Women's Health and Women's Rights.

An Introductory Note

Sudha Sundararaman

A striking feature of contemporary experience in India is the systemic failure in addressing the health needs of a major proportion of the population. Particularly disturbing are the women's health indicators. From the NFHS of 2005 -2006, we find only three statistics that are related to women's health status: All of these are matters of deep concern and indeed are only the tip of the iceberg.

- 33% of women are malnourished.
- 56.2% of all women and 58% of pregnant women are anaemic as compared to 26% of men.
- 37.2% of women have experienced domestic violence.

The other national statistic that we have which is reflective of women's health is the maternal mortality rate (MMR). The number of maternal deaths is now estimated at 301 per 1,00,000 live births – in 2001 – 2003. This is still three times the goal of 100 that we set ourselves in 1983, when the National Health Policy was being adopted. These dismal figures are symptoms, which have their roots in a number of causal factors that are interlinked, and that reinforce each other.

Patriarchy and Women's Health:

Patriarchy's most direct adverse impacts on health relate directly to the value it accords women. Patriarchy acts at the level of the family

- Through cultural practices and social conditioning which compel her to eat last and eat the least, and reduces her access to education and health care.
- Through an excessive work burden which is often invisible, but which in a context of reduced access to nutrition also, makes her underweight and highly prone to anaemia,
- Through child marriage. According to the latest NFHS data 44.5% of all marriages have the girls age of marriage as less than 18 year of age. Further 16% of 15 to 19 year olds were mothers or pregnant at the time of the survey. It is curious that a state that has always been overeager to impose a two child norm for so many completely unrelated reasons, is on the other hand so reluctant to implement a long standing law on its books that prevents child marriage.
- Through violence unleashed against women within and outside the home.
- Through active daughter "dis-preference" leading to discrimination, denial of health care, and elimination of the female foetus (sex selective abortion)

Interestingly patriarchal son preference is also clearly one of the most important drivers of larger family sizes. When queried about family size in the NFHS survey, 83.2% of all women wanted no more than two children and 88% to 89% of women with one son and one daughter or those with two sons wanted no more children. But only 62% of women

with two daughters were clear on limiting the family size. Son preference has thus clearly emerged as one of the biggest drivers of population growth.

Patriarchal restrictions also act at the level of the community in reducing women's access to public services and entitlements. Whether it is health care, education or food security, early childhood care or sanitation, women's access is less and the problems due to such lack of access are more. Women's ability to make decisions that are needed to safeguard her health are curtailed. Women have little control even over their own body. Whether in choice of partner or in ensuring safe sex, or whether it is in being able to protect herself and her children from violence and its consequences, women's autonomy is still compromised. Patriarchy also acts by the way institutions of health care and health programmes are designed and the way they function. When combined with high poverty levels, the situation gets further exacerbated, as the women become even more vulnerable due to the poor living conditions and the work conditions caused by poverty.

State policy and women's health

Recent policy statements by the Govt. express apparently serious concerns about the state of women's health. The India Country Report highlighting the Platform for Action 10 years after Beijing (2005) for instance states that the approach to women's health has evolved over the 90s from a target oriented approach into a more holistic integrated life cycle and needs based approach. Its aims are to ensure that women's health is a public health priority, and that it is viewed in a holistic manner, that encompasses decline in the incidence of diseases, improvement in access to and the quality of services, and empowers women to make informed choices.
But what is the reality?
There is a consistent refusal by the government to democratize health entitlements, and to sanction in legal terms the principle of health as a fundamental right. This trend is part of a larger neo liberal agenda where market linked growth replaces equity as the preferred objective. When this neo-liberal agenda combines with a persistent patriarchal framework, the impact on women's health is extremely negative. Women's health needs are on the one hand marginalized and ignored. On the other hand, there is a compulsive attempt to place the blame for her ill health at her own doorstep, and indeed to portray her as the cause of a great deal of the problems of society, since it is she who reproduces, and breeds children.

Narrowing, trivializing, then neglecting agendas for women's health

At a general level policy tends to reduce comprehensive primary health care needs of women to just reproductive and child health care. These are further trivialized into some elements of care in pregnancy and immunization and family planning services. Then on closer examination we find that even on these three aspects the government has not progressed very far. Thus immunization rates are stagnant at 43.5% and even measles immunization has only reached 58.8%. Antenatal care also reaches out to only 51% of all women.

It needs to be pointed out that even a focus on reproductive health requires public health facilities to provide health care for reproductive tract infections, for infertility, for access to safe abortions- but visit any facility and these are unlikely to be present. Further, a life cycle approach to women's health requires the system to also address adolescent health care needs as well as menopausal health care needs. Yet despite talk about these almost nowhere would we see these services in place. At best in each state there are a few token clinics. Programmes for prevention or early detection of common cancers of the cervix, uterus and breast are also non existent though these cancers are very much preventable and a larger cause of women's deaths than even maternal mortality.

There are also very few women doctors in the system- and this factor alone would contribute to poor access for women. There is insufficient privacy- and ability to examine women. A few states have tried to use nurses to provide some of the reproductive care where female doctors are not available. But again these are token representations and are seldom appointed in sufficient numbers. At best a part time doctor providing a few hours of services is added in.

Failure even on maternal care

We need to note that despite official focus on maternal mortality reduction as a substitute to all elements of reproductive health and women's health, the system has been unable to make any substantial dent on reducing maternal deaths. At one level, causal factors, ranging from child marriage, the frequency of pregnancies, the widespread prevalence of anemia, the work burden and lack of proper environment, gender discrimination within and outside the household, - all feed into the situation. Another set of reasons that contribute to this failure relate to inability to organize skilled assistance at birth, the absence of referral transport systems or emergency obstetric care services, and lack of access to safe abortion services. The inability to solve these basic issues has been both a failure of public investment and a failure of governance and sometimes even of technical competence in health planning. The fragmented top-down approach to health planning, the refusal to take many of the basic steps needed to strengthen public health systems and a thrust towards substitution of the task of building public health systems with outsourcing all its delivery systems as the only possible alternative have all been constraints on achieving these goals.

The National Population Policy statement of 2000 had underlined the failure of targeted sterilization, and asserted commitment to the " Development is the best contraceptive" approach. Despite this many states continue to have incentives and disincentives based on the 2 child norm. We have seen how the conditionality of the 2 child norm has been used to penalise poor, dalit, tribal and backward caste women. Their right to stand for panchayat elections is so subverted, as also their right to avail of certain welfare schemes. This is one of the biggest injustices that we have to resist. Studies on the subject have shown that the 2 child norm is not only an ineffective family planning strategy. It is also a reason for the elimination of female foetuses in a big way, contributing to terribly skewed child sex ratios.

Meanwhile despite Supreme Court rulings, the quality of sterilization services for women continues to be low. In many areas the demand for safe sterilization is actually much greater than the actual service provided. Of the 56 % who use any method of contraception and the 36% who have opted for female sterilization the corresponding figure for vasectomies is only 1% (NFHS). The low performance in vasectomies are not only due to poor demand for these services- they are also due to a poor supply of these services – despite vasectomy being a far easier option to train and supply services for, as compared to tubectomy. Promotion of vasectomy is also almost non-existent. The obsession with control of women's reproductive capacities to the detriment of choice has actually had adverse repercussions on the provision of safe family planning and contraceptive services.

Issues of Women as health care providers:

Most effective health care providers in the public health system are women. The anganwadi worker, the ASHA, the ANM, the staff nurse, all together account for a major part of the health care providers. Yet their own conditions of service, their own support systems, their own security and even their own health cannot be safeguarded within the discriminatory and patriarchal designs of health care provision. ASHA is treated as a volunteer and paid a performance-based incentive; the anganwadi worker is paid an honorarium, not a wage. The ANM and staff nurse are insecure, have a greater part of the work burden and little support. There are no grievance redressal mechanisms in place and little protection from harassment.

Misuse of Modern technology

The 2007-2008 budget announced by the Finance Minister, while claiming sensitivity to gender concerns, has completely exempted the trial of new drugs from service tax, so as to make India a preferred destination for drug testing. This blatant move towards liberalization is a dangerous portent for women who have already suffered at the hands of unethical MNCs testing controversial injectible contraceptives, and hormonal implants on poor women. Indian women would become the convenient guinea pigs at negligible cost to the company testing the drug, and at maximum risk to their own selves.

The most modern and expensive technologies of pre conception sex selection are hitting the Indian market bringing in ultramodern variants to sex selective abortion. The unregulated commercial private sector in health care is a major contributor and promoter of this evil. It is a telling example of how without addressing social discriminations we cannot expect the introduction of modern technology alone to solve our problems. What actually happens is that technology like ultrasound that has the potential to be used to improve women's lives and make pregnancy safer for women is actually used to do the very opposite - to eliminate women.

Globalization and Privatization of health systems

Globalization and the neo-liberal agenda has had a direct and adverse impact on public health systems. Since the nineties we have seen a systematic effort to run down public health systems and offer private health care services as an alternative. One form in which the neo-liberal agenda manifests is by the declining budgetary allocation to health. As it is public health expenditure accounts for only 0.9% of the GDP and there are indications that even this is declining. If we further examine where this money is going we find that a few items like pulse polio and HIV control are seeing major increases whereas expenditure on hospitals, on basic health facilities and even on routine immunization is actually facing significant decreases. Further, major programmes of public health are becoming more and more linked to foreign donor agencies, or to major NGOs, and we are witness to a deliberate withdrawal of the state from its responsibility of providing health care in many critical areas.

