA a reality. In the `bargain', they managed to trivialise, sometime even vulgarise, so lofty an idea. There are rumblings that they would attempt to perpetuate this charade by substituting the year 2000AD by 2020AD! Whether they are successful in this venture will determine the extent of the pressure that will be exerted by the masses to wrest their democratic rights from the ruling classes.

THE WORLD HEALTH ASSEMBLY RESOLUTION OF 1977 AND THE ALMA ATA DECLARATION

The WHA Resolution of 1977 (1), referred to in the foregoing section, opened up a new vista in the concepts and practice of the discipline of public health; it can be called an important watershed. It had called for ushering in of Health For All within a time frame of 23 years using the newly articulated public health philosophy called Primary Health Care (8). It became HFA-2000/PHC. WHO and UNICEF got together to sponsor a special Conference on Primary Health Care involving representatives of all the countries of the world at Alma Ata, in the then Soviet Union, in 1978 to draw up a charter for PHC (8). Some of the major features of the Declaration are being mentioned below.

1. **Health as a Fundamental Human Right:**

2. **People as the Prime Movers for Actions Concerning their Health:** This distinguishes HFA-2000/PHC most from conventional public health discipline. Health issues start from the people; people are the pacesetters, rather than a pre-packaged `techno-managerial' implant on them. It gives primacy to what Ivan Illich (9) calls endogenous capacity of people to

enable them to cope with health problems to their satisfaction. Starting from home remedies, it also includes different forms of medical practices and practices by various forms of indigenous healers, including midwives. To use Illich's words again, it seeks to demystify and deprofessionalise medicine. It also visualises involvement of the people in the planning, programming, implementing and evaluating the health services that are meant for them. It is the task of social scientists working in health fields to articulate these "people's" dimensions.

3. **Intersectoral Actions Related to Health of the People**: As mentioned while referring to `Health' in Health For All, it is emphasised that the public health services are a mere component of a wider package of actions which make major contributions to raising health of the people.

4. **Social Control Over Health Services**: Even when people find that their endogenous coping mechanisms are not adequate to deal with certain health problems faced by them and they need referral support, people's representatives should have a say in the moulding of the support services so that these services are in tune with their requirements and socio-cultural settings; they are also meant to strengthen people's coping capacity. This concept of social control is a component of democratic decentralisation envisaged in the Constitutional Amendment to empower Panchayati Raj institutions.

5. **Ensure Coverage of the Entire Population**: This too is a crucial task. It requires implementation of the `For All' component of Health For All. It lays emphasis on equality, equity and ethics in offering the community health services.

6. **Ensuring Integration of the Preventive, Promotive, Curative and Rehabilitative Services**: HFA-2000/PHC emphasises a holistic approach to dealing with health problems; health problems should not be dealt with in a fragmentary or selective manner. Health of an individual is indivisible.

7. **Use of Appropriate Technology**: People, rather than market and other considerations should determine choices of technology. Data on epidemiologically assessed health problems, which also cause concern to the people, ought to used to develop people oriented technologies.

8. **Use of Traditional Systems of Medicine**: The Western system of medicine is after Western in origin. Over centuries, people from developing countries have developed their indigenous systems of medicine. Particularly in those countries these systems should find a place for conditions where they are found to be equally or more efficacious than the Western system.

9. **Use of Essential Drugs**: Only those drugs which are considered essential by WHO for treating most of the conditions encountered by the people should generally be used.

The Alma Ata Declaration asserts (8): `Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as a part of development in the spirit of social justice'.

The Declaration also endorsed the WHO definition of Primary Health Care: `Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall socioeconomic development of the community. It

is the first level of contact of individuals, the family and community with the national system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process'.

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

HFA-2000/PHC presents a new philosophy of public health. It provides a perspective for shaping of health services for all the countries of the world. Notwithstanding what has been mentioned as the `least requirements', a start can always be made in the process PHC even under most severe limitations of resources, by promoting endogenous coping capacities and use of traditional systems of medicine, for instance.

