Politics of Primary Health Care

SINCE the seventies, in many national and international circuits of health bureaucracies, Primary Health Care (PHC) has become a panacea for all the evils of the poorer nations. The WHO has projected it with all its convictions and the member nations have accepted it with equal vigour. According to the Alma Ata declaration:

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

Today when this strategy has been accepted by such a large number of countries, there is a need to examine its potential strengths and weaknesses.

The idea that health is closely related to people's living and working conditions and that it is an outcome of their socio-economic environment was vocalised by men in different fields like John Snow, Engels and later Virchow in the West. It manifested itself in the sanitary movement of the 19th century. In India and other parts of the East it had much deeper roots, visible in the method of ancient medical science itself and in the cultures of Harappa and Mohenjodaro. In India during the struggle for Independence, a demand for comprehensive health care was a part of the national movement. Why then this sudden fervour now for projecting PHC as a new concept by international and national official circles?

To understand the politics of PHC one has to understand the role that UN and WHO have played in the overall politics of the world. Always supporting the interests of the imperialist nations, these organisations have used the liberal tools of aid, support and providing consultancy to diffuse, control and direct crisis situations. The effort to develop an alternative World Economic Order in the 70s was one such spurious exercise and as a part of it, was proposed the notion of alternative health care for the third world.

The motives behind it were to check impending destructive and costly reactions from and within third world nations whose poverty, disease and squalor were becoming threats to stability. PHC was the baby of the liberals in the imperialist camp and WHO projected it as the solution to poor nations' health problems—with full promise of help and support, but a clear understanding that the local political structures alone will give shape to the implementation of Primary Health Care! Such an international strategy which offers free help without any political price is obviously seeking change in health situation with or without the political will of the local government. It is interesting that the international terms of trade are in total contradiction to this attitude. Even though one knows that some liberals have their hearts in the right places, this conflict in international strategy needs serious analysis to understand the reasons for this special concession to health.

At the national level the concept of PHC acquires multiple dimensions. Given the particular hue of the government, the implications have varied from Africa to south east Asia and Eastern Mediterranean regions. The issue is what use does a national government make of the concept? Does it use it as the concept is presented by the Alma Ata declaration and make it a part of its effort to develop an integrated strategy for the betterment of its people, as in Angola, Tanzania and Mozambique or does it allow the concept to degenerate into a slogan behind which the same old strategies with some new features continue to be implemented—at a faster rate perhaps with the additional inputs from the international fund givers—as in India and Pakistan?

A grasp on the national politics of PHC requires an understanding of the country's socio-economic and political structure and the nature of its government and health service structures. Only such an understanding allows one to assess the potentialities or limitations of the system to achieve PHC. An example of the interplay between PHC and politics is the level at which it is integrated into the planning process of a country. Thus, the Chinese and Vietnamese incorporated PHC in the very process of national planning right from the period of their independence without giving it a name. In contrast, India made so much fuss and then relegated PHC to the care of the health ministry while the overall planning processes took its own directions. Yet another example is the implementation and outcome of programmes introduced under the banner of PHC. These programmes which may have a potential of providing much needed services are overtaken by the local power elite through their links with the health and administrative bureaucracies. The nature of the latter thus becomes the primary determinant of the outcome. The Community Health Guides scheme and the drinking water supply through borehole hand pumps in India are two such examples.

Another dimension of the PHC efforts at the national level is the setting of priorities and the selection of technology. In India despite the official acceptance of implementing PHC by 2000 AD, the heavy emphasis on urban-based services and curative approach in rural areas continues with heavy dependence on expensive equipment and drugs. The drug policy needed to provide PHC is yet to be formulated. Can issues of priorities and technology be then isolated from politics? A simple but revealing example is the supply of "electrolyte" packets in the Community Health Guides' kits! Does it not show links between the health administrators and the drug industry who know that addition of so many salts to the basic mixture only increases cost and not effectivity?

