UPDATE

news and notes

Health in Seventh Plan: Boost to Private Sector

IF recommendations of the Bhore Committee (1946) are to be considered as some kind of a bench mark for health planning, then one has to admit that all the plans for the health sector, including the latest one, have failed to live upto it. For instance, the Bhore Committee has suggested that for a population between 10,000 and 20,000 there should be a 75 bedded Primary Health Centre (PHC) which would provide coordinated preventive and curative services through doctors, public health nurses and health assistants. However, 40 years later even the 6th Five Year Plan (1980-85) target of one PHC with only seven or eight beds for a 30,000 population is far from realisation.

Implementation of health sector plans have never been taken seriously because:

a. The health sector is not considered a priority area of development by the government. Since the power base resides with the kulaks upon whom the vast rural landless and marginal and small farmers are dependent for their livelihood state resources are mainly used to strengthen the surplus appropriation capabilities of the kulaks and the bourgeosie.

b. The private health sector and the system of private practice of medicine has prevented the government from appropriating the medical and health functions by providing sops such as 'charitable hospitals' and 'voluntary hospitals' that provide 'concessional' care.

c. Government planning and programming has never taken into account what the actual requirements of the people are—people have always been 'given' what the government thinks the people want, and even that does not reach the people; and

d. The Government's obsession, under the influence of imperialist agencies, in planning and implementing health programmes, has always been with family planning.

The Seventh Five Year Plan (1985-90) in the above sense is no different from the earlier plans. It provides an even more vigorous support to the private and 'voluntary' sectors and the entire focus is on improving the management of the various programmes under the health sector. And the historical trend of a reduced proportional allocation to the health sector is continued.

In the first five year plan the health sector constituted 3.82 per cent of the total plan outlay but began to decline in each subsequent plans—3.01 per cent, 2.63 per cent, 2.12 per cent, 1.92 per cent, 1.86 per cent and 1.88 per cent. That this decline in health sector allocation is due to greater investment in population control activities is obvious from the fact that allocations to the family planning (FP) sector have increased from 0.005 per cent of total plan outlay in the first plan to 1.80 per cent in the Seventh Five Year Plan. Even the ratio proportion of allocation between FP and Health Sector has increased from 0.002 to an astounding 0.96 per cent between the First and Seventh Plans. A correlation between the percentage allocations to health and FP over the Seventh Plan periods shows a high negative correlation (Pearson's r) of -0.88. Along with the narrowing ratio gap between health and FP, this r value is a clear indication that the growth of the public health sector has been sacrificed in favour of family planning activities.

Reviewing the performance of health programmes the Seventh Plan document states that, "Most of the concerned (disease) control programmes suffer from poor management and monitoring... Health management support and supervision is an area that needs considerable strengthening."

Further, the Seventh Plan emphasises the need to provide greater support to the voluntary sector in both health and family planning. This is in keeping with the promise given in the National Health Policy of 1982, 'The policy envisages a very constructive and supportive relationship between the public and the private sectors in the area of health by providing a corrective to re-establish the position of the private sector' (India, 1985).

That the focus of the health sector will continue to be family planning activities is made clear by the following statement in the Seventh Plan document *intersectoral co-ordination and co-operation and the involvement of voluntary agencies in the programme (of the government) will be necessary in this (FP) programme to an even greater extent than in health.* Add to this the large allocation to the family planning sector of Rs 3,256.26 crore which as a proportion to the health sector allocation of Rs 3392.89 crore is the highest ever (proportion = 0.96).

Another important feature of the health sector in the Seventh Plan is its recognition of non-communicable diseases as an important area for development; "Development of specialities and superspecialities will need to be pursued, with proper attention to regional distribution.". Whereas with regard to the highly prevalent communicable diseases, they mainly affect the deprived masses, the Seventh Plan document stops at saying that the programmes have failed in achieving their targets and therefore only better management is the answer.

Related to the focus of diseases of the priviledged few the plan recommends a special priority to new medical technology, especially biotechnology and electronics. The special attention that AIDS, cancer and coronary heart diseases are receiving and the current boom of the diagnostic industry is a clear indication

where the health sector priorities lie.