POLITICAL ECONOMY OF HEALTH FOR ALL AND THE ALMA ATA DECLARATION

From the hindsight of the past 23 years, it looks so ironical that such a profound public health philosophy, which all the countries solemnly pledged to commit themselves to got almost completely erased from the memory of most of the people who were entrusted with the responsibility of improving the health status of their peoples. Worse still, national leaders of many of the countries of the world, which includes India, have not hesitated to trivialise it and reduce it to serve as a catchy propaganda gimmick to divert attention of the masses of the people from the leaders' failures to fulfil the promises they had made earlier.

From a standpoint of sociology of knowledge even more astonishing is that very few scholars of the discipline of public health, even in some of the

topmost institutions of the world, have retained their commitment to the public health principles enshrined in HFA-2000/PHC, which they had so vociferously applauded when the Declaration was made. It is a frightening manifestation of the extent of decline in intellectual honesty, integrity and rectitude even among some of the foremost scholars of the discipline. Under such conditions, it is not unexpected that even fewer among them would have gone on to analyse the forces which led to the formulation of HFA-2000/PHC and its subsequent abandonment. This reflects the sea change that has taken place in the power structure, both within and between most of the countries of the world. However, as in the case of Rudolf Virchow's seminal observations made in 1848, HFA-2000/PHC, as a solid, people oriented, scientifically substantiated way of dealing with community health problems, its value will remain long lasting.

Why, then, this revolutionary thinking in public health took place at all? A possible explanation for the evolution of HFA-2000/PHC can be sought in the interplay of the socio-cultural and political forces during the post-war years. Apart from the ravages caused by the war, there were two sets of events that dominated the international political scene. One was the intense socio-political change which followed the overthrow of the colonial rule in a large number of countries, which were grouped as `underdeveloped' or `developing' countries, later branded as the Third World. The other was the outbreak of the `Cold War' between the two power blocs. The developing countries, inherently weak as they were, took advantage of the rivalry between the two power blocs to form the Non-Aligned Movement (NAM) to get the urgently needed development assistance for themselves. Health and health services formed an obvious area of common interest to NAM and the Soviet Bloc. The Alma Ata Declaration represented the outcome of this joint effort. They could build such a `strong' movement around this non-controversial area that it swept the other bloc and other fence sitters to join them in order to give what later turned out to be a facade of a global agreement.

India turned out to be vocal advocate of the Declaration, as it fitted well with its `soft state' character. Starting from the radical recommendations of

the Sokhey and Bhore committees, it had tried to grapple with the class contradictions by committing itself to one radical move after another. The contradictions arising from the declaration of National Emergency in 1975-77 almost overlapped with the time of the Alma Ata Declaration, when the new government which came in place of the discredited one, resurrected the Sokhey Committee recommendation to have community health workers for rural areas and launched the catchy slogan of entrusting "People's Health in People's Hands" (10). Helped by the other catchy slogan of HFA-2000/PHC, the slogan, HFA, was stretched to the limits to gain the maximum advantage to perpetuate the soft state.

WESTERN RESPONSE TO ALMA ATA DECLARATION: INVENTION OF SELECTIVE PRIMARY HEALTH CARE

Apparently the power equation in the Cold War soon dramatically swung in favour of the rich capitalist countries. The reaction of the rich countries of the world to declaration of such radical assertions as health as a fundamental human right, self-reliance and self-determination by the poor peoples of the world was swift and sharp. It was an awe-inspiring demonstration power by these countries of imposing their will on the poor of the world. As a tactical measure, these countries, who along with many developing countries, thought it prudent to go along with the wave of enthusiasm that was generated at Alma Ata. However, soon they came forward with a counter-measure, to launch what can be called a `counter revolution'. They called it `Selective Primary Health Care' (SPHC) (11), to focus on what they called only on selective, cost-effective measures on the plea that most of the developing countries could not afford the comprehensive approach of HFA-2000/PHC. As is quite apparent from foregoing presentation, this was a patent misreading of the philosophy of HFA-2000/P6HC. Furthermore, virtually no scientific evidence was adduced to justify the selective approach.

