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STATE SECTOR IN HEALTH CARE

State in Health Care

THE Indian tradition of state intervention in health care is quite old. During the reign of Asoka in 3rd century BC, besides other social welfare measures, the state established medical centres for man and animals, undertook planting of medicinal herbs and trees, and supply of potable water through wells along the highways. Similar medical centres were claimed to have been established in the neighbouring countries at Asoka's instance (Thapar, 1973). In modern times, a major role of the state in health care service has universally been recognised and accepted. Politics of each country determines the nature of intervention and quantum of contribution by the state. For instance, in the socialist countries the state has assumed the entire responsibility; UK operates the unique National Health Service; in Canada and New Zealand, the state bears almost the entire expenditure; in many European countries the allocation by the state is ever increasing; and in the third world a similar feature is discernible. In India pressure on the government to spend more on health care is quite strong. The state's role varies ranging from the direct and absolute state administration to indirect and partial intervention.

In India, the situation is somewhat peculiar. The state has undertaken the entire responsibility of health care of the personnel of the army, parliament and the railways; partial responsibility of the other employees of the government and public undertakings. and a dubious responsibility of the mass of people. Historically, modern health service owes its beginning to the British presence. Although the first legislation in this respect, the Quarantine Act, had been introduced in 1825, real concern for a state operated health service appeared after the 'Indian Mutiny' or 1857 in the context of the over-riding political necessity to safeguard the health of the troops and the European civilians. All health intervention were geared to achieve this objective. However, endemic and often epidemic prevalence of communicable diseases as well as political compulsions put sustained pressure upon and eventually forced the government to do something for the native civil population which relied largely on traditional indigenous system (see SHR, Vol II, No 3). Montague-Chelmsford Constitutional Reforms of 1919 and later the Government of India Act, 1935 decentralised the responsibilities which devolved almost entirely on the provincial and local authorities. This constitutional framework and the policy outlined in the report of the Health Survey and Development Committee (1946) had been the basis of policy guidelines for the national governments.

Article 47 of the Indian Constitution clearly avows, under the Directive Principles of state Policy, the state's responsibility to raise, "the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". Here, the 'state' actually means the seat of the Union Government. But the VII Schedule allocates almost all responsibilities to the provincial governments, e g, public health, sanitation, hospitals and dispensaries, drugs, family planning and population control, medical education, medical profession, prevention of the extension of communicable diseases from one state to another and vital statistics have been placed under the Concurrent list, while the Union list mentions only Port Quarantine, and determination of standard in 'scientific and technical institutions' meaning perhaps also medical institutions. In actual practice, however, the Union Government deals with international health relations, promotion and conduction of medical research, regulation of production, quality control and trade of drugs, regulation of standard of medical education, vital statistics, and medical care of employees. National disease control/eradication programmes, family planning, MCH, drinking water supply, etc, are financed by the Union Government and operated through provincial health organisations. Moreover, there are several other spheres where the Union Government makes some contributions, e g, medical education, health education, health information, dissemination, drug production, development and promotion of other systems of medicine, rehabilitative medicine, paramedical training, etc. Provincial Governments, on the other hand, not only enjoy almost absolute autonomy in health care operations both at the policy and implementation levels, but are supposed to exclusively provide for medical care and public health services. Juridically therefore, it may be argued that the Union Government contirbutes more than its share in health care services.

But then one fundamental aspect is missing in such analysis. Health care includes, as is now widely known, adequate nutrition, safe water and sanitation, healthy environment, education, employment, etc. Solution of these problems is necessarily dependant on the economic system and political programme, i e, the conduct of the Union Government. It may therefore be held that the basic determinants of health necessary for the protection, maintenance and improvement of health of the people are to be provided by the Union Government and the Provincial Governments are responsible for the provision of universal medical care which is no less an important determinant, if not the most.

Till now the health of a community of people or that of country is measured and appraised by certain parameters, e g, infant mortality rate, death rate, expectation of life at birth, sanitation, per capita consumption of food and safe water, etc. In the context of such parameters, India has made steady progress in the post-independence period. But in the context of desirable goals and international standards the Union Government admitted that such progress brought little benefit to the Indian masses and the health situation of the country was still precarious and alarming (GOI 1982).

In the background of this reality the Government of India endorsed the WHO target of "Health For All By The Year 2000 AD" which called for the following intermediate goals:

1985—Providing right king of food for all;

1986—Providing essential drugs for all;

1990—(a) providing adequate basic sanitation for all;

(b) providing adequate supply of drinking water for all;

(c) immunisation of children against six common

diseases, *viz*, measles, whooping cough, tetanus, diphtheria, polio and TB.

Needless to say, the targets for 1985 and 1986 remain unrealised. But the point is—'food for all' has already been a declared goal of the Indian State since the adoption of the constitution. A period of three and half decades has made it obvious that the Indian State has neither the means nor the political will to achieve that goal. Hence, the endorsement of the targets set up by the WHO appears to be either a mere formality or an exercise in duplicity.