Another form in which this dismantling of public health system manifests is by replacing the goal of building a public health delivery system that provides comprehensive primary and secondary health care with several ad hoc arrangements that provide very limited package of services and then to equate the provision of these services with the provision of public health care. Typical of this is what is happening in urban health care. As urbanization proceeds at a hectic pace, instead of building up a network of health facilities equivalent to the primary health centre and CHC, we find that a number of public private partnerships (PPP) are being promoted. Under these PPPs the deal is that an NGO or private health care provider is hired to provide just immunization and antenatal care and some contraceptive services. The route being traversed is from adhoc NGOisation and ensuing lack of accountability to outright commerce driven private domination of healthcare.

The larger context

Globalization's adverse impact on women's lives is through the destruction of livelihoods that result from its policies is by now well established. Reduced access to natural resources, loss of markets due to unfair trade policies especially for the agricultural sector, reduced public investment in rural infrastructure and employment creation, the increased distress migration of rural families into rapidly growing urban metropolis where they are illegalized, denied all public services and their labour exploited, and the feminization of poverty that is an outcome of all these trends – depict the inhuman face of globalization. Growing hunger, insecurity of livelihoods, consequent increases in level and scale of malnutrition have emerged as major drivers of poor and ill health. Additionally, discriminations on the basis of class, caste, ethnicity, race, disability, sexuality, age, religion and other statuses handicap many sections from access public services and equal opportunities for advancement in addition to their economically weaker positions.

Our protests against structural adjustments reflect our concerns about the manifestations of neo-liberal economic policies by which women are most severely impacted in their access to public services. These include the ever-increasing food insecurity, cuts in public spending and privatization of early childhood care and education services and the privatization of water and common resources.

Ultimately, it is impossible to significantly alter the health status of women unless the social determinants of health are addressed. An overwhelming majority of diseases can be prevented by the supply of clean drinking water, by providing adequate nutrition, by ensuring proper sanitation. Yet even today, the existing public health infrastructure in our country is loaded in favor of the curative aspects of health. The condition of public services in rural areas as well in the proliferating urban slums is dismal. Women need to have access to safe housing, employment with a minimum income, time to take some rest, all these contribute to her health status. This would also require a more effective utilization of the panchayat and local governance structure to assure that basic amenities are provided.

The current scenario demonstrates the need for a common agenda of action on health linking up all the forces working towards pro people policies. It is important to evolve a joint struggle which witnesses the participation of academic and the activist to ensure this. Ultimately, women's health cannot be isolated from the larger trends and policy decisions. A change in the LPG policy directions, combined with a more holistic approach which is gender sensitive is essential to effect an improvement in women's health status

A Critical Look at Health Policy

Brinda Karat

Introduction

Every seven minutes, a woman dies in India in a maternity related death. Fifty children below the age of five die every half hour. These deaths are certainly avoidable. The UNICEF has calculated that there are at least a million avoidable deaths of under five year old children in India every year. There is something seriously wrong with a system, which has such a high rate of avoidable child deaths. Next year will mark the 30th anniversary of the International Conference on Primary Healthcare held in Alma-Ata, where a declaration was adopted to which India was a signatory. It made a commitment to adopt policies to achieve "health for all". It defined health in the following terms: "health, is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity, health is a fundamental human right and the attainment of the highest possible level of health is a most important social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector." Thirty years down the line, despite somewhat similar sentiments repeated in the National Health Policy of 2002, we have failed in practice to live up to that commitment.

Problems with Present Health Policy

There are two basic features of the current health scenario in India. The first is the fast growing private sector in health including the entry of corporates, MNCs and the trend of big pharma companies setting up hospitals. On the other hand there is the highly inadequate, understaffed, public health sector.

Healthcare is increasingly going out of the reach of the poor. It has been assessed that 40 per cent of all patients admitted to hospitals have to borrow money or sell their assets including land in order to meet medical expenses. Next to dowry, health expenses are the biggest reason for debt. It is also estimated that 25 per cent of farmers are driven below the poverty line because of health expenses. India is one of the countries, which has the highest out of pocket expenditure on health, around 82 per cent of all health expenditure. Most people have to go to private doctors and hospitals to get treatment. The primary motive for the private players is not to make healthcare affordable for all but to reap profits.

Delinquency in the private healthcare industry

The slogan of health is wealth has been transformed into ill-health is wealth for a section of those providing medical services. Despite the mushrooming of the private players in healthcare, government regulation in the sector has been virtually absent. The healthcare institutions in the private sector get concessions from the government in the form of land, tax relief and lower charges for basic utilities and in return they are supposed to provide a percentage of free beds for the poor. However, none of the private hospitals implement

this as made clear in the PIL in the Delhi High Court resulting in a landmark judgement by Justice Qureshi. The top 20 private hospitals in the national capital had been given big concessions on certain conditions of providing free services to the poor. Not a single one of these hospitals, many of which were registered as trusts and charitable hospitals had complied with the conditions. The judgement made a sharp indictment and called upon the government to strictly ensure compliance. However this has not happened and on the contrary the health policies being followed are an abdication of responsibility of ensuring that the private hospitals live up to their commitment of serving the poor by setting some uniform standards for private hospitals without which no registration will be allowed.

While exploitative commercial practices are rampant, there are no rules and laws to take action against the delinquents. This is a grave distortion in the present health policy, which needs to be rectified. The private sector in health needs to be tamed, to be made socially accountable but regrettably, the health policy in the name of public-private partnership actually protects and pampers the private health sector.

National Rural Health Mission

The National Common Minimum Programme (NCMP) of the UPA government adopted in 2004 took the NHP forward through a commitment to raise the expenditure on health to 2-3 per cent of the GDP. The following year the National Rural Health Mission (NRHM) was adopted, which was supposed to be an important initiative to converge and coordinate the myriad health schemes through a process of decentralisation and increase in community participation thus replacing the vertically programmed model. It is too early to make a detailed assessment of the NRHM. There are surely some welcome aspects of the NRHM, especially the shift away from equating health with population control, an effort to bridge the urban-rural gap and the emphasis laid on building infrastructure for the public health delivery system.

However, there are some areas of concern like the issue of user fees for health services, which is sought to be imposed as a conditionality during the discussions with state governments over signing MoUs. Although in the course of the debate in parliament, the minister made a categorical assurance that the RHM does not envisage the levying of user fees on any of the services, in reality this is what is happening. For example the main role of the Rogi Kalyan Samitis which was conceptualised as an avenue for community participation, has actually turned out in some states to be a committee to increase the financial viability of the Primary Health Centres (PHCs) and hospitals by suggesting the different types of user fees that can be levied! This goes against the interests of the poor. It is a travesty of the “health for all” concept to introduce user fees when the majority of those who use the public health system do so because they cannot afford expensive private healthcare.

Another issue that was raised in the debate was that of the role of ASHA (Accredited Social Health Activists). ASHA is seen as the crucial link to provide community access to health services and also as a para-health worker. Although more community based health workers are needed, the conceptualisation of ASHA is problematic. She is at the

bottom of the ladder after the auxiliary nurse midwives (ANMs) and the anganwadi workers, themselves victims of exploitation. At the same time the role of ANMs is being neglected and ASHA is being posed almost as a substitute. It is essential to work out a mechanism for an integrated and comprehensive approach for ANMs as well as ASHAs.

While the ASHA is expected to do a whole range of jobs, no allocations have been made for her remuneration by the government. Either it is expected that she would provide free labour for the community or it is envisaged that she would collect user charges from those accessing health services. The burden of the entire community health sector is thus on the frail shoulders of an unremunerated ASHA! This is not only unjust but completely untenable. The minister in his reply did assure parliament that provisions had been made for the payment of ASHA but this is an aspect that needs to be checked in the different states. Reportedly 3.5 lakh ASHAs have been selected and 2.25 trained. It is necessary to make contact with this vast women workforce and help them in every possible way.

Another problem with the present health policy is that in the name of strengthening rural health services, urban health services have been completely ignored. A huge influx of migrant workers continue to take place from rural to urban areas, who are forced to stay in urban slums where access to health facilities is as bad as in rural areas. The present health policy has no separate plan for urban health, but it is put under the general allocation of flexible programmes. It is essential for the union Health ministry to plan proper schemes for urban health.

Neo-Liberal Policies Responsible

Besides the glaring problems with the existing health policy, there also exist a huge gulf between policy declarations and their implementation. While the official explanations of corruption and inefficiency of the public service delivery system is valid to a great extent, the basic problem lies elsewhere. The present policies, which in their origin and approach owe more to World Bank prescriptions of neo-liberal reforms than to the international declaration in Alma Ata on universal healthcare, has a built in bias towards withdrawal of the state from its responsibilities and reposing faith upon private initiatives to deliver the goods. Health is not just about disease, drugs and doctors but about ensuring the basic parameters of health linked to adequate nutrition, food security, clean drinking water, housing, proper sanitation and a pollution free environment. The neo-liberal policies being pursued by the government are yielding outcomes, which far from meeting these goals are worsening and aggravating the situation. Rather than leading to health for all, neo-liberal policies are causing hunger and deprivation and therefore ill-health for a larger number of people.