These anomalies in the approach were repeatedly pointed out to the exponents of SPHC in many articles in learned journal (12). However, these scientific arguments and data were simply ignored and the idea of

SPHC was relentlessly pushed forward. At a major conference at Bellagio in Italy (13), top executives of international organisations and major bilateral health agencies like the UNICEF, WHO, the World Bank and the Rockefellar Foundation and a large number of like-minded academics and health administrators from different parts of the world were brought together to get endorsement for SPHC. Later on, there was yet another similar conference at Kartaghena, Colombia (Bellagio-II) (14) to reinforce the decisions taken at Bellagio-I.

In a dramatic turn around, UNICEF and WHO, who were the sponsors of the Alma Ata Conference on Primary Health Care undertook the task of being the pacesetters for implementing SPHC. The World Bank joined this venture soon after. Offering attractive monetary incentives to the elite national leaders and using the political clout of the rich countries, they opened a virtual barrage of what they termed as international initiatives on the poor countries of the world (15).

Universal Programme of Immunization, Global Programme on AIDS, Global Programme on Tuberculosis, Global Polio Eradication Programme, are examples of some of the major programmes. The exponents of these global programmes ignored the simple fact of highly diverse conditions prevailing in different countries and that it would be a gross folly to implement a single, streamlined pattern of programmes on a global scale. Besides, these programmes lacked most elementary requirements of public health research in the stages of their conceptualisation, planning, programming, implementation and evaluation. For instance, in many countries, there were virtually no baseline data of a minimal acceptable reliability and validly for the six diseases that were sought to be controlled in the immunization programme. Similar has been the case with tuberculosis; in this case, where the objective was to *control* the disease on a worldwide scale, the authorities concerned did not even care to develop a reliable and valid method of measuring the epidemiological impact. Such scientifically flawed programmes were imposed on the people from above; also, they were technocentric, they were dependence producing and they were far from being cost-effective. The selective

approaches were the very antitheses of what was conceptualized in the formulation of HFA-2000/PHC.

Such nonchalant disregard for some of the basic tenets of the discipline of public health by those who claim to be children of the European Enlightenment has been discussed in greater detail on earlier occasions (15). Relentless pushing of a pre-fabricated global programme, suppression of information, use of disinformation and misinformation and ostracisation of persons who dare to produce arguments and data which are contrary to the adopted approach are hallmarks of fascism. Recalling his suffocating days as a scholar of public health policy analysis during the fearful days of the McCarthy era in the US, Vicente Navarro (16) has termed the experience as worse than the fascism he encountered while he fought during the Spanish Civil War; he had called it Intellectual Fascism. The Western response to HFA-2000/PHC very well fits that description.

The almost openly arrogant interventions by the rich countries in the health services of the poor ones is associated with the rapid increase in their political and economic power during the 1980s and 1990s. The 1980s saw a sustained depletion of the strength of the socialist bloc, which culminated at its total disintegration by the end of the decade. The 1990s saw a unipolar world which used organisations such as the IMF, the World Bank and the World Trade Organization as instruments to promote its political, economic and military interests. Imposition of the pre-fabricated global initiatives in health is an outcome of this arrogance of power, which, unfortunately for all concerned, led them to practise Intellectual Fascism.

THE STATE OF THE HEALTH SERVICE SYSTEM OF INDIA

The sweeping changes in the international power structure and major erosion of the Non-Aligned Movement in the past two decades had profoundly influenced a developing, dependent, soft state like India. Indeed, the national leaders, whom Myrdal had described as belonging to the privileged upper class, who used the new responsibilities to acquire

still greater privileges for themselves and their class, actually cooperated with the health and health services agenda imposed on India by the rich countries through various international agencies. Because of the class character of the national leadership, social and economic actions to raise the health status `For all' have not received much attention from them. Significantly, the even those politicians and academics, who claim to follow egalitarian ideologies like socialism and communism have betrayed the interests of the oppressed classes; this betrayal was exposed glaring when some of the parties professing to follow egalitarian ideologies came to power in some states, including those of West Bengal, Kerala and Tripura. It is also noteworthy that those who managed to capture political power by invoking the causes of the Dalits, the backward castes and the Adivasis did not bring about any significant improvement in the health status even of the oppressed who belonged these groups. This critical issue of caste-class relationship has escaped attention of social scientists of all hues.