Turning to the matter of medical intervention which is dominated almost exclusively by the provincial government, we need to face certain facts:

(1) State medicare is practically free to all without discrimination from millionaire to pauper; though in respect of finance and administration there are provincial boundaries services are available to all transcending such boundaries; those who enjoy guaranteed medicare through certain agencies are also welcome to the state's free medicare; and even foreigners are not put to any restraint in obtaining free medicare from the state institutions.

(2) There exists a strong and evergrowing private sector of medicare consisting of hospitals, nursing homes, clinics, diagnostic set-ups and dispensaries, which constitute ¾th of the medicare field.

(3) Overall superiority in specialisation, sophistication, modernisation and excellence is still attributed to the state sector for various reasons.

(4) State medicare institutions are disproportionately concentrated in the urban areas, and the rural institutions, meant ostensibly for comprehensive health care, have mostly turned into curative agencies.

Conceptually therefore, state medicare is delivered more on the principle of charity and not obligation or welfare. It is not then surprising that the resulting situation is disorganisation, deterioration in quality, unscientific practice, corruption, chaos and frequent break-down of law and order. In the ensuing 'free for all' for the cost-free medicare, the weaker sections are deprived of health care.

Medicare is provided to the industrial workers through the unique Employees State Insurance (Medical Benefit) Scheme, financed jointly by the workers and the employers, regulated by the joint body of employees, employers, Union and Provincial Governments and medical profession, and operated by the provincial governments. Services are rendered for sickness, maternity and employment injury. This scheme could be viewed as a forerunner of national health service but there is a big difference in the matter of financing compared to the similar schemes in other countries.

Financing of health services in India presents an interesting story. While the share of the allocation on health care has steadily been reduced in the Union budget in the successive 5-Year Plans, that on family planning increased with a sharp upward jump in the 4th Plan. In terms of GNP it has not exceeded 0.5 per cent compared to 5-10 per cent in several developed countries—(GOI, 1975, 78, 79, 80-81). In terms of the state's share in the total health expenditure of the country, India (24 per cent) is way behind not only the developed countries but even Sri Lanka (50 per cent) (Roemer, 1984).

Steady increase of state intervention in health care is a distinct feature of capitalist society and it is explained in various ways. It is argued that state health care expenditure is a form of social wage to the labouring class and it serves the need of capital for the steady flow and reproduction of labour power and to maintain/increase productivity. This view is also discounted by the argument that historically the technological changes or a relative scarcity of labour have been found to be more effective than higher rates of medical expenditure in obtaining increased productivity (Doyal an Pennel, 1979). While there is positive evidence that public health legislation of the 1840s in UK resulted in improving the productivity of labour, in India, fluctuating state expenditure on health does not appear to bear any corresponding relationship with availability of labour in the market. There is broad agreement among the marxist commentators that the ruling class meets the social needs of capital through the state invervention in health care or for that matter through all social welfare measures. It provides a benevolent image for the state maintaining support for the existing system, and developing the dependency on the state. It legitimises bourgeois ideological underpinnings. On the other hand, it is asserted that increasing state intervention is the product of the social demands of labour, achieved through class struggle. Fluctuation of the magnitude of intervention generally corresponds with the differing intensity of class struggle. Then again it is argued that there is actually no contradiction between the two explanations and there is no single-factor explanation of social policy. Social demands of labour seek increase in social wages and public ownership of means of production. Social needs of capital are served by employment absorption of surplus population and provision of social services pre-empting conflict and unrest from unemployment, uncertainty and physical distress. The nature and number of the combination of factors depend on the historical situation, level of development of productive forces and relations of production and the level of class struggle. "There is no clear-cut dichotomy between the social needs of capital and social demands of labour. Any given policy can serve both. Indeed, social policies that serve the interests of the working class can be subsequently adapted to benefit the interests of the dominant class. . . Indeed history shows that concessions won by labour in the class struggle become, in the absence of further struggle, modified to serve the interests of the capitalist class" (Navarro, 1976).

What role of the state do we then envisage for an egalitarian health system? The distorted nature of medicine under capitalism and the discriminatory delivery of health care have produced diverse reactions. Total state control or nationalised health care, integrated health care meaning integration of other relevent state services with health service, decentralised health care calling for peoples participation and sharing of power in planning and administration, debureaucratisation, i e, replacement of generalists' control by professionals, people's health in people's hands signifying vague assertion of self care and self-contained community management—are some of the prescriptions. The reactions seem to ignore the determinist nature of state intervention. With the growing magnitude of socialisation of the production process, the state inevitably assumes more and more

(Continued on page 108)

whereas I have distinguished between doctors with hardly any administratively supervisory or executive function, e g, the junior doctors on the one hand, and the medical officers who have to perform these functions on the other. If one goes to any Primary Health Centre, one would immediately come across a series of executive, supervisory tasks over the work of the paramedics that the medical officer has to do. It is because of their status as 'officer' that the MOs at PHC get well-built quarters or bungalows (though no such accommodation has been built in many new PHCs;) whereas the junior doctors share one room amongst 2-4 doctors. The MOs get a salary which is higher compared to that of the junior doctors though junior doctors are many a times clinically more competent and are more overloaded with work. The MOs can be compared with the parademics also. The salary and the facilities that the medical officers have, are more than would be explained purely by their training if we compare them with the paramedics (like the ANMs). It is because of their dominant position as officers that many medical officers illegally earn money with impunity through private practice. Medical officers *as wage-earners* have many problems and that is why they have been unionising. But marxists, scientific socialists should not point out only to their problems but also must bear in mind their status as officers.