The recently released NFHS-III data for 2005-06 show that one third of all women in India have a lower than normal body mass index. 56.2 per cent of all women and 58.2 per cent of rural women suffer from anaemia. The number of pregnant women who are anaemic has increased by 8 percentage points since the last survey to 57.9 per cent. When pregnant and lactating mothers suffer from high anaemia, it is not surprising that the number of infants between 6 to 35 months who are underweight is also a whopping 79.2

per cent, up 5 percentage points since the last survey of 1998-99. The data also shows that the worst affected are tribal women, followed by dalit women and others from the backward sections. They constitute the poorest; most deprived and exploited sections of our people.

The union Health ministry is currently running a campaign to encourage breast-feeding for children that it is important for the health of the child. No one will deny this. However, the Health ministry should be asked how anaemic mothers can breast-feed their children unless their anaemic status, which is a direct outcome of malnutrition, is alleviated? Over and over again women are being made to feel guilty — you are not breast-feeding your baby, it is your fault that infant mortality rates are so high and so many babies are underweight. The main issue of food insecurity and malnutrition among women is conveniently bypassed. The maternal mortality rates (MMR) in India are extremely high at 301 deaths per lakh live births, much higher than China at 56 and Sri Lanka at 92. But even these high MMR rates in India constitute just 11 per cent of deaths of women of the same age group. Most women die of other equally avoidable diseases related to anemia and malnutrition. It is a shameful reality that food subsidy is sought to be curtailed by successive union budgets in this backdrop of hunger and malnutrition and the public distribution system being dismantled rather than moving towards its universalisation as promised in the NCMP.

This is a prime example of how neo-liberal policies are creating a chasm between declared health policy objectives and ground realities. Without a sound universal food security policy one cannot ensure the prerequisite for good health. The same goes for the absence of drinking water. Stomach ailments, particularly diarrhoea, are among the worst fallouts of the failure to provide safe drinking water for people living in urban slums and in the poorer parts of rural India. Millions of people every day are afflicted with water related and water borne diseases. Children are particularly badly affected: of all the millions of children under 3 who require oral rehydration only 26 of every 100 children affected received the treatment last year. Inadequate resource allocations have prevented the government from ensuring access to drinking water for large segments of the population.

Wrong Prioritisation

A problem with the health policy is that of low or wrong prioritisation. For example, a most disturbing aspect of the national health profile is the widespread prevalence of vector borne diseases. Malaria continues to debilitate vast numbers of our population, particularly in tribal areas. Areas in the Northeast region are currently experiencing an increase in the numbers of malaria cases, including the more dangerous strains. A large number of deaths are taking place. Even the official figures, which are gross underestimates because most of the deaths go unreported, show that the incidence of malaria has increased in the last few years, as have the deaths. There were 1.8 million reported cases of malaria in the country last year but the blood examination rate was less than 10 per cent. The reported deaths which are a gross underestimate still show an

increase from 963 in 2005 to 1441 in 2006. In other words almost 4 people die every day of malaria. Incidences of all vector borne diseases like Japanese encephalitis, dengue and chikungunya are on the rise. The misplaced priorities of the government can be seen in lower allocations for disease prevention programmes over the last few years. Although TB was supposed to be eradicated we find from official figures that this is far from the case. Although the direct observed treatment (DOT) can claim some success, the incidence of drug resistant TB is still unacceptably high, requiring much more expensive drugs for treatment. The government has set up a national disease surveillance system to monitor the spread of epidemics and to take immediate measures. This is a welcome step; however, it is inexplicable why chikungunya and Japanese encephalitis have not been included in the list of diseases to be surveyed when in the last two years many states have been affected by these diseases.

The government appears to have set HIV/AIDS on high priority. It is indeed a matter of deep concern that only around 7 per cent out of an estimated 5.2 lakh HIV/AIDS affected persons are currently receiving treatment and the coverage should be expanded. But even as attention towards the prevention of HIV/AIDS is necessary, that attention should not come at the cost of the other disease control programmes. The allocation for the national AIDS control programme is Rs 720 crore in budget 2007-08, while the allocation for all the national disease control programmes taken together (which includes vector borne disease control programme, TB control programme, leprosy control programme, trachoma and blindness control programme, iodine deficiency disorders control programme, integrated disease surveillance programme and drug de-addiction control programme) is only Rs 884 crore. The international health agenda is dominated by the control of HIV/AIDS and major funding from international agencies like USAID and Bill Gates Foundation comes into that area, but surely it is for the Indian government to ensure that the other disease control programmes which are equally important for our country are not underfunded. Especially, the allocation for vector borne disease control programme needs to be much higher than what it currently is, if it has to make a difference.

Another example of lopsided prioritisation is the deteriorating record of the universal immunisation programme for children. At present, out of every 100 children who require immunisation only 47 are immunised under this programme. This clearly reflects a dismal picture. Researchers in public health as well as those working in the field have expressed apprehension that the pulse polio programme, which continues to be a vertical programme, has not only not succeeded in eradicating polio but has actually taken attention away from routine immunisation. The allocation for routine immunisation is only Rs 300 crore in budget 2007-08 while the allocation for the pulse polio immunisation programme is Rs 1289 crore. It is essential to give as much or more importance to routine immunisation as the government is currently giving to the pulse polio programme.

Janani Suraksha Yojana

The Janani Suraksha Yojana is a new and important scheme of the union Health ministry under the NRHM. It is a welcome scheme to give incentives for institutional deliveries, which at present are only around 32 per cent of total deliveries. This is expected to bring down the maternal mortality rate. However, there are two basic flaws in the scheme. Firstly, it is restricted to over 19 year old mothers only. While it is desirable to have a situation where the consciousness of the society is raised so that children are not born to mothers below 19 years of age and that the anti child marriage legislation is implemented, it needs to be recognised that the present realities are such that a large number of women between the ages of 16 to 18 do give birth to children. These mothers often do not have a choice, either in terms of their early marriage or in terms of childbirth. While initiatives to prevent child marriages and promoting later childbirth should be intensified, excluding pregnant women below 19 years from institutional deliveries is an unjust punishment to them. Secondly, the scheme is restricted to the birth of only the first two children. This is another attempt to punish the mothers for circumstances which are often beyond their control. Denying institutional deliveries to mothers for the birth of the third child is another unacceptable measure of population control. Such a policy victimises women. These provisions need to be removed from the scheme if its main goal of lowering the MMR is to be achieved. Objectives like prevention of child marriage, underage pregnancy or family planning should be pursued through the existing channels and not by introducing unjust provisions in the Janani Suraksha Yojana.

When this issue was raised in parliament the minister assured the house that he would reconsider the scheme to make it more inclusive.

State of the Public Health System

The public health system comprises a three tier structure — the primary structure with sub-centres and primary health centers (PHCs), the secondary sector with community health centers (CHCs) and the tertiary sector with big public hospitals. These centres are supposed to be based on a certain population as per the following norms:

Sub-centres 1 per 5000 population in general areas and 1 per 3000 population in tribal areas
Primary health centers: 1 per 30,000 population for general areas and 1 per 20,000 for tribal areas
Community health centres (hospitals) 1 per 1.2 lakh population in general areas and 1 per 80,000 for tribal areas.

Shockingly the central government in many cases is still using the 1991 population database to fund the sub-centres and the ANMs. When this was pointed out to the health minister, he gave an assurance in parliament that the norms are being changed and that the centre would increase funds for ANMs.

Today all the three sectors are in shambles in most parts of the country. According to the rural health infrastructure bulletin 2006, there is a nationwide shortfall of 20,903 sub-centres, 4803 PHCs and 2653 CHCs. Moreover, 21 per cent of sanctioned posts for doctors are vacant, 39 per cent of PHCs had no lab technicians and 18 per cent had no pharmacists. In the CHCs, 54.4 percent of all sanctioned posts were vacant. In many places particularly in remote tribal areas the centres exist only in name.

The truth is that many of our trained personnel do not want to go and serve in the villages. We support the recommendations of various government committees that internships should include a mandatory term in rural areas as also other suggestions like incentives etc., for rural postings. The key to improve functioning of PHCs, however, is to ensure necessary infrastructure through proper buildings and availability of medicines and equipments. It is only through a combination of such steps that compulsory rural postings can be implemented. But equally important is the urgent necessity to increase the numbers of doctors, nurses and auxiliary nurse midwives (ANMs). This is an aspect that is ignored by current approaches by the government. It seems to have abdicated its responsibility of providing opportunities for medical education to the private sector.

Today 80 per cent of medical colleges are in the private sector, which are concentrated in 5 states. Students pay huge capitation fees to get admission. Someone who has paid 20 lakh rupees as admission fee is unlikely to be willing to go to a remote village to serve the poor. What is required is a huge investment to start government medical colleges. At the same time a separate legislative initiative is required to control the exorbitant fees being charged by private colleges. Similarly, in spite of the huge demand for nurses there are only about 200 odd government run nursing schools, the rest being in the private sector. The government needs to ensure affordable training for nurses in order to meet the gap. The third aspect is that of training schools for ANMs. At present if each sub-center is to have two ANMs we need at the very least one lakh ANMs. For this it is essential to have training schools at the district level. This will also encourage tribal or dalit women from the community so that they will stay on in the village and meet the health needs. They should also be encouraged to join nurses training. West Bengal has a positive experience in ANM training and recently 70 training schools have been set up to meet the demand. It is only through a conscious effort to increase the number of medical cadres at all levels that the public health system can be revamped.