There have also been major changes in the socio-economic, demographic and political landscape. Despite assigning top priority to population control, with the allocation shooting up from Rs 6.5m in the First Plan to Rs 65,000m in the Eighth Plan (a 10,000 fold increase!), the population of the country increased from 351m in 1951 to the present figure of over a billion, as if `greater the allocation, the greater is the population growth'! (17). Thus the country has not only to cope with the problem of development needs of an almost a three-fold increase in the population since Independence, but it had to suffer the devastating impact on its health services system because of assigning an overriding priority to the family planning programme for more than four decades.

The ruling class felt threatened by the rising population growth (17). They contended that `the fruits of development are being eaten away by the increasing population'. In doing so it did not occur to them to ask the simple question: who had been eating the fruits of development since the country gained independence? Understandably, when they saw, rather simplistically, population growth as a threat to their privileges, and they

were not willing to share much of the fruits of development with the long deprived masses of the people, it was almost deterministic that they should have thought of using coercion to get people sterilised. It was also deterministic that they did not think health workers to do this job as thoroughly as they would like. It was assigned to the bureaucrats, who still retained the tradition of the British days of using coercive measures to perform the task assigned to them by their employers. In 1967, the Union Ministry of Health was literally broken into two departments - those of health and family planning. The family planning department was handed over to the bureaucrats. People, particularly the more vulnerable sections, became the `targets' for sterilisation of their own government. With passage of time bureaucrats took over almost all the key positions, both family planning and health fields. This has been perhaps the most damaging malady that had afflicted the health services of the country: the health and family planning services were led by personnel who were not only not qualified for the job, but they also could not be held accountable for their decisions, as they were frequently transferred to other positions. The political leadership presided over this rather macabre drama of decimation of the health and family planning services of the country. The common interests of the politicians and the bureaucrats created a nexus between the two. This also suited the interests of the international agencies, as they found them more pliable for selling their own agendas. The oppressed had to suffer the consequences of such an unholy nexus.

The previous two decades also saw further neglect of the infrastructure of the health services because of imposition of the ill conceived, target oriented global initiatives on the country. The IMF/World Bank backed initiation of the Structural Adjustment Programmes to bring about economic liberalisation and globalisation of the economy dealt yet another major blow to the growth and development of the health services system of the country. This was in the form of severe cuts in the already inadequate national and state budgets for the basic health services, encouraging greater participation of the private sector to provide curative services for the upper classes and launching schemes for cost recovery from those who had been getting free services from government health

institutions, as was envisaged in the recommendations of the Sokhey and Bhore Committees and in the Alma Ata Declaration.

That the population of the country shot up from 351m in 1951 to more than a billion at present ought to be enough of a indictment for the bureaucrat-driven family planning programme. After a great deal of procrastination and rejection of policy guidelines given by a serving Prime Minister and a 'high-powered' committee, the bureaucrats have come out with their own version of a new population policy about a year ago. It maintains the dominance of the bureaucrats over the programme. There are the now familiar promises of making the programme broader based. There is little evidence that even these not very well conceived ideas have been put into practice.

Data from a large number of extensive field surveys have revealed the enormous extent of damage caused to the health service system of the country due to acts of omission and commission of the concerned authorities. Only a brief mention of a few them will serve the purpose. The state of 'health' of the health services system is discussed by this author in detail in monograph entitled: '*india's Forgotten People and the Sickness of the Public Health Services: A Prescription for the Malady*'. Only a summarised version has been published so far (18). Even a not very deep analysis of the state of the health service system in the Ninth Five Year Plan(1999-2002) does not present a very flattering picture (19). It points out: '(1) Persistent gaps in the manpower and infrastructure, specially at the primary health care level; (2) Sub-optimal functioning of the infrastructure; poor referral services; (3) Plethora of hospitals not having appropriate manpower, diagnostic and therapeutic services and drugs; (4) massive interstate/interdistrict differences in the performance as assessed by health and demographic indices; availability and utilisation of services is poorest in most needy and poor states/districts; (5) Sub-optimal intersectoral coordination' (P.171).