Contrary to Das's assertion, I have not 'discounted trade unionism as such', nor have I said that doctors should behave as if the world around is not commercial. I only wanted to point out the fact that Das has not given any class-characterisation of doctors though the title of his article raises this expectation and though he raised this question in the text also. Instead, the article gives an account of the problems faced by the doctors without looking at their contradictions and hence becomes a kind of a one-sided defence of the interests of doctors.

—ARS

(*Continued from page 77*)

responsibilities to serve the needs of the dominant class. Total state control is a hightened level in the process of socialisation. On the other hand, at the present moment it is obvious that total state control is not equivalent to people's control. Our conception of people's state or proletarian state has received a jolt from the experience of the socialist countries. People's participation also remain elusive without sharing in power. A rethinking is perhaps in order to conceptualise people's control in political and organisational terms.

But then it is also on observable fact that total state control or major state control, in whatever form, have brought about more equitable distribution of health care among the people. Its contribution in human values has proved to be immense.

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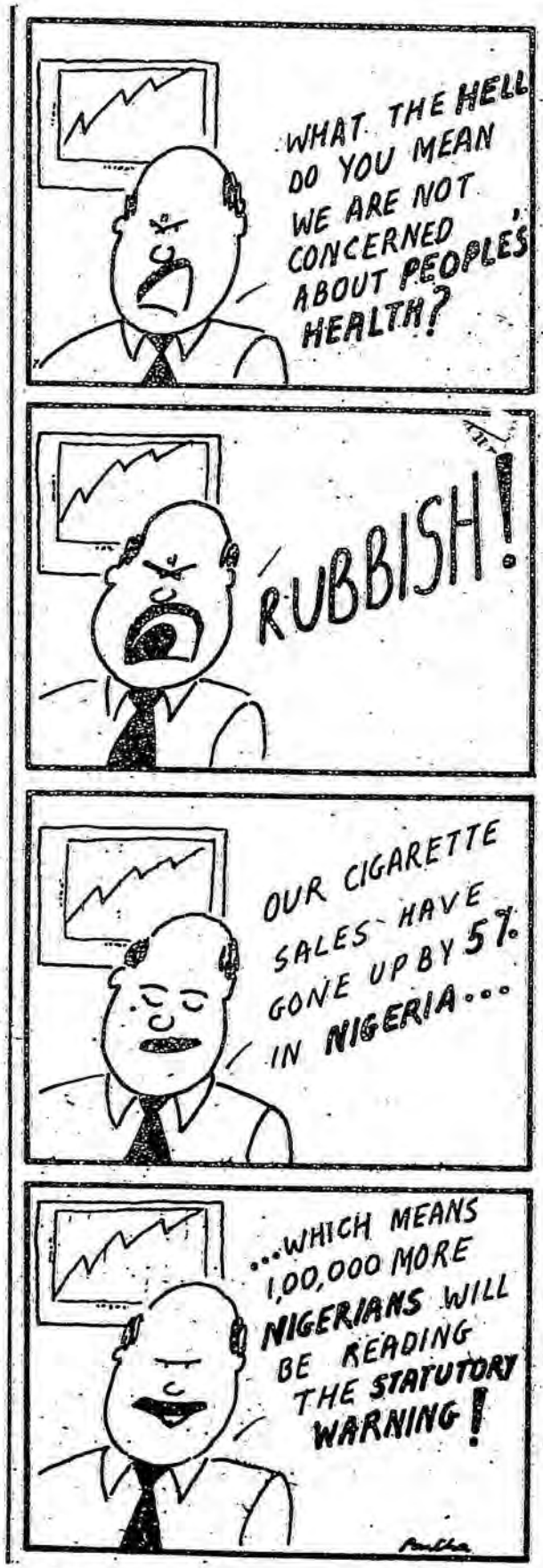
—Smarajit Jana



Political Economy of State Health Financing

ravi duggal

In a capitalist state the government is a functionary of capitalism—its role is to protect and strengthen it. Thus the state's behaviour even with regard to the health sector programmes, is a function of private capital.

The health sector started with a very low priority and has gradually gained an increased share of the state's expenditure, the growth rate of health and family planning expenditures has been much greater than both the growth of government expenditure and the gross domestic product. But this does not reflect an improvement in health-care services provided by the state. Why this is so and what role state financing of health care has played is examined in this article with specific reference to two states, Gujarat and Maharashtra.