Finally, it is interesting to note that the health sector plan does not comment on the drug industry on which the national disease control programmes are greately dependent. Drugs and pharmaceuticals are left to the Industries sector where no mention of essential drugs is made. Even with the major communicable diseases being national programmes, (leprosy, tuberculosis, malaria, blindness, filariasis, goitre and guinea worm infestation) there is no concern in the plan document about shortages of these essential drugs which are imported in bulk inspite of a sophisticated pharmaceutical industry in India.

Ravi Duggal

Local Health Traditions and Primary Health Care

LOCAL health traditions are primarily based in the use of local flora, fauna and minerals. A very significant aspect of the local health traditions and its practitioners is their self-reliant nature. These traditions are of an entirely autonomous character rooted in a community's social traditions of knowledge and supported from within the community. No government or any other agency has ever been required to offer any direct support to these traditions of health-care. A seven-day meeting was held in November 1985 at Karjat, Maharashtra, to discuss ways for strengthening local health traditions related to primary health care. People from 30 rural organisations interested and active in the community health field from Kerala, Tamilnadu, Andhra, Karnataka, UP, Bihar, MP and Maharashtra attended the meeting.

Most of the groups previously carried the prejudiced impression that local health cultures were based on blind belief or purely an empirical experience because this is the false propaganda that western science had spread about indigenous knowledge. In fact, to date not a single serious evaluation exists of the strengths and weaknesses of any local health culture in any part of India, despite the fact that millions of Indians still subscribe to traditional health practices. There is evidence to establish that Ayurveda is the scientific mainstream behind all the local folk and tribal health traditions in India. There appears to be a symbiotic relationship between the two. The mainstream drawing strength from the particular experiences of numerous local streams and the local streams in turn being enriched through interaction with the mainstream.

The meeting observed that a sort of cultural genocide (which began about 200 years ago) on the local health culture of thousands of village communities is yet taking place in independent India. This is inspired by the Western ethno-centric outlook of the Indian scientific establishment. Ironically although local health traditions are in fact more comprehensive in scope and cover all and more than the usual elements that are expected from the 'primary health care' programmes of the government, these local traditions are being totally ignored and suppressed.

When one talks about the scientific temper in India, we usually impose an essentially European 'mainstream' cultural tradition (Europe also had non-mainstream scientific traditions, e.g., based on writings of Goethe) on the Indian people. There is in fact also an indigenous scientific temper that still persists amongst millions of our rural folks and amongst the tribals. This indigenous scientific temper is indeed very different in content and form from the European one and it is only cultural arrogance and intolerance that may make us blind to its value.

Strengths and Weakness of Local Health Traditions

In the Karjat tribal block over the last 5 years a detailed documentation of the local health tradition is being undertaken. Similar work is being conducted in other parts of Maharashtra (Nanded district, Gadchiroli and Poona district), as also in Warangal in AP, Ranchi in Bihar and Coimbatore district in Tamil Nadu.

Although the local traditions are comprehensive in their 'scope' they undoubtedly reveal several weaknesses in treatment procedures and diagnosis when subjected to critical evaluation by the science of Ayurveda. Although with regard to the use of local herbs the local tradition has an amazing knowledge of local flora its ecology, identification, types, etc, knowledge about properties of plants is incomplete. There are perhaps several reasons which may explain how and why these weaknesses have set in—in the first place the local traditions are 'oral' traditions of knowledge and in the natural course of things oral traditions the world over have been found to decay over 'time'. They need to be revitalised from time to time in order to regain 'vigour'. An external reason for the current decay of local traditions is the derision, neglect and oppression they have suffered due to the intolerant attitude of the western scientific tradition towards these practices. A third reason is the break of active links during the last few centuries with mainstream science of ayurveda. This has resulted in mutual losses. These weaknesses however do not detract from the comprehensiveness of the local traditions, nor reduce their potential for making the community self-reliant in its primary health care needs.