For more than 25 years there has been a plan to have 25-bedded hospital for every 100,000 of the rural population, now called Community Health

Centre (CHC), to extend referral facilities to primary health centres. A recent study by the Programme Evaluation Organisation of the Planning Commission (20) offers a frightful picture of the functioning of the system. It was conducted in 31 CHCs in 16 districts located in 8 states. Eleven CHCs have not attended to any referral cases, while 18 have been working sub-optimally. As against the required strength of five specialists in each CHC, more than 70 per cent of them are running with one or no specialist at all.

The Voluntary Health Association of India had got together a number of experienced health specialists, health administrators and bureaucrats to form the Independent Commission on Health in India (ICHI). in the covering letter by the ICHI members when they personally presented the report to Prime Minister Vajpayee on May 1998 (21), expressing deep concern over the decay of health family planning services in the country, they had observed: 'The outbreak of malaria in a virulent form in many parts of the country, return of Dengue and Plague, the dramatic increase in the diseases of yesteryear like Tuberculosis are some clear signs of this decay. Regrettably, the response of the system to this situation has been sporadic, feeble and unprofessional. The system wakes up from its slumber when there is an outbreak of a particular crisis and then returns to its former state of inactivity..... . We feel that the nation needs to address this critical issue of continuing decay in the health and family welfare situation in the country. This calls for decisive action from the highest level. Otherwise we might enter the 21St. Century as a nation with diverse unsolved ailments and ill health'. More than two and a half years have passed, there is still no specific action to meet the situation.

The data from the National Family Health Survey of 1998-99 (NFHS-II) (22) were released in November 2000. The focus is on childbearing women and children - essentially family planning programme under a new nomenclature, Reproductive and Child Health. Nevertheless, within these limitations and with the well known problems of sample errors and errors in interview based data from a wide variety if interviewers and respondents, it brings out the dismal health and health services in the

country (P. XVIII). As many as 540 mothers still lose their lives for every 1000 childbirth; 58.4% still have childbirth at home; and, 51.8 % suffer from anaemia. 74.3% of the children in the 6-35 month age group suffer from anaemia; 45.5% are stunted, 47.0% are wasted, and 15.5% are underweight. Only 42% of the children received all vaccinations; despite repeated special efforts to have full coverage for eradicating poliomyelitis, only 62.8% were covered. Despite making it compulsory in 1982, less than half of the household use iodised salt (P.XXVII). Only 40.3 per cent of the women had heard of AIDS, out whom a third had no idea of ways to prevent it (P.XXVIII). 48% were found to be using some form of contraception, as against 41% in NFHS-I (P.XXI); infant mortality has gone down to 68 from the (1991-92) NFHS-I figure of 79 (P.XXIII). Women continue to marry early and very few use modern spacing methods. It concludes that the bulk of the population of the country is still far from attaining the replacement level of births. Thus, the rise in population goes on, though on a slackened pace.

A PERSPECTIVE FOR THE COMING YEARS

Political considerations have formed both the bases HFA-2000/PHC and the success of the national leaders in trivialising the call for Health For All since 1978. These considerations will determine the whether the country will have Health For All in the coming years. Will the politicians be allowed by the masses to go on making egalitarian pronouncements without following them through to set up an appropriate implementing machinery? It is likely that increase in consciousness among the oppressed people about their democratic rights will make it difficult for the politicians to cling to power and perpetuate the soft-state character of the government by stooping to invoking dynastic, caste or religious and other ethnic loyalties. The highly privileged upper class, which has derived enormous advantages from the current dispensation, will resist forgoing their such undeserved advantages. The oppressed will have to wrest their rights from their exploiters. It could turn out to be long, grinding struggle or the very launching of the struggle will force the exploiters to see the writings on the wall and usher in a more democratic system of

governance. A much-strengthened democratic government will be able to find a rightful place among the comity of nations, which will enable to get better terms for itself in the international political and economic arena.