THE health sector is popularly perceived as being part of the social services sector. The corollary to this being that it automatically becomes largely a responsibility of the state. This perception is common even among the most advanced capitalist states.

Health and education (besides unemployment insurance in a few countries) are the 'classical' sectors within the umbrella of state welfare. Over the years, all over the world, these two sectors have increasingly been supported through public finance for various reasons. The most important being the predominance of the view that they are a social service and therefore, not in the direct interest of private capital. Nevertheless, they being an important social need had to be met, and therefore public finance became the provider increasingly.

The historical consequence of this development has been a greater role for the state in meeting the needs of the people. Since state finances come largely from taxes the household and corporate sectors have gradually begun to feel the brunt of letting the state take care of the social sector. Given the nature of the capitalist state there comes a point beyond which taxing private capital becomes a threat to capitalism itself. Thus emerges a "fiscal crisis of the state" and there is talk of cuts in welfare and social expenditures. The pressures of capitalism in its pursuit of surplus appropriation is responsible for this.

Advanced capitalism, especially monopoly capital, and the state have a love-hate relationship. Love, because the survival of capitalism is dependent on state protection and support, and hate because increased state expenditures mean enhanced taxes and public debt that may terminate in a fiscal crisis, or worse a social one.

Of late this realisation has hit capitalism, which sees the dangers inherent in an increased burden of state welfarism. The result is increased "corporate welfare". This is happening in the USA in a large way and the health sector is the best illustration. Expansion of private health care (especially corporate) in the last three or four years in the USA has been phenomenal. What is more is that it has also been realised that the social sector, especially health, can be a highly profitable one. This is largely facilitated by modern technological advances in health care. For instance in the USA between 1980 and 1984 corporate revenues in health care grew from $ 25 billion to $ 118 billion, along with increased monopolisation through mergers and takeovers (in spite of anti-trust suits). And in the same period, of the 37 largest health and welfare corporations only two lost money, whereas 13 more than doubled their revenues and 11 more than quadrupled their revenues (Stoesz, 1986).

This trend is true for most advanced capitalist countries and is fast emerging in backward capitalist countries too. In the last two years in India over Rs 200 crore have been spent by the corporate sector in setting up 60 diagnostic centres (CT scan etc.) all over the country, of which 46 were set up by the United Group alone (Business India, Dec 29, 1986).

This, however, does not mean that the state health care sector is on the decline. Historically the state health sector as well as other state welfare and development programmes have served the needs of private capital (see Galper, 1975). We will return to this later.

The state financed health care sector in India is 'patronised' by only about one-third of the country's population, of this roughly 80 per cent being urban. That is two-thirds of India's population utilise private services for health care; and the state's health services are concentrated disproportionately in urban/industrial areas. It may also be noted that municipal health services, railway, defence and mining health services, as also those services provided by public sector undertakings are not accounted for under 'state health expenditure'.

Health is a state (provincial) subject and therefore the responsibility of providing health care vests with the concerned state. However, the union government does make a substantial contribution to the states through grants and centrally sponsored health programmes. Besides, policy making and planning for the health sector has largely been determined by the centre.

The state health sector in India incorporates three components (a) Medical Services including CGHS and ESIS, (b) Public health (including water supply and sanitation) and (c) Family Planning (including MCH). Family Planning is almost entirely a centrally funded programme (it falls under the concurrent list). In this paper we will look at the health sector as including only the first two components, treating family planning independently.

The major sources of data for state spending on health care are (a) The Combined Finance and Revenue Accounts (CFRA) of the Union and State governments compiled by the Comptroller and Auditor General of India, (b) Summarised Accounts in the Indian

Economic Statistics: Public Finance, compiled by the Department of Economic Affairs of the Ministry of Finance, and (c) The Performance Budgets of health ministries of the respective states.

In the CFRA data is available state-wise but the disaggregation is of little use because the categories used are administrative ones like 'establishment', 'direction', 'grants' etc. However, the state's Performance Budgets give programmewise expenditures but these documents are not easily available; and if available are too voluminous for a time-series analysis. Therefore, in this paper national aggregate figures will be used for an overall analysis, and a case study of programme based analysis will be done for Maharashtra and Gujarat states.

State Financing of Health in India

The Indian constitution in its 'Directive Principles of State Policy' has vested the state with responsibility for providing free health care services to all citizens.