We must extend our appreciation to all the doctors and medical personnel who continue to work in the government sector and in government hospitals in spite of the tremendous difficulties and drawbacks. Some of the finest doctors are practicing in hospitals like AIIMS taking on huge workloads and caring for their patients, whether they are the poor or affluent. It is necessary for the government to improve the working conditions and extend other facilities to all government hospital personnel.

Recently AIIMS has been in the news for the wrong reasons. It became a centre for the anti-reservation agitation. A recent report of the Thorat committee has highlighted casteist practices against dalit students. It is essential to take remedial action to protect the rights and dignity of dalit students. At the same time, the autonomy of the institution

must be protected and as the Supreme Court which intervened in the matter commented 'the minister and the director" should act in the best interests of the institution.

Massive Increase in Funding Required

What is required today is a massive infusion of funds from the central government to re-energise the public health system and create both physical and social infrastructure. It is here that the neo-liberal philosophy becomes an impediment. In 1991 when the neo-liberal policies were initiated in India, the public health expenditure to GDP was a paltry 1.3 per cent. This had come down to 0.9 per cent in 2001-2002 and has increased only marginally since. This puts us among the lowest in the world in terms of public health expenditure to GDP — we spend more than only five countries — Burundi, Myanmar, Pakistan, Sudan and Cambodia. While the Finance minister may be proud that India has supposedly joined the trillion-dollar economy club, the monthly per capita expenditure on health is at a dismally low level of less than 17 rupees. Prior to economic reforms in the mid-80s, public health expenditures accounted for 3.95 per cent of the budget. By 2001, this had dropped to 2.7 per cent and further down to 2.4 per cent in 2005. Even a restoration of budgetary support to levels achieved in the 1980s would mean a doubling of allocation. We can look at these figures in another way. By 2008-09, assuming the current growth rate, we should be spending nearly five times more than what the state and central governments, put together, presently spend on health.

Another serious concern is the shortfall in the actual expenditure as compared to the outlay approved in the budget. The actual expenditure always falls short of the approved outlays. The table below shows that from 2002-03 to 2005-06, the actual expenditure of the ministry of Health and Family Welfare has always fallen short of the budgetary outlays by significant margins- between 9 to 18.5 per cent

Year	Approved Outlay for MoH & FW (in Rs crore)	Actual Expenditure (in Rs crore)	Difference between Approved and Actual (%)
2002-03	6480.00	5276.45	(-) 18.5 %
2003-04	6480.00	5735.08	(-) 11.5 %
2004-05	7988.00	6634.45	(-) 17.5 %
2005-06	9332.00	8500.00*	(-) 9.0 %

**Revised Estimates*

Therefore, there is a vicious circle. We need more resources, but we cannot fully utilise the resources we have. One of the reasons relates to the moribund status of the health infrastructure as we have discussed earlier. Infusion of sub critical resources does not help, because the infrastructure and the delivery system in its present state is incapable of delivering. The answer is to greatly enhance infusion of resources together with an overhaul of the existing infrastructure. Without such an approach, the grand policy declarations of the union Health ministry will only be a reminder of the promises unfulfilled.

Drug Policy

The Health ministry has other important institutions working under it like the Drug Controller General of India (DGCI). This authority has many important roles such as licensing for new drugs, assessing medicines in market and weeding out or banning those where subsequent research has been found to be harmful, checking spurious drugs, giving permission for clinical trials etc. Thus its regulatory and monitoring role is extremely important for a proper drug policy yet shockingly it has only 29 officers working under it. Obviously with such a small staff strength even if comprising of the best officers the DGCI cannot fulfill its important responsibilities. In Delhi alone there is a huge centre in the middle of the city where thousands of spurious drugs are traded but no action has been taken. Again as far as the issue of weeding out drugs from the market, including where later research has shown the drug to be harmful as for example Aralgan which was banned, most cases have arisen out of PILs against the specific drug and not through any proactive steps on behalf of the DGCI. Even today India has the most lax policy as far as permitting the sale of such drugs is concerned. But even as it cannot fulfill present responsibilities, the ministry wants to encroach into state jurisdiction and take over licenses for drug manufacture also which will cause further problems and should be opposed. The DGCI's reputation was deeply affected when two of its most important functionaries in the past were hauled up for corruption and one even had to spend time in jail. Instead of learning from this experience, the Health ministry has not put in place any checks and balances or any mechanisms to make the working more transparent. It is important to ensure that the health of citizens does not get compromised under corrupt officials succumbing to powerful pharma lobbies.

Clinical Trials

The only area where the DGCI is active in granting permission to pharma companies to conduct clinical trials in India. We had earlier protested against the changes made in the relevant Schedule Y of the Drugs and Cosmetics Act, which has removed the earlier protection provided against exploitative clinical trials. Today, India has emerged as the favoured destination for MNCs based in advanced countries, who want to use Indian people as guinea pigs in tests which cost them 60 per cent less than in their own countries mainly because of more stringent client protection laws there. In India there are no provisions for compulsory insurance or compulsory compensation. Most hospitals, which allow clinical trials, do not even have functioning ethics committees. Shamefully in the budget 2007, the Finance minister actually cut all taxes on clinical trials thus further helping pharma companies. It would be more appropriate and in the interests of our people if the government ensured a set of stringent regulations to govern clinical trials.

Standards

In view of the increasing demand for ayurvedic drugs, not only in India but across the world, it is also essential to put in place a clear protocol which includes listing of all ingredients in indigenous medicines so that consumers are aware of what they are consuming. The Health ministry also needs to play a bigger role in ensuring safety

standards in food and beverages. Recently the ministry gave a clean chit to Coke and Pepsi regarding their pesticide content. But in spite of an assurance given in parliament by the minister of Health, standards for the permissible levels of pesticides or other such harmful products in colas and carbonated drinks are yet to be set. These standards must be established without delay and action taken against all those who violate those norms. In view of the increased presence and operations of the domestic and foreign companies in food and pharmaceuticals, the government should gear up to frame and implement effective regulations.

Conclusion

In its influential 1987 document Financing Health Services in Developing Countries: An Agenda for Reform, the World Bank stated, "The approach to health care in developing countries has been to treat it as a right of citizenry and to attempt to provide free services for everyone. This approach does not work". The reforms in the health sector in India since 1991 have been guided by this philosophy. The result has been a decay of the public health institutions and mushrooming of the private healthcare industry, which has excluded large sections of the population from affordable and quality healthcare. It has to be realised that for the healthcare system to work it must be a universal right accessible to all. And unless the state plays the central role in the health sector, both in terms of fund allocation as well as creating and maintaining infrastructure, the objective of health for all shall remain a mirage.

Joint Statement

On CMP, Health and Population Policy Initiatives

Over the last fifteen years India has witnessed a sharp decline in the state's commitment to public health. Thus today our country has the fifth lowest public health expenditure in the world. As the National Health Policy admitted, this is, at 0.9 per cent of the GDP, lower than the average in even Sub Saharan Africa. Along with decreasing state spending on health, increasingly policy measures have encouraged the growth of the private sector in health care so that today we have the largest and least regulated private health care industry in the world. Evidence from across the country indicates that access to health care has declined sharply over this period. The policy of levying of user fees has impacted negatively upon access to public health facilities, especially for poor and marginalised communities and to women. As health care costs have increased sharply, it is not surprising that medical expenditure is emerging as one of the leading causes of indebtedness. At the same time, this has been accompanied by policies that have reduced access of the poor to public distribution systems of food so that per capita availability of food has shown an alarming decrease.

It is thus not surprising that in addition to starvation deaths, the huge load of preventable and communicable diseases remains substantially unchanged. Infant and child mortality take an unconscionable toll of the lives of 22 lakh children every year. We are yet to achieve the National Health Policy 1983 target to reduce the Infant Mortality Rate to less than 60 per 1000 live births. More serious is the fact that the rate of decline in the Infant Mortality Rate, which was significant in the 1970s and 80s, has remarkably decelerated in the 1990s. 130,000 mothers die during childbirth every year. The NHP 1983 target for 2000 was to reduce Maternal Mortality Rate to less than 200 per 100,000 live births. However, 407 mothers die due to pregnancy related causes, for every 100,000 live births even today. As per the National Family Health Surveys in the last decade, the MMR has increased from 424 to 540 maternal deaths per 100,000 live births. Partially as a result of population policies, the disincentives and the two-child norm contained in them – at variance with the National Population Policy (2000) and the commitments made at the ICPD in Cairo – there is a massive shortfall of girls in the 0-6 years age group due to Sex Selective Abortions (SSA). Violence against women has grown, and taken many new forms, including a huge increase in so-called "honour killings". Indeed it would be no exaggeration to state that population policies have added to this violence.

Hope from UPA Govt

It is thus with hope that we looked forward to the United Progressive Alliance government to initiate policy measures to arrest these trends. Although the Common Minimum Programme was committed to a substantial increase in health spending, this is not evident in the financial allocations made: the budget outlay for 2004-05, adjusted for inflation, shows no increase in the outlay for health and an 11.9 per cent increase for family planning, clearly indicating skewed priorities.

However, more alarmingly, the single line, "A sharply targeted population control programme will be launched in the 150-odd high-fertility districts", from the CMP has been acted upon to unveil policy measures for 209 districts in the country. This is a truly unfortunate move, with grave consequences for thousands of women and children from the poor, marginalised communities, especially dalits and adivasis, who along with deprivation, suffer higher levels of morbidity and mortality, and a high unmet need for health and family planning services.