Workshop Report

Documentation of Local Flora: On the first day participants accompanied by the botanists from 'Maharashtra Association for Cultivation of Science' and AVR Educational Trust, Coimbatore, visited the local forest and collected 25 illustrative specimens of locally used medicinal plants. There were detailed discussions on the basic botanical notes that should be taken about each plant and what parts of a plant are essential to collect for purposes of identification and how plants can be pressed and dried and put into herbarium sheets.

On the same day, in the evening there was an introductory talk on Dravya-Guna Shastra which is

about the theory and methods by which Ayurveda establishes the properties of plants and predicts their effects on the human body.

The next two days of the workshop were spent in observing and participating in the preparation of medicines by processing plants in various ways. Nine different basic techniques of processing of plants were demonstrated *viz*, kadha, swaras, tel, ark, ghanwati, shar, satv, malam and choorna.

Documenting Local Health Care Practices: Two days were spent on understanding some of the strengths and weaknesses of the local traditions regarding (1) mother and child care (2) home remedies and (3) the treatment of common ailments and first aid. The ADS presented participants with a copy of the type of questionnaire they had used to study the local traditions which could be used as general model for similar studies elsewhere—but the detailed format may vary from region to region.

Food and Nutrition: The sixth day was spent in discussion on two subjects, *viz*. the basic natural principles of ayurveda and the ayurvedic theory of nutrition. As a result of this western ethnocentric view, today under the banner of spreading science to villages, very many sound nutritional practices of villagers are being destroyed and undermined because of lack of understanding of the Indian nutritional science.

On the seventh day there was dispussion around the historical analysis of the colonisation of the Indian mind by the mainstream west—a process which began 200 years ago and continues even today under a political leadership which wants India to 'catch up with the west' in the 21st century. A view was put forward that perhaps it was at a historical moment of weakness that the Indian civilisation accepted the cultural and inellectual traditions of their colonisers and that this acceptance was not based on any critical process of evaluation of the western traditions.

It was unanimously resolved to form an informal national committee, the Lok Swasthya Parampara Samvardhan Samiti for strengthening local health cultures. The AVR ayurvedic trust, Coimbatore, agreed to act as the secretary of the committee.

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Drug Multinationals and WHO

THE unofficial, information links between multinational corporations and some UN agencies have long been debated. The ICP (Industry Co-operative Programme) within the FAO was a prime example, and had to be dismantled once the links were discovered by action groups. On the other hand, the WHO prescription for a rational drug policy is well known, has been recommended for *all* countries, developed and underdeveloped and is often adduced as proof of the WHO's neutrality. Its prime principal contribution has been the selection of a list of essential drugs numbering 250, and which the WHO has suggested is more than adequate for a population's basic health programmes, a list, of course, that has not enamoured the WHO to the drug multinationals.

The new drug policy has reversed many of the offensive features of the drug scene available in most third world countries including India, where the production of a large number of inessential and harmful drugs has led to a decline in the production of basic and essential drugs. Despite what critics of the Bangladesh drug policy, instigated by drug MNCs have claimed, the new policy has led to an increase in the production of essential drugs, has reduced prices and improved drug investment by the very same companies who have tried to criticise the policy in the past.

Concerned about these positive developments and their possible impact on other third world countries, the drug MNC have now recruited a Sri Lankan lawyer to write a book attacking the policy. The book is entitled, *The Public Health and Economic Dimensions of the New Drug Policy of Bangladesh,* is written by D C Jayasuriya, and sponsored by the apex organisation of drug multinationals worldwide: The International Federation of Pharmaceutical Manufacturer's Association.

Jayasuriya uses his former WHO consultancy status to give his 'evaluation' of the Bangladesh drug policy some measure of legitimacy, which it, being a sponsored study, readily lacks. The document is being passed about as a 'WHO document on the Bangladesh Drug Policy'.

More interesting is the fact that the document has been sent to the personal addresses of Drug Controllers, Health Ministers and other influential administrators in all Third World countries. This has not however been done in Bangladesh, where a whisper campaign instead has been let loose to say that the "WHO has published a document against the drug policy." The WHO is obviously aware of these developments and has yet not distanced itself officially from the Jayasuriya 'evaluation'.