TABLE 1 A: HEALTH EXPENDITURE, GDP AND GOVERNMENT EXPENDITURE IN INDIA BY PLAN PERIOD

(Rs Crores)

Plan Period		State Health Expenditure (a)				(c)	(c)	(c)	(c)
		Medical and Public Health*	Family Planning	Total Health	Per Cent Plan (b) Expenditure	Private Medical Expenditure	Total Govt. Expenditure	GDP at Current Market Prices	Population in crores (plan-period average)
	1	2	3	4	5	6	7	8	9
I	5 years	197	0.15	197.15	38.7	NA	8915	50175	38
	annual average	39.40	0.03	39.4			1783	10035	
II	5 years	420.8	2.2	423	51.3	NA	13520	66235	42
	annual average	84.16	0.44	84.6			2704	13247	
		(113.6)	(1366.67)	(114.55)			(51.65)	(32.0)	
III	5 Years	939.1	24.9	964	37.1	2227	23080	99890	46
	annual average	187.82	4.98	192.8		445.4	4616	19978	
		(123.1)	(1031.81)	(127.89)			(70.7)	(50.8)	
Plan Holiday	3 years	723	70.4	793.4	39.5	2237	21213	155390	51
	annual average	241	23.47	264.5		745.7	7071	31078	
		(28.31)	(371.28)	37.18		(67.4)	(53.18)	(55.56)	
IV	5 years	1954	284.5	2238.5	47.9	5629	53255	227395	55
	annual average	390.8	56.9	447.7		1125.8	10651	45479	
		(62.15)	(142.43)	(69.26)		(50.97)	(50.6)	(46.34)	
V	5 years	4201.1	538.2	4739.3	49.5	6578	103305	411810	62
	annual average	840.22	107.64	947.9		1315.6	20661	82362	
		(115)	(89.17)	(111.7)		(16.85)	(93.98)	(81.1)	
1979-80	annual	1320.9	121.8	1442.7	50.5	1567	31670	107444	66
VI**	5 years	11152.4	1626.2	12778.6	52.8	11479***	262150	846670	71
	annual average	2230.48	325.24	2555.7		2295.8	52430	169334	
		(165.46)	(202.15)	(169.6)		(74.5)	(153.7)	(105.6)	

(Figures in parenthesis are average percentage growth rates over the previous period)

* Includes water supply and sanitation, CGHS, ESIS, ICMR, Medical Education and Research.

** Last two years of the VIth plan are budget estimates/allocations.

*** 4 years as reported in 'National Accounts' and fifth year estimated by the author at Rs 2930 crores.

TABLE 1 B: RATIOS

Per Capita Per Annum Health Expenditure (Rupees)		Ratio FP: Medical and Public Health (Per Cent)	Ratio Pvt Medical :State Medical and: Public Health (Col. 2) (Per Cent)	Per Cent State Health (Col 4) of Total Govt. Expenditure	Per Cent State Health (Col. 4) of GDP
State (Col. 4)	Private				
10		11	12	13	14
1.04	—	0.08	—	2.2	0.39
2.01	—	0.52	—	3.13	0.64
4.20	9.68	2.65	237.14	4.18	0.96
5.20	14.62	9.74	309.40	3.74	0.85
8.14	20.47	14.56	288.07	4.20	0.98
15.29	21.22	12.81	156.58	4.59	1.15
21.86	23.74	9.22	118.63	4.55	1.34
36.0	32.33	14.58	102.92	4.87	1.51

Table 'A' Complied from: a) Comptroller and Auditor General of India: *Combined Finance and Revenue Accounts*, GOI, years 1951-52 through 1981-82 and Department of Economic Affairs: *Indian Economic Statistics*: Public Finance, Ministry of Finance, GOI, 1982.

b) CBHI: *Health Statistics in India* 1984, Ministry of Health, GOI, 1985.

c) CSO. *National Accounts Statistics*, Ministry of Planning, GOI, Years 1965 through 1986.

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Where does the state stand on this issue?

Analysis of finances of the state reveals that the health sector started with a very low priority and has gradually gained an increased share of the state's expenditure, stabilising between four and five per cent of the government's total expenditure. Similarly state expenditure on health care has shown marginal increases over the years with regard to proportion of the Gross Domestic Product. Table 1 'A' and 'B' presents data in this regard by various plan periods.

The most interesting finding that emerges from this data is that the growth rate of both health and family planning expenditures have been much greater than both the growth of government expenditure and the gross domestic product. Further, as per the estimates of 'National Accounts' we see that the gap between state health expenditure and private medical expenditure is narrowing. These facts are indicative of high investment in the state health sector, but, unfortunately, the results of health programmes do not corroborate this. Why is this so?

Firstly, the level of investment and expenditure in the state health sector, though experiencing a growth rate higher than total government expenditure, is at a fairly low level. For the year 1984-85 the allocated expenditure for the entire state health sector was Rs 3,287.8 crore, working out to a meagre Rs 43.84 per capita per annum (1.54 per cent GDP and 5 per cent of government expenditure). This includes expenditure on medical services and national disease programmes, public health and PHC, water supply and sanitation, CGHS, ESIS, MCH, family planning, medical education and research, health bureaucracy, construction of new health centres and hospitals. At today's market prices providing the above services adequately to the entire population free of cost requires much more expenditure than is earmarked presently.