Regressive Programme

These 209 districts in which the "sharply targeted population control programme'' are to be launched are precisely the same districts with poor indicators for social development, especially female literacy, infant and child survival, maternal morbidity and mortality and other indicators of human and gender development. Instead of a package of health and development measures, what is being proposed is concentrating on a sharply targeted population control programme in these districts in five states. This profoundly regressive policy relies on targets for sterilisation, coercive incentives and disincentives, and massive subsidies to the private sector, recalling the worst days of India's family planning history. Not only do such measures violate basic human rights, they have also been shown to be demographically unnecessary in bringing down population growth rates.

The declining Child Sex Ratio (CSR) is one deeply worrying indicator of the outcomes of such short-sighted population policies. Between 1991 and 2001, in urban areas, the CSR has declined from 935 to 903 and in rural areas from 948 to 934. More ominously, between January and June this year, in Delhi the Sex Ratio at Birth indicates 819 females being born for every 1000 males; in the prosperous and educated South Delhi zone, where demographic transition has by and large been completed, only 762 females were born for every 1000 males. A recent study by the Ministry of Health also indicated the dolorous outcome of the imposition of the two-child norm for contesting elections. A large majority of those disqualified on this ground were dalits, the adivasis and women from poor families, defeating the very purpose of democratic decentralisation. Further, the study indicated that this norm had acted as an incentive for SSA. Clearly then population stabilisation in this form cannot be the goal since it leads to profoundly unbalanced populations.

We therefore demand that the programme measures for these 209 districts be unreservedly scrapped. We cannot have a population policy that does not hinge on equity and gender justice. There should thus be no National Population Mission. ***Issues concerning women's health and reproductive rights can only be part of a larger package of a health and social development policy.***

We welcome the UPA's commitment to increasing state spending on health, but this should be entirely devoted to strengthening the universal and comprehensive primary health care (PHC) system. Increasing state spending cannot become the vehicle to increasing public subsidy to the private or NGO sectors, which in fact require regulation.

It is evident from the CSRs that the private sector has played a deeply regressive role in health care provision.

The Tenth Plan proposals for health and nutrition need to be reviewed keeping epidemiological priorities in mind. ***A basket of technologically determined vertical programmes cannot substitute for a systematic strengthening of a comprehensive, universal, integrated PHC system.***

Ten years after Cairo, if the commitments made there have to have meaning, it is clear that we cannot have RCH without PHC; nor indeed can we have gender-just population policies without the enabling conditions of health and development. What we have demanded is the minimum and non-negotiable. We are still hopeful that the UPA government promises something new.

[This statement was signed by Action India; All India Democratic Women's Association (AIDWA); Centre for Social Medicine and Community Health (CSMCH), JNU; Centre for Women's Development Studies (CWDS); Delhi Science Forum (DSF); Jan Swasthya Abhiyan (JSA); Joint Women's Programme (JWP); Medico-Friend's Circle (MFC); National Federation of Indian Women (NFIW); Saheli; Sama and Young Women's Christian Association (YWCA)]

October 6, 2004

Kerala Women: New initiatives to meet the challenges

P.K.Sreemathi,
Minister for Health and Social Welfare, Government of Kerala

In the health sector, Kerala is well known for its achievements in basic health indicators. The Infant Mortality Rate is 13 (per 1000 births) in Kerala compared to the national average of over 400 and equaling many developed countries. The life expectancy of Kerala women is 76 years compared to the national average of 66 more significantly, the male-female ratio in the population is 1000:1058, whereas the ratio is reversed in many major Indian states. The Maternal Mortality Rate which shows the number of women dying due to pregnancy and delivery related problems is 110 in Kerala against a national figure of 400 per one lakh cases. 99% of the deliveries in the state take place in the hospitals, of which there is a strong network in the state, both in the public and private sectors.

The high female literacy rate of over 90% has been attributed as the main factor contributing to these achievements, which itself has resulted from more than a century old tradition of state patronage for education- especially education of girls. The first school for girls was started in by the Queen of Travancore in the early nineteenth century itself, later upgraded as a college for women. The work of Christian missionaries in the spread of education has also been acknowledged. The first EMS led Government brought in revolutionary measures in the education sector by expanding the number of Government schools and putting an end to the clutches of private school managements who were exploiting teachers.

Health care had also received attention from the rulers of Travancore which could boast of the first Primary Health Centre established in the country in 1910. Public hospitals which provided free health care to the people were set up in many parts to meet the demands from the people. The first popular Government of 1957 which brought in land reforms and many path breaking pro-poor legislations also took steps for expansion for Government hospitals across the state, especially the northern parts in Malabar which was neglected under the British rule.

All these achievements of the state in health and education are facing newer and newer challenges. Reports show a rising trend in Maternal Mortality Rate which is attributed to anaemia and poor health condition among pregnant women, postpartum hemorrhage, pregnancy induced hypertension etc. There is an alarming increase in nutritional deficiency in women especially among poorer sections of the population. On the other hand there is a worrying increase in the number of caesarian operations in the state, most of which are unnecessary from the point of view of safe delivery. The figures are as high as 40% in many hospitals against an accepted figure of 15-20%. It is said the doctors are being asked to perform caesarian operation to get an auspicious birth date for the offspring. The private hospitals may also be encouraging this in unwanted cases also due to lust for money. In spite of the high literacy rates and health awareness, women

continue to be the target of birth control measures, with tubectomy being the most preferred method. The safer and trouble free vasectomy of men is very rarely adopted.

Another problem facing the state is the rise in the aged members of the population. The percentage of the population of over 60 years which is 11% at present is expected to rise to over 20% by 2030 and 30% by 2050. With the higher female life expectancy, the number of women among the aged population will be naturally higher. Another aspect of the problem is that many of the elderly women are widows who have nobody to depend on after the death of their husbands. The elderly women also tend to have many complex health related problems and lack of any source of income makes their life miserable.

Lakhs of working class women depend on the traditional industries like coir, cashewnut and handloom and in the fishing and plantation sectors. The health problems faced by these women working in very shabby and unhygienic conditions need special attention.

The return of many communicable diseases including new forms of viral fever like chikun gunya have posed great challenges threatening the public health achievements in the state. On the other hand, non communicable diseases like diabetes, heart diseases, hypertension, cancer etc. are on the increase accounting for about 40% of cases of morbidity and death.

Public health sector was neglected by the previous UDF Government which believed in the policy of withdrawal of the state from this all important sector and tried to promote privatization. The share of Government investment in health sector decreased every year. Medical and nursing education was thrown open for exploitation by the private self-financing colleges. The public hospitals were awfully lacking in resources, facilities and accountability. The new LDF Government which came to power in May 2006 has taken a series of measures to tackle these problems and put the public health system in the state back on rail.

It has taken steps to rejuvenate the public hospitals and institutions at the primary, secondary and tertiary levels by completing long pending, unfinished projects and taking up new projects. The unutilized funds under the National Rural health Mission were channelised for upgradation of the Community Health Centres. A new scheme for modernization of existing Women and Children Hospitals was got sanctioned and steps are afoot to start new W&C hospitals in 9 districts. Two new Government nursing colleges were started to cater to the increasing demand of nurses nationally and internationally. (Malayali nurses are well known for their dedicated service). The seats in three Government Medical colleges were increased by 50 each, which is as good as starting two new medical colleges.

A strong point in the LDF Government's approach to public health care is the role of Local Self Governments. Since 1996, the public health institutions upto the District level are transferred to the local bodies. The health department is closely working in association wit the local bodies to upgrade the facilities in the hospitals and to launch

people's health programmes in the locality by involving Hospital management committees and ward level Health and Sanitation committees with people's participation.

Steps were taken to distribute the pending financial assistance for poor women under the Janani Suraksha Yojana. A new scheme for counseling and care for adolescent girls was taken up. The honorarium for Anganawadi workers and helpers was enhanced by Rs.150/-. A scheme for giving retirement benefits to them is under consideration.

The Women's Commission which had become defunct was reconstituted and steps have been taken to set up Jagrata Samithies at the Panchayat and District levels by involving women's organizations to intervene on women's issues. The implementation of prevention of Domestic Violence Act was taken up in right earnest by appointing 31 Protection officers and selecting Service providers. A new Women's Policy is being drafted by a committee in consultation with women's organizations to frame policy measures needed to meet the challenges faced by women of the state in various sectors.

From Primary Health Care to A Right to Health Movement: The Indian Experience

Jan Swasthya Abhiyan

Section I: Remembering Alma Ata and the Primary Health Care Approach

The PHC approach, abandoned by countries and international agencies soon after the Alma Ata Declaration, continues to be as relevant today as it was 30 years ago. It would be useful to remind ourselves of the important elements of this approach and the Alma Ata Declaration which elaborated this approach.

- Stresses a *comprehensive* approach to health by emphasizing interventions that promote and protect health, such as food security, women's literacy, access to clean water, etc. It looks at health beyond disease, drugs and doctors (as is done in the biomedical approach to health).
- Promotes *integration* of different programmes and services at all levels of the health care system, rather than rely on separate disease control programmes which have little interaction with each other.
- Emphasizes *equity* and recommends addressing imbalances at different levels, viz. the neglect of rural populations, and of socially and economically marginalized groups.
- Advocates the use of *'appropriate' health technology*, and health care that is socially and culturally acceptable.
- Emphasizes appropriate and effective *community involvement* in the health care system.
- Adopts a strong *human rights perspective* on health by affirming that health is a fundamental human and by placing the responsibility on governments to act on this.