The requisition of a Third World individual to attack a socially useful policy from another Third World country, at the obvious behest of drug MNCs is deeply disturbing. No action has been taken against Jayasuriya despite the fact that these developments have been brought to the attention of the Director General of the WHO, Dr Halfdan Mahler himself.

We believe that part of the reasons for the incapacity or unwillingness of the WHO to act firmly is rooted in the financial indebtedness of the WHO to countries like the USA. For example, it took a full two years before Dr Halfdan Mahler himself publicly approved the Bangladesh drug policy. There is need for more unambiguous approach. If necessary, the WHO should seriously consider alternative sources of funds to act more forcefully in the interests of all drug consumers.

Even now it is ironic that the WHO is unwilling to act when it sees an attack on a drug policy that is based on the recommendations of the organisation itself.

Third World Network

Why don't you write for us ?

This periodical is a collective effort of many individuals active or interested in the field of health or interested in health issues. The chief aim of the journal is to provide a forum for exchange of ideas and for generating a debate on practical and theoretical issues in health from a **radical or Marxist** perspective. We believe that only through such interaction can a coherent radical and marxist critique of health and health care be evolved.

Each issue of the journal highlights one theme, but it also publishes (i) Discussions on articles published in earlier issues (ii) Commentaries, reports, shorter contributions outside the main theme.

Our forthcoming issues will focus on : Primary Health Care, Medical Technology, Agricultural Development and Health, Health in People's Movements.

If you wish to write on any of these issues do let us know immediately. We have to work three months ahead of the date of publication which means that the issue on Primary Health Care is already being worked on. A full length article should not exceed 6,000 words and the number of references in the article should not exceed 50. Unless otherwise stated author's names in the case of joint authorship will be printed in alphabetical order. You will appreciate that we have a broad editorial policy on the basis of which articles will be accepted.

We have an author's style-sheet and will send it to you on request. Please note that the spellings and referencing of reprint articles are as in the original and are NOT as per our style.

We would also like to receive shorter articles, commentaries, views or reports. This need not be on the themes we have mentioned. These articles should not exceed 2,000 words. Please do write and tell us what you think of this issue.

All articles should be sent in duplicate. They should be neatly typed in double spacing, on one side of the sheet. This is necessary because we do not have office facilities here and the press requires all material to be typed. But if it is impossible for you to get the material typed, do not let it stop you from sending us your contributions **in a neat handwriting** on one side of the paper. Send us two copies of the article written in a legible handwriting with words and sentences liberally spaced.

The best way to crystallise and clarify ideas is to put them down in writing. Here's your opportunity to interact through your writing and forge links with others who are, working on issues of interest to you.

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THE EARTH IS A SATELLITE OF THE MOON

The apollo 2 cost more than the apollo 1
the apollo 1 cost enough.

The apollo 3 cost more than the apollo 2
the apollo 2 cost more than the apollo 1
the apollo 1 cost enough.

The apollo 4 cost more than the apollo 3
the apollo 3 cost more than the apollo 2
the apollo 2 cost more than the apollo 1
the apollo 1 cost enough.

The apollo 8 cost a whole lot but you didn't feel it
because the astronauts were protestants
they read the bible from the moon,
bringing glad tidings to all christians
and Pope Paul VI blessed them when they returned.

The apollo 9 cost more than all the rest together
including the apollo 1 which cost enough.

The great-grandparents of the people of Acahualinca
were less hungry than the grandparents.
The great-grandparents died of hunger.

The grandparents of the people of Acahualinca were
less hungry than the parents.
The grandparents died of hunger.

The parents of the people of Acahualinca were less
hungry than the people who live there now.
The parents died of hunger.

The people of Acahualinca are less hungry than
their children.
The children of the people of Acahualinca are
born dead from hunger,
and they're hungry at birth, to die of hunger.

The people of Acahualinca die of hunger.
Blessed be the poor, for they shall inherit the moon.

LEONEL RUGAMA
(NICARAGUA)

Leonel Rugama was a member of the Sandino National Liberation Front. He and another comrade were trapped in a house in the city of Managua in January, 1970. The house was surrounded by troops and war materiel. The two men put up a courageous fight which lasted several hours. When their ammunition ran out, the army finished them off. Rugama was 20 years old.