Secondly, a large proportion of health expenditure in the III, V and VI Plan periods, when the growth rate of health expenditure had been the highest, went into infrastructure development i e, water supply schemes and construction of health centres. In fac more than one-half of the medical and public health expenditure since the III Plan period is spent on water supply and sanitation. The plan holiday period and IV Plan, when capital expenditure was very little, show low growth rate in health expenditure. And, in spite of this the health infrastructure remains poor. Even today the government is nowhere near the level of infrastructure and facilities recommended by the Bhore Committee in 1946.

Thirdly, between 70 and 80 per cent of the investment and expenditure in the state health sector goes to the 30 per cent population in urban areas. This mismatch (of rural-urban disparity) by the state is in spite of the fact that urban areas also have access to other public and quasi-public health care facilities such as municipal and other local body hospitals and dispensaries, municipal protected water supply and sanitation, municipal funded medical education, ESIS and CGHS for industrial and government workers and so on. For instance in 1983 in Maharashtra, of the total 478 state-owned (central and state government) hospitals and dispensaries 432 (90 per cent) were in urban areas and of all the state owned beds 97 per cent were in urban areas. And of all the beds in Maharashtra (public and private) 30 per cent were in Bombay city alone (SBHI, 1983).

Fourthly, leaving aside the preventive and promotive services, the curative services provided by the state, especially in the rural areas, are grossly inadequate. That curative services are the priority demand of the people vis-a-vis health is evident from various studies that have shown that even in rural areas the private medical practitioner provides services for between two-thirds and three-fourths of illness episodes in the population.

Following from the above, the private medical sector becomes a strong adversary to the state sector because the former is totally curative-oriented, because it is 'efficient' and non-bureaucratic, because it is 'effective' and most importantly because it is easily accessible

TABLE 2: HEALTH FACILITIES IN INDIA
(selected years)

Year	No of Hospitals	Population Per Hospital (In lakhs)	No of PHCs	Rural Population Per PHC (In lakhs)	No of Beds	Population Per Bed	Percent of Rural Beds	Percent of Hospitals Owned by the State	Percent of Beds Owned by the State	No of Dispensaries	Percent of Dispensaries Owned by the State
1951	2694	1.3	—	—	117000	3199	NA	NA	NA	6515	NA
1956	3307	1.2	725	4.4	157000	2554	25.0	NA	NA	7100	NA
1961	3094	1.4	2565	1.4	230000	1930	NA	NA	NA	9406	NA
1966	4147	1.2	4631	0.8	304000	1628	NA	NA	NA	10236	NA
1971	3976	1.4	5112	0.8	331000	1673	NA	NA	NA	10897	NA
1974	4014	1.5	5283	0.8	355461	1668	13.7	62.6 (16.0)	69.5 (16.2)	10200	NA
1982	6805	1	5739	0.9	504538	1405	17.2	50.8 (44.3)	68.1 (26.7)	16754	60.9 (14.1)
1984	7181	1	7210	0.8	536370	1378	17.43	49.3 (45.3)	68.1 (26.7)	21780	51.8 (29.6)

(Figures in brackets are percentages in private sector; the remainder is facilities owned by local bodies)
Compiled from: CBHI: Health Statistics in India/Pocket Book of Health Statistics, Ministry of Health, GOI, respective years.

when needed.

And finally, the credibility of the state's rural health services is very low. This is largely due to its obsession with family planning targets. Over 60 per cent of the PHC staff's time is spent on family planning work.

Thus, the high growth rate of health expenditure is a deceptive feature, because disaggregated it reveals the unhealthy direction of growth. In the following paragraphs the data in each column in Table I is analysed in detail.

Medical and Public Health

In the health sector the Britishers did not leave any significant legacy of an infrastructure. Therefore, a beginning from scratch had to be made after Independence. What was left by the British was an exhaustive Plan called the Bhore Committee Report, a small network of civil hospitals, a few medical colleges in premier cities and a network of military and railway hospitals. No rural health infrastructure of any significance existed at the time of Independence. The expenditure by the British state was meagre (see Appendix 1).

However, even after Independence the Indian state did not deem the health sector to be a priority. In the First Plan period the state spent an average of Rs 39.40 crore per year which was only 2.2 per cent of total government expenditure and only 0.39 per cent of the GDP; much less than what the British government had been spending. At the end of the First Plan, besides 725 PHCs there were 3307 hospitals, and 7100 dispensaries in India, the majority of hospitals belonging to the state (breakup of ownership for this period is not available).

In the Second Plan period the expenditure on medical and public health more than doubled and this pattern continued in each subsequent plan, except during the 'plan holiday' and the IV Plan when growth rate of health expenditure showed a drastic decline. Health facilities too increased but they remained heavily skewed in favour of urban areas. With the launching of the Minimum Needs Program, from the IV Plan onwards rural health infrastructure began to receive some significant attention.