If the concept of PHC is getting distorted in the hands of the not-so-democratic government and is becoming a tool for creating two types of services, one for the rich and the other for the poor, should it be criticised, rejected, accepted as an unavoidable distortion or used to broaden the base of democratic movements? These are some of the questions which need to be answered by those who are working in the

interest of people's health. Can PHC as a concept become an inspiration for those involved in people's struggle for their rights? If PHC is an outcome of total development then it should be. And what have people's democratic and left movements done about it?

There are many small or regional projects experimenting with implementation of primary health care. What is the role of such projects in focussing upon the issue of PHC or in diluting it?

In academic circles, in the name of professionalism and the need to achieve results, a concept of "selective PHC" has been circulated which means let us not talk of comprehensive development but do what we can without disturbing the existing balances. This is attractive to those who would like to go back to singing praises to powers of technology and managerial competence. There is need to examine such concepts threadbare to show their reactionary ideology as well as non-feasibility.

Are there any lessons that we can draw from the experiences of the socialist countries which have tried to provide health care not in isolation, but as a part of their total developmental processes? These are the major questions which need to be addressed when one is dealing with the bipronged weapon of Primary Health Care.

This issue examines some of the problems raised in the editorial. Guy Poitevin describes his experiences in taking up health issues as a part of larger movement for socio-economic change. Manisha Gupte comments on the ideology and perspective of the maternal and child health programme and points out that without a questioning of the role of the women in society, any such programme would be ineffective. Asha Vohuman reports on the mass immunisation programme which was launched with such fanfare in Bombay in 1983, not so much because of its potential impact on the health of the children but because the minister in charge needed a visibly successful campaign to consolidate her political gains. The reprinted article from *International Journal of Health Services* provides a historical background of the concept of public health and raises some questions about holistic health alternatives emerging in the US. And in the non-theme section we have Jytte Willadsen discussing the question of the sexist bias in medicine. As a doctor herself she also touches upon the problems encountered in bringing about any changes in the very male oriented medical establishment in Denmark.

We have as usual the Update and Dialogue sections. Sujit Das continues the discussion on the role of doctors; Ulhas Jajoo responds to Anant Phadke's review of his book *When the Search Began (RJH, I: 1)* and *AS* questions if drug therapy in psychiatric problems does not have a place in the present socio-political context.

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XIII Annual Meet of MFC

Medico Friend Circle will hold its XIII Annual Meet at Seva Mandir Training Centre, Kaya (near Udaipur), Rajasthan, on 26th and 27th of January 1987.

The theme chosen for discussion this time is *"Family Planning in India: Theoretical Assumptions, Implementation and Alternatives".* Family Planning has generally been considered an important part of Primary Health Care, but over the past two decades, it has come to occupy a key place amongst the country's development strategies. Is its elevation to the level of a panacea, for the problems facing the people, based on well examined theoretical assumptions? What effects has the policy of incentives and coercion had on the performance of other health programmes? Out of the existing contraceptive methods which is the least harmful? Do some of these methods need to be rejected outright? Are there safer alternatives? These are some of the issues to be discussed at the Meet.

As usual there will be no reading of papers. Background papers on related topics will be circulated beforehand to facilitate discussions. They include: (a) Problem of population versus resources (b) Theoretical assumption of FP policy in China (c) Critical examination of the FP policy in the context of the child survival hypothesis (d) Comparative analysis of the dangers of pregnancy and contraception (e) Women as the main targets of FP policy (f) The paradox of higher FP performance in tribal areas (g) Incentives and coercions—effects on Primary Health Care (h) Pattern of resource-allocation in our Five Year Plans (i) Evaluation of the existing FP methods (j) Natural Family Planning methods as safer alternatives.

We invite you to attend the Meet and share your views and experiences. We also invite you to write background papers on any other topic to the theme. Your note/paper should reach the Convenor's office by the **31st November.**

Participants are as usual expected to pay for their own travel. Simple boarding and lodging facilities will be available at the venue, on a payment of Rs. 20/- per day per person. We charge a small registration fee to cover the cost of the cyclostyled background papers. Return reservation facilities are also available. If you wish to attend, please write to: **Dhruv Mankad, Convenor, Medico Friend Circle, 1877, Joshi Galli, Nipani-591 237.** We will then send you the venue details and background papers.