A very faint echo of restiveness among the `forgotten people' was discernible in the recent movement by some sections among them to demand actions by the authorities to provide them will better health conditions. As a counterpoint to the World health Assembly, where the meek national leaders of the poor surrender the interests of their people in return for ludicrously cheap sops, some socially concerned people got together to organise a worldwide People's Health assembly' (PHA) at Dhaka to raise the voice of the voiceless against the obviously manipulative, grossly unethical moves by WHO and other international agencies controlled by the rich countries of the world.

That there is an early inkling of assertion of democratic rights among the voiceless in India became apparent in the way it decided to participate in the PHA. Many dedicated workers got together to set up a people's organisation, called Jan Swastya Abhiyan, which took the first tentative steps to reach out to the unreached by mobilising some people, starting as village gatherings, then moving on to block, district and then state levels to send delegates to raise their voices in an unique assembly of about 2000 people at Calcutta on November 30-December 1, 2000, under the banner of Jan Swasthya Sabha (JSS). A national Coordinating Committee had been formed to organise the JSS. The JSS adopted a National Health Charter (23) which highlighted the plight of the forgotten people. In the preamble to the detailed document the JSS had raised some of the key issues concerning them. It reads:

"We, the people of India stand united in our condemnation of an iniquitous global system that, under the garb of `Globalisation' seeks to heap unprecedented misery and destitution of on the overwhelming majority of the people of this globe. The system has systematically ravaged the economies of the poor nations in order to extract profits that nurture a handful of powerful nations and corporations. The poor across the globe,

including the sections of the poor in the rich countries, are being further marginalised as they are displaced from home and hearth and alienated from their source of livelihood as result of forces unleashed by this system. Standing in firm opposition to such a system, we reaffirm our inalienable right to and demand for comprehensive health care that includes food security, sustainable livelihood options, including secure employment opportunities, access to housing, drinking water and sanitation and appropriate medical care for all, in sum, the right to Health For Al Now!"

The Charter goes into detail to elaborate on the preamble to include the details of the Alma Ata Declaration on Primary Health Care. The PHA, meeting at Dhaka on December 4-8, 2000, adopted most of the elements of the Indian Charter in the global charter adopted by it. The task before the people is to use the radical pronouncements in the Indian and PHA Charters to exert pressure on the national leaders to fulfil the sweeping promises they have been making to the people since Independence. The outcome of the voiceless people's struggle wrest from the ruling elite their right to involvement in the decisions that concern them will decide the shape of health and health services in the country in the coming years.

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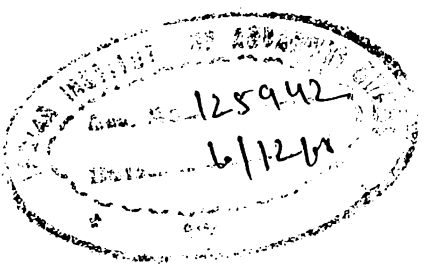

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For the citizens of India the past half-a century has been too long a period to wait for moving toward the promised land of liberty, equality, fraternity, and justice..... We have to strive for the realization of an inseparable trinity: equality of all religions, equality of all castes, and economic growth with full employment.

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The Indian ruling-class had the advantage of availability of vastly improved knowledge of health and disease. It was, therefore, possible for the rulers to plan a healthy model of development. But the Indian State due to its very nature did not launch a pro-people, planned, healthy model of development. It is, therefore, no surprise that t... has been no radical improvement in the health of the ordinary Indians.

In India, even today, malnutrition and insta... heavy toll..... Forty percent of Indian popu... drinking water, 75% our people do not have a l... million man-days are lost annually due to diar... children die every year due to diarrhea. Increased urbanization should ha... meant access to clean safe drinking water to large proportion of Indians. But unplanned development and continued poverty meant proliferation of slums, now accounting on an average, 20% of the urban population. Urban slums are centres of modern instantiation and of resurgence of malaria ..... In short, the old killer diseases of the Indian people, diarrhea, malaria, TB.... etc. continue their ravage.