Table 2 lists health care facilities in India. It is evident from this table that the health infrastructure is very poor even today, especially so in rural areas. The best indicator of health care facilities is the number of hospital beds available to the population. The earliest year for which this break-up is available is 1956 when 25 per cent of all hospital beds (government, local body and private) were located in rural areas that had 80 per cent of the country's population. This declined to 13.7 per cent in 1974, clearly indicating that the rural areas had been neglected grossly where investment in the health sector was concerned. Even where PHCs are concerned it is clear that the number of PHCs added over the years has not been adequate for the rural population as between 1966 and 1984 the PHC: Population ratio has remained constant at one PHC

TABLE 3: MEDICAL EXPENDITURE BY SELECTED CORPORATE AGENCIES

Organisation	Per Employee Family Annual Expenditure (Rs)	Reference Year,
TELCO (b)	1106	1982-83
National Rayon (b)	860	1982-83
Ashok Leyland (b)	717	1982-83
BHEL (a)	830.47	1980-81
Railways (a)	310.45	1980-81
SAIL (a)	677.93	1980-81
Air India (a)	725.00	1980-81
CGHS (c)	271.90	1980-81
ESIC (c)	80.99	1979-80
Bombay Municipal Corporation (d)	70.08	1983-84

Source: a Lok Sabha Estimates Committe, 22nd report, Ministry of Health, GOI, 1982.
b ORG, *Health Financing in India*, ORG, Baroda, 1985.
c CBHI, *Health Statistics in India*, Ministry of Health, GOI, 1983.
d BMC, *Performance Budget Estimates* 1985-86, BMC, Bombay, 1985.

TABLE 4: PLAN OUTLAYS IN THE HEALTH SECTOR—INDIA

(Rs crores)

Health Programme	Plan Period (Plan Holiday Period Excluded)						
	I	II	III	IV	V	VI	VII
1. Control of communicable diseases.	23.10	64.0	70.5	127.01	168.61	524.0	1012.67
2. Primary Health Centres, Hospitals & Dispensaries	25.0	36.0	61.7	164.78	155.62	*720.1	*1283.87
3. Education, Training and Research	21.6	36.0	56.3	98.22	111.76		
4. Minimum Needs Programme (Health)	—	—	—	—	29.47	576.96	1096.35
5. Indigenous Systems of Medicine	0.70	4.0	9.8	15.83	27.72	*	*
6. Family Planning.	0.40	3.0	27.0	315.00	516.0	1010.0	3296.26
7. Water Supply & Sanitation	49.0	76.0	105.3	407.00	1022.0	3922.02	6522.47
8. Other Schemes	20.2	6.0	11.2	27.69	40.81	*	*

* Included in Health Programme 2 and 3.

Sources: 1. CBHI: Pocket Book of Health Statistics of India, Ministry of Health, GOI, 1976.
2. Planning Commission, Sixth Five Year Plan 1980-85, GOI, 1980.
3. Planning Commission, Seventh Five Year Plan 1985-90, GOI, 1985.

for 80,000 population. This stability (sic) is also true of the hospital/population ratio.

However, the point that emerges most significantly from Table 2 is the fact that since mid-seventies there has been a sharp rise in the proportion of health facilities in the private sector as compared to the state sector. Thus, in 1974 the private sector accounted for only 16 per cent of hospitals in the country but within a decade the private sector's share of hospitals rose 2.83 times to 45.3 per cent, and that of the state sector declined from 62.6 per cent in 1974 to 49.3 per cent in 1984. The change in the proportion of hospital beds in either sector was not as sharp.

Therefore, it becomes very clear that both the "high" growth rate of the state health sector and the narrowing gap between state and private health sector expenditures is only an illusion created by aggregated data.

Family Planning

Expenditure on family planning (now including MCH, CHG scheme and the EPI program) is almost entirely financed by the central government through 'plan' funds. Allocations to FP have increased at a phenomenal rate in each plan period. Between the First and the Sixth Plan periods the *allocation* increased from Rs 0.65 crore to Rs 1010 crore i.e. 1554 times, and more astoundingly FP *expenditure* increased from Rs 0.15 crore to Rs 1626 crore or 10840 times, whereas total plan expenditures in the same period increased only 50-fold and health expenditure (plan and non-plan) only 57 times. Computing this growth rate may sound unfair because FP started with a very insignificant allocation in the First Plan period but the fact remains that the growth of family planning expenditure has been at the cost of expenditure on health care services. In the VII plan for the first time plan allocations (revised) to FP are higher than that for health.

Further, in each plan period we see a decline in growth rate of family planning expenditure and the growth has been the lowest, ironically, in the Emergency period (Vth Plan). Therefore, this computation too is unfair. This is the illusion that aggregate statistics project!.

Notwithstanding this, the growth of family planning expenditure remains higher than that of health expenditure. And further, it may be noted that at the implementation level a large proportion of resources and personnel-time allocated to health is used for family planning work because the latter ranks as priority number one in state policy making. (For details on Family Planning financing see Duggal, 1986).