Conscious of the social and political contexts in which Health is located, the Alma Ata Declaration also called for peace, reduced military expenditure and a 'New International Economic Order' to reduce the health status gap between developing and developed countries.

As we can see the PHC approach to Health has within it a holistic understanding of health and its social, political, cultural and economic determinants. Unfortunately there has been a tendency to confuse the approach with health delivery at the "primary" level of the health care system. By association it is sometimes presented as cheap, low-technology care for poor people in poor countries. In some measure this has been a deliberate ploy to discredit the PHC approach. As we have seen above, the PHC approach does not talk of intervention at just one level, it is based on a number of principles. These principles apply to any Health Care system, irrespective of whether it is a low or middle or high income country – it works as well in a poor developing country as it does in a rich industrialised country. The PHC approach is about maximizing our efforts and outputs in any setting. It was based on this approach that the Alma Ata Declaration gave a call for Health for All by 2000 AD.

The Demise of Health for All

We stand now, 25 years after the Alma Ata Declaration. Clearly the promises made in the Declaration have remained unfulfilled. What were the reasons for this? What were the reasons for the abandonment of the PHC approach by the global community, within a few years of it being proposed? The reasons were many – here we discuss some of the most important ones.

Economic Factors

The inability of poorer countries to pledge even a fraction of the resources required to sustain their health care systems has its origins in the economic crisis that engulfed poorer countries since the early 1970s. The crisis translated into savage cuts in government spending on social sectors such as health. This attack on the public system of health care led to it falling into disarray and in its attracting criticism from those who depended on it. Ironically, the same forces who brought about this change (the World Bank and IMF, as we shall see later, and even country governments themselves) joined in the chorus to blame public health services. It also forced people to look for other options, leading to a boost to the private sector and its increasing legitimization.

Health sector reforms promoted by the IMF and World Bank

The IMF and World Bank jumped in with their own prescriptions, promoting their brand of "Health Sector Reforms". None of these reforms were aimed at strengthening the public health system. Instead they contained a series of policy recommendations that were designed to systematically undermine the public system and at the same time promote the private sector. These prescriptions were tied with a package that was supposed to bail out the floundering economies of the poor countries. The three major elements of these policy prescriptions were:

- The growth in user fees;
- The segmentation of health care systems;
- The commercialization of health care.

User Fees and the Denial of Access

The impact of this transfer of responsibility for health care financing onto households has been disastrous, particularly for the poor. Global evidence suggests that the introduction of user fees is deterring more and more from accessing the public health system. User fees also work against people being able to use the system regularly, leading to their stopping medication before they should. Votaries of the use of user fees argue that the negative effects can be offset by not levying user fees on the poor. Unfortunately this is something that almost never works. On the contrary it encourages extortion and patronage when care providers are poorly remunerated. Nor is there evidence that user fees prevent the so-called "frivolous" use of government health services.

The segmentation of health care systems

Going hand in hand with the levying of user fees is the global trend to segment health care into public health care for the poor and private health care for the rich. On the face of it this seems an attractive proposition, one that the World Bank has been actively propagating. The Bank now advocates that governments in poorer countries should not attempt to provide comprehensive care to all. Instead, it says, they should only spend in providing a "minimum" package of services. Clearly this is in direct contrast to the PHC approach that recommends "comprehensive" health care services for all.

The argument in favour of this segmentation is obvious – government resources can be directed at those who cannot pay, while those who can are serviced by the private sector. Unfortunately this argument is based on an extremely shallow and simplistic view of how health systems work. Such a system results in the rich opting out of the public system and at the same time also drawing away resources, political clout and accountability from the public system. What is left is a 'poor service for poor people'.

A parallel private and public sector also allows the private sector to choose to cater to the most lucrative and leave the poor, the elderly and the seriously sick for the public sector. The division of health care systems into one for the poor and the other for the rich is not accidental, it appears to be a clear ploy that reflects the present socio-economic inequities and is an effort to reinforce them further.

Commercialization of Health Care

The collapse of the public sector has led to the emergence of a disorganized and unregulated private sector in developing countries. Ultimately this kind of behaviour converts health into a purchasable commodity in the market – with only those who can afford the costs being able to access it. This trend is backed by the medical-industrial complex and pharmaceutical companies. Market driven health care is starting to affect the public sector as well. Starved of finances, these institutions are being asked to raise their own resources, making them act in ways similar to the private sector and resulting in the exclusion of those who are poor and most in need of care.

Votaries of commercialization argue that a market based system improves quality of care and efficiency, because of competition between providers and because consumers have more choice. Nothing could be farther from the truth. Patients – especially poor patients — rarely have enough knowledge to choose between different options, or to negotiate better terms. Competition does not improve quality if people cannot make an informed choice. Instead multiple providers only target the affluent, and the poor are left with virtually no options. Private care is notorious for flouting regulations, and the necessity to regulate them places a burden on public finances. A system with multiple providers is inefficient because it cannot make use of "economies of scale" in the case of purchases, or in the provision of services. Such a system also works as a barrier to developing important public health instruments that need to be applied consistently and universally, such as disease surveillance systems. Competition between providers also harms collaboration between different providers – an important part of quality care.

Misplaced Priorities: Selective Health Care and Cost-Effectiveness

The PHC approach was undermined by the collapse of the public health system. The second major blow to the PHC approach came in the form of the concept of 'Selective health care'. The concept refers to a limited focus on certain health care interventions, as distinct from comprehensive health care.

Selective Health Care was propagated with the understanding that rather than wait for a fully resourced system that can provide comprehensive care, it is prudent to promote a few interventions that can produce the largest change in outcomes. Selective care soon came to be associated with "vertical" programmes, i.e. separate programmes with specific structures and management, each targeting a specific problem. The approach reinforced the biomedical orientation of care that is premised on the belief that a specific technology can target a specific health problem. Clearly this is in direct contradiction of the PHC approach that located health in a complex set of social, economic and environmental factors.

In many countries, the approach disrupted the development of a comprehensive health system. Many of vertical programmes were donor driven, and controlled as well as implemented by international donor agencies.

Bringing Back the "public" in Health Care Systems

The "public" has virtually disappeared from health care systems in many parts of the world. At the same time health care systems are either hostage to donor-driven agendas, or are being handed over to the private sector. If we are to reverse this trend, short-term solutions will not work. All the complex factors responsible for the demise of the public sector will need to be addressed.

In order to do so it is necessary to nail the wrong perceptions and blatant untruths about the public sector. There have been systematic attempts to portray the private sector as more "efficient" and to argue that market-based competition and incentives lead to better care and more choices. Such arguments turn a blind eye to the fact that the public sector has played the major role in almost all situations where health outcomes have improved significantly. Health systems that have depended on the public sector have been the norm, rather than the exception, in almost the whole of Europe. The success stories of health system development – viz. Sri Lanka, Costa Rica, Cuba – are success stories of public sector health systems. The success of the public sector is not limited to health care systems. Publicly-funded research in national institutes of science and universities has laid the foundations for many, if not most, developments in the medical sciences.

There are several important reasons why the public sector needs to play a leading role in health care systems – no matter which part of the world we are talking about. First, people have a right to health care that is not dependent on their ability to pay. This cannot be ensured unless the health care system in a country is public funded and administered. Not markets, but Governments, can ensure that health systems address the needs of the poorest and the most marginalized. This does not mean that public health services are "poor services for poor people". They should be seen as attempts by to provide the best services possible to all, while addressing the special needs of those who are most vulnerable.

Second, an equitable and efficient health care systems requires to be planned systematically based on local conditions. Only a public sector driven system can do this. It is impossible for a profit-driven, fragmented system with multiple (often contradictory) objectives, to do so. It is only a public system that can effectively strike a balance between preventive and curative services. It needs little intelligence to comprehend that a private system cannot and will not be involved in preventive services.

Third, only an adequately financed public service can break the link between the income of health care providers and the delivery of health care. Unethical behaviour of health care providers is directly linked with the fact that if care is linked to profit, more ill health means more profit! Non-governmental initiatives – especially the not-for-profit kind – have a role to play in health systems. But this role supplements public funded systems and cannot be asked to replace such systems.

Section II: The Policy Framework in India

Health services in India at the time of Independence were a function of the socio-economic and political interests of the colonial rulers. The post - independence era witnessed a real effort at providing comprehensive health care, and in extending the infrastructure of health services. However the improvements in our health delivery system did not match the needs of the vast majority of our people. After initial efforts in the first two decades after independence, the country's commitment to providing affordable and easily accessible comprehensive health care services suffered due to lack of adequate resources being pledged for the same. So much so that the Govt.'s "Statement on National Health Policy"(1982) was forced to state "In spite of such impressive progress, the demographic and health picture of the country still constitutes a cause for serious and urgent concern."

Thus, neither the stated commitment of the Government, nor its implementation, was able to make a significant dent in the status of health or in health care delivery systems. In addition, the impact of an urban elitist bias in medical education as well as in medical services detracted from the ability of the Indian State in providing Health care to the poor as well as those in rural India. Continued emigration of doctors, rush for super specialities, development of corporate hospitals and polyclinics, and an incredibly large and near universal trend to irrational use of drugs and technology are all trends that are a consequence of this bias. As a result, the major disease-load of the population has continued to be unacceptably high and, in recent years, health indicators like Infant and Child Mortality Rates have started stagnating after the downward trends seen earlier.

As noted earlier, the Indian State's allocation for health care has been extremely low by global standards, resulting in a large majority of people having to access the private sector. Even the meagre allocation for health has not been optimally utilised, resulting in extremely poor quality of services provided by the public sector. Thus, to a very large extent, health services and health care in India tends to respond to the existing 'market demand'. The vast health needs of the majority of the people do not figure as part of this "demand" for there is neither the awareness nor the organization nor their participation in

the making of these decisions. This trend has accelerated since the initiation of neoliberal economic reforms in the country from the late 80s

Neoliberal "Reforms" – Impact on Health Care

This situation was compounded with the initiation of neoliberal economic reforms in the country in 1991. These reforms marked a major shift in the government's policy towards social sectors like health. These policies sought -- by way of fiscal austerity measures -- to cut Govt. spending and subsidies in social sectors, reduce direct taxes, increase administered prices, liberalise trade by reducing tariff rates and providing other incentives for foreign investments, privatise public enterprises, deregulate the labour market, etc. The policies were designed to clear the path for withdrawal of the State from the social sectors like health, education, food security, etc. The ideological barrage associated with the reforms package served to confer legitimacy to the virtues of the private sector and the market. In the process, the supposed inability of the state to sustain funding of education, medical care and public health, programmes for provision of drinking water, etc., seems to have gained acceptance.

The immediate fallout of the new policies was a cut in budgetary support to the Health sector. The cuts were severe in the first two years of the reform process, followed by some restoration subsequently. Thus, outlay on Health fell from 1.9% of plan investment in 5th Plan to 1.6% in first two years of 90's, and then increased marginally to 1.8%in 8th Plan outlay. This squeeze on the resources of states was distributed in a fairly secular fashion over expenditures incurred under all developmental heads. Health care was a major casualty as the share of states constitutes a major portion of expenditure. A similar kind of squeeze in resource allocation was felt in all programmes, largely financed by the states, including water supply and sanitation. As a result of the rollback on expenditure on health care, the expenditure by the Govt. on health care has fallen from 1.4% of the GDP in 1991 to 0.9% in 2002.

Compression of funds available with states has had a number of far reaching effects. Generally, expenditures on infrastructure (buildings, rentals, salaries, etc.) tend to take up an inordinately large part of total expenditure. They constitute 70-80% (or more) of expenditure for most major programmes, and the trend is most distorted in the case of rural programmes, viz. rural hospitals and primary health centres. Faced with limited funds, the burden of cutbacks are increasingly placed on supplies and materials. Ultimately a skeletal structure survives, incapable of contributing in any meaningful manner to amelioration of ill-health.

Expenditure patterns on health care are grossly skewed in favour of urban areas. Expenditure cuts further distort this picture with the axe on investment falling first on rural health services. As a result of this rolling back of state support to health care the first major casualty in infrastructure development has been the rural health sector. There has been a perceptible slowing down in infrastructure creation in rural areas.

The extent of cuts in health sector funding by the state and the consequent impact, as part of the reform process are, in a sense, peripheral issues. The central issue that needs attention is the theoretical underpinning of the reform process vis a vis state involvement in social sectors like Health. It is important to note that structural adjustment policies are geared to restructure the economy in a certain manner and not to improve welfare measures. Reforms initiated in this country and elsewhere start from the premise that present levels of subsidies to the social sectors are unsustainable. So prescriptions for restructuring of the health sector are designed, not to provide the best possible health care, but to maximise outputs from greatly reduced state support.

India's situation in terms of spending of Health Care is different from most developing countries on two counts. At 6% of GDP spent on health care, India spends more on health care in percent terms than most developing countries. At the same time, at 16%, government spending of the total expenditure on Health Care, India ***is one of the lowest in the world***, both in actual terms as well as in percentage terms. It may be contrasted with 70-80 per cent share of expenditure on health care by governments in most of N.Europe, and even the 44 per cent expenditure by the government in the U.S. While successive Five-Year Plans have shown a fall, in percentage terms, in allocation for health care, the present *mantra* of liberalisation is being used to legitimise further privatisation in the health sector. Health expenditure in India is thus already heavily distorted in favour of the private sector. It should be understood that the extremely low level of public funding in India is not a new phenomenon. In fact successive Five Year Plans have shown a fall in percentage terms, in budget allocation for health care.

There has been little effort towards sustained investments to build up health care infrastructure in the country. To be fair, periods of stagnation have been punctuated by sporadic efforts to enhance public health funding. Mention may be made in this context of the National T.B. and Malaria programmes of the fifties and sixties and the Primary Health Care Programme in the late seventies and early eighties. In the case of all these programmes, much of the earlier gains were frittered away as the initial infrastructure created was not supported in later years by matching investment. In fact between 1985-86 to 1990-91 there was already a major slow down or decline in State expenditures on Medical and Public Health. This was more glaring in the case of capital expenditures for setting up of new infrastructure.

Misplaced Emphasis on Vertical Programmes

This is not to suggest that optimal use has been made of public health expenditure in the country before the reforms process. In fact, quite to the contrary. Much of the blame for what is today being termed the "resurgence of communicable diseases" lies in strategies adopted well before the reforms programme in the country. These strategies relied on various centrally administered programmes (vertical programmes) for disease control and prevention. Such programmes included the National programmes on Tuberculosis, Malaria, Leprosy, Immunisation, Diarrhoeal diseases, Blindness and Family Planning. With no integration at the level of delivery, these programmes were insensitive to local conditions, unresponsive to local needs, highly bureacratised and inefficient. These

programmes were accountable to officials situated in the national and state capitals, and had little or no scope for flexibility based on local conditions. Local populations were indifferent and in some cases hostile to such programmes, resulting in fair measure to the very poor utilisation of Government health facilities in many areas.

Oblivious to these trends the government has geared itself towards the show-casing of the "market orientation" of health care policies. Investment in the private hospital sector was very low in the 1970s, but since then it has grown at an exponential rate. This was fuelled by a slowing down of investment by the State and simultaneous incentives given to the private sector in the form of soft loans, subsidies and tax exemptions. In recent years new medical technologies have further added to the impetus, with increasing participation from the Corporate sector. This coupled with the impending entry of insurance multinationals, has cleared the path for the Indian health care sector being taken over by forces that control the global "market" for health care. In the process, the health needs of an overwhelming majority of Indians are being increasingly ignored.

Penetration of the Private Medical Sector

The abandonment of the government's basic duty in providing health care facilities has greatly enhanced the ability of the private sector to penetrate into the health sector. The distinction between health care and medical care is important and needs to be noted. *Health care* involves a lot more than just medical care, i.e. diagnosis and treatment of illnesses. Health care involves nutrition, drinking water and sanitation facilities, good housing, and a lot more. These aspects of health, for obvious reasons are not provided by the private medical sector.

But what of the medical care that is provided by the private sector? There is a fundamental contradiction that exists in the concept of private medical care. By definition private medical care can survive only if it is profitable. What logically follows is that a private medical care provider stands to profit from ill-health—*the more people fall ill and the longer they remain ill, the larger the profit for the care provider!* Additionally, as the poor have less money, much of the so called 'quality'private sector tends to be concentrated more among the better off citizens while the "quacks' serve the poor.

We have commented earlier about the fact that developed economies continue to pledge resources on public funded health care—to the tune of 70-80% of total health care costs. They do so, not out of any altruistic motives, but because conventional wisdom dictates that health care in the private sector is expensive and inefficient. And yet, our government wishes to argue that privatisation of health care leads to more efficient utilisation of resources!

In spite of all the virtues of the "free-market" that are being sought to be foregrounded, the private sector is thriving because of a host of direct and indirect subsidies it receives from the government. It is ironical that a government which declares that it makes poor economic sense to "subsidise" health care for the poor, provides such subsidies to the private and corporate medical sector, which caters exclusively to the needs of the rich.

Thus, after providing medical education at a very nominal cost the government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals.

The government also provides incentives, tax holidays, and subsidies to private pharmaceutical and medical equipment industry. It allows exemptions in taxes and duties in importing medical equipment and drugs, especially for expensive new medical technologies. *The government has allowed the highly profitable private hospital sector to function as trusts which are exempt from taxes, thereby exempting them from contributing to the state exchequer even while being allowed to make huge profits*. Moreover, medical and pharmaceutical research and development is largely carried out in public funded institutions but the major beneficiary is the private sector. Many private practitioners are given honorary positions in public hospitals, which they use openly to promote their personal interests.

The decade of the nineties has seen another transition taking place in the private health sector. Prior to this, the private sector consisted of a large number of individual practitioners and private hospitals and nursing homes run by medical professionals. For the first time, today, we see the entry of the *organised corporate sector* in medical care. As the practice of medicine becomes more technology intensive, the role of the medical professional is becoming narrower. The control of technology has thus become the key factor in determining who or which entity controls private medical care. Corporate entities, given their ability to invest in "state of the art" medical technologies, are fast wresting control of the medical care "industry". Henceforth, the return on investment made by such corporations, and not any esoteric concept of professional ethics, will determine the kind of care provided. As corporates try to maximise profits they will attempt to further push up cost of medical costs by introducing high cost technologies, and expensive diagnostic aids and medicines. This is not merely an imaginary futuristic scenario. In the United States, such an approach to medical care has lead to health care costs being the highest in the world. Alongside the move towards reduced support to health care facilities, the government's new-found fascination with health insurance is designed to facilitate privatisation of the health sector.

Section III: Wide Ranging Impact – Denial of Health Care at All Levels

The consequences of the policies related to health care are being widely felt. Some glaring instances include the following:

- **Infant and Child mortality snuffs out the life of 22 lakh children every year,** and there has been very little improvement in this situation in recent years. We are yet to achieve the National Health Policy 1983 target to reduce Infant Mortality Rate to less than 60 per 1000 live births.[2] More serious is the fact that the rate of decline in Infant Mortality, which was significant in the 1970s and 80s, *has slowed down in the 1990s*.
- **130,000 mothers die during childbirth every year**. The NHP 1983 target for 2000 was to reduce Maternal Mortality Rate to less than 200 per 100,000 live births. However, 407 mothers die due to pregnancy related causes, for every 100,000 live

births even today. In fact, as per the NFHS surveys in the last decade Maternal Mortality Rate has increased from 424 maternal deaths per 100,000 live births to 540 maternal deaths per 100,000 live births.

- **Three completely avoidable child deaths occur every minute**. The four major killers (lower respiratory tract infection, diarrheal diseases, perinatal causes and vaccine preventable diseases) accounting for over 60% of deaths under five years of age are entirely preventable through better child health care and supplemental feeding programs. The most recent estimate of complete immunization coverage indicates that only 54% of all children under age three were fully protected.
- **About 5 lakh people die from tuberculosis every year**, and this number is almost unchanged since Independence! 20 lakh new cases are added each year, to the burgeoning number of TB patients presently estimated at around 1.40 crore Indians!
- India is experiencing a **resurgence of various communicable diseases** including Malaria, Encephalitis, Kala azar, Dengue and Leptospirosis. The number of cases of ***Malaria has remained at a high level of around 2 million cases annually*** since the mid eighties. By the year 2001, the worrying fact has emerged that ***nearly half of the cases are of Falciparum malaria,*** which can cause the deadly cerebral malaria.
- A growing proportion of Indians *cannot afford health care when they fall ill*. National surveys show that the *number of people who could not seek medical care because of lack of money increased significantly* between 1986 and 1995. The proportion of such persons ***unable to afford health care almost doubled***, increasing from 10 to 21 % in urban areas, and growing from 15 to 24% in rural areas in this decade.
- ***Forty percent*** of hospitalised people are *forced to borrow money or sell assets to cover expenses.*
- ***Over 2 crores of Indians are pushed below the poverty line*** every year because of the catastrophic effect of out of pocket spending on health care.
- Irrational medical procedures are on the rise. According to a study in Chennai, ***45% of all deliveries were performed by Cesarean operations,*** whereas the WHO has recommended that not more than 10-15% of deliveries would require Cesarean operations.
- Due to ***irrational prescribing***, an average of 63 per cent of the money spent on prescriptions is a waste. This means that nearly two-thirds of the money that we spend on drugs may be for unnecessary or irrational drugs.
- The pharmaceutical industry is rapidly growing -- yet only 20% of the population can access all essential drugs that they require. Many drugs are being sold at 200 to 500 percent profit margin, and essential drugs have become unaffordable for the majority of the Indian population.

The above facts, startling as they are in their own right hide severe disparities between the well off and the poor, the urban residents and rural people, the adivasis and dalits and others, and between men and women. They include:

- The *Infant Mortality Rate in the poorest 20% of the population is **2.5 times higher** than that in the richest 20% of the population.*
- A child in the 'Low standard of living' economic group *is **almost four times** more likely to die in childhood* than a child in the better off 'High standard of living'

group. An Adivasi child is one and half times more likely to die before the fifth birthday than children of other groups[3].

- A girl is 1.5 times more likely to die before reaching her fifth birthday, compared to a boy! The ***female to male ratios*** for children are rapidly declining, from 945 girls per 1000 boys in 1991, to just 927 girls per 1000 boys in 2001. This decline highlights an alarming trend of discrimination against girl children, which starts well before birth (in the form of sex selective abortions), and continues into childhood and adolescence (in the form of worse treatment to girls).
- A person from the poorest quintile of the population, despite more health problems, is ***six times less*** *likely to access hospitalization* than a person from the richest quintile. This means that the poor are unable to afford and access hospitalization in a very large proportion of illness episodes, even when it is required.
- The delivery of a mother, from the poorest quintile of the population is ***over six times*** *less likely to be attended by a medically trained person* than the delivery of a well off mother, from the richest quintile of the population. An adivasi mother is half as likely to be delivered by a medically trained person.
- The ratio of *hospital beds to population in rural areas is* ***fifteen times*** *lower* than that for urban areas.
- The ratio of *doctors to population in rural areas is* ***almost six times lower*** than the availability of doctors for the urban population.
- Per person, *Government spending on public health is* ***seven times lower in rural areas***, compared to Government health spending for urban areas.

The above are a direct consequence of the virtual dismantling of the public health infrastructure, as shown by the following state of Primary Health Centres:

- Only 38% of all PHCs have all the critical staff.
- Only 31% have all the critical supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs.
- In spite of the high maternal mortality ratio, 8 out of every 10 PHCs have no Essential Obstetric Care drug kit!
- Only 34% PHCs offer delivery services, while only 3% offer Medical Termination of Pregnancy.
- A person accessing a community health centre would find no obstetrician in 7 out of 10 centres, and no paediatrician in 8 out of 10.

Section IV: Initiatives to Remedy the Situation

It is but obvious that a large number of initiatives are required to remedy the present situation. Some immediate steps related to the *health care system* that need to be taken include:

- ***National Public Health Act*** mandating assured provision of basic health services: The Union health ministry may initiate the process by having a discussion in the Central Council on Health (including all state health ministers) and developing a consensus on the issue. Passing a 'National Public Health Act' (stipulated long

back by Bhore committee-1946 and Mudaliar Committee-1961), which would specify a set of basic health services to be available to all as a right, including legal obligations of public and private health care providers, health rights of citizens, standards of care and certain proportion of public funds to be earmarked for public health. State governments to pass corresponding 'State public health services rules' within specified time.

- ***Making health care a fundamental right by suitable constitutional amendment***: The formulation of a National legislation mandating the Right to Health care, with a clearly defined ***comprehensive*** package of health care, along with authorization of the requisite budget, being made available universally within one year.
- The Government should undertake a ***review of the National Health Policy (2002)*** to foreground the Primary Health Care approach and the goal of Universal access to comprehensive health care; along with elimination of measures to promote the private medical sector and 'medical tourism'.
- Significant ***strengthening of the existing public health system with commitment to quality coverage and equity***, especially in rural areas, by assuring that all the required infrastructure, staff, equipment, medicines and other critical inputs are available, and result in delivery of all required services at the primary secondary and tertiary levels. These would be ensured based on clearly defined, publicly displayed and monitored norms. Health services need to be integrated and vertical programs must be phased out
- The ***declining trend of budgetary allocations for public health needs to be reversed***, and budgets appropriately upscaled to make optimal provision of health care in the public domain possible. At one level adopting a fiscal policy of block funding or a system of per capita allocation of resources to different levels of health care, with an emphasis on Primary Health Care will have an immediate impact in reducing rural-urban inequities by making larger resources available to rural health facilities like Primary health centres and Rural hospitals. Simultaneously, the budgetary allocation to the health sector must be increased substantially, targeting the 5% of GDP as public expenditure on health care as recommended by the WHO.
- If the public health system fails to deliver it should be treated as a legal offence, remedy for which can be sought in the courts of law. The public system must ensure all elements of care like drug prescriptions, diagnostic tests, child birth services, hospitalization care etc.
- ***Universalisation of the ICDS scheme*** should be undertaken in a time bound framework, along with the convergence of the scheme with state health services.
- There is a need for a range of policy measures to eliminate discrimination, and to provide special quality and sensitive services for women, children, elderly persons, unorganised sector workers, HIV-AIDS affected persons, disabled persons, persons with mental health problems and other vulnerable groups. Similarly, situations of conflict, displacement and migration need to be addressed with a comprehensive approach to ensure that the health rights of affected people are protected.
- Putting in place a ***National legislation to regulate the private health sector***, to adopt minimum standards, accreditation, standard treatment protocols,

standardised pricing of services etc. Also a mechanism to be put in place to regulate private medical colleges.

- The government operationalise a system and set up a ***central fund for procurement of essential drugs***. Such a central fund could be utilised for procurement of a set of essential drugs in all states, to be made available through Sub-centres, PHCs and CHCs. This fund could be matched by a state essential drugs fund and transparent, rationalised procurement and distribution system at state level. The model being pursued in Tamil Nadu could possibly be examined for this purpose.
- ***Effective drug price control and promotion of rational drugs***: Steps be taken to impose price control on all drugs of the National Essential Drug List in a phased manner. This would require amendment of the DPCO (2002) and a thorough review of the 2002 Drug Policy.
- The state should introduce a new ***community-anchored health worker scheme***, and implement it in a phased manner with involvement of people's organizations and panchayati raj institutions, in both rural and urban areas, through which first contact primary care and health education can be ensured.
- All state level coercive population control policies, disincentives and orders should be removed and disproportionate financial allocation for population control activity should not be allowed to skew funding from other important public health priorities.
- Streamlining of ***medical education to create a basic doctor*** ensuring a wider outreach and improvement of access to health care services in all areas. Regulation of the growth of capitation based medical colleges