Private Medical Expenditure

It has already been pointed out earlier that over two-

TABLE 5: DISAGGREGATED STATE HEALTH EXPENDITURE FOR MAHARASHTRA AND GUJARAT—VI PLAN PERIOD
(Rs million)

Programme	Maharashtra			Gujarat		
	1980-85	Annual Average	Per cent Plan	1980-85	Annual Average	Per Cent Plan
1. Direction and Administration	870 (5.48)	174.0	9.1	70.14 (1.1)	14.03	16
2. Medical Relief	1772.8 (11.16)	354.56	7.5	1216.30 (19.17)	243.26	7
3. Training	9.1 (0.06)	1.82	0	34.38 (0.54)	6.87	34
4. Medical Education	661.1 (4.16)	132.22	32.2	262.42 (4.13)	52.48	12
5. Control of Common Diseases	1302.9 (8.2)	260.58	61.8	746.03 (11.76)	149.2	35
6. MNP	602.8 (3.8)	120.56	93.1	457.93 (7.22)	91.58	13
7. ISM	241.6 (1.52)	48.32	3.5	170.32 (2.68)	34.06	9
8. ESIS	1203.2 (7.58)	240.64	2.8	558.59 (8.81)	111.72	0.67
9. Other Expenditure/Services/ Loans	248.1 (1.56)	49.62	6.1	138.74 (2.18)	27.75	24
10. Nutrition Programme	NA	NA	NA	324.86 (5.12)	64.97	20
11. School Health	NA	NA	NA	2.05 (0.03)	0.41	87
12. Family Planning	1435.4 (9.04)	287.08	99.5	927.81 (14.62)	185.56	NA
13. Water Supply & Sewerage	7536* (47.45)	1507.2	50*	1434.3 (22.6)	286.86	67.3
Total	15883 (100)	3176.6		6343.87 (100)	1268.77	

(Figures in brackets are percentages to total)
Source: ORG, Health Financing in India, ORG, Baroda, 1985.
* Plan expenditure was Rs 3768 million. Since the non-plan figure was not available the author has estimated it to be half each.

thirds of health care services utilisation is in the private sector and the remaining is divided between the state sector and other public and quasi-public institutions.

In Table 1 we see that the growth of private medical expenditure has been much slower than the state health sector. As a result the gap between the two has narrowed down to almost unity during the VI plan period. This is contradictory to two facts indicated in earlier sections. Firstly, that between two-thirds and three-fourths of health care utilisation is in the private sector. And second, that the growth rate of the private health sector after mid-seventies has been very high (see Table 2).

Therefore, this data on private medical expenditure computed by the CSO in 'National Accounts Statistics' is highly questionable. Studies carried out by the Foundation for Research in Community Health indicates much higher estimates of private medical expenditure. For the year 1983-84 it has been estimated that the total health expenditure in India was Rs 16,386.41 crore or 8.33 per cent of the GDP. Out of this only 11.7 per cent was spent by the state, 60.4 per cent was spent by private households, 22.7 per cent by the corporate sector (private and public) for its employees and 5.2 per cent by local bodies. Also, with regard to private household health expenditure a gross rural-urban disparity is seen—in rural areas an astonishing 94 per cent of health expenditure was borne privately by households whereas in urban areas this burden was only 35 per cent of their health expenditure (*FRCH*, 1981). This is mainly because urban areas have access to better state and other public (such as municipal) health care facilities as also to employer or insurance sponsored health care programmes. Expenditure of selected agencies is presented in Table 3. *Ratios*: A few selected ratios have been computed from Table I and are presented in Table I 'B'. The data in this Table speaks for itself and it has also been referred to in earlier sections. Therefore, we leave it at that.

State Health Expenditure on Health Programmes

As mentioned earlier disaggregated data for state health expenditure for the nation is not available on a programme-wise basis, except for plan expenditure. Therefore, we will look at the state (provincial) level to get a detailed breakdown.

Where plan expenditure is concerned consolidated data is available for eight categories. Table 4 presents this data. It is clear from this table that water supply and sanitation leads as expenditure number one grossing between 30 per cent and 50 per cent of the health sector Plan—it has grown in each plan period taking a larger proportion each time.

Family planning on the other hand started by being the lowest funded programme in the first plan (0.3 per cent) to gaining second position (27.56 per cent) after water supply, by the V Five Year Plan. As a consequence all the other programmes have suffered and have had a smaller share in each subsequent health plan since family planning took over the second position in the IV Plan. Thus the priority of the state in the health sector is fairly clear—strongly in favour of FP at the cost of other crucial health programmes.

Unfortunately such a breakup is not available for state health expenditure outside the plan. But at the state-level detailed disaggregation is available. Table 5 gives a breakup of various health programmes for Maharashtra and Gujarat during the VI Plan period. Water supply and sewerage is the largest single category of expenditure in each sate—as a percentage it is as high as 47.45 per cent in Maharashtra and only 22. 6 per cent in Gujarat.

If one leaves aside water supply, then medical relief accounts for the largest category of expenditure in both Maharashtra and Gujarat. This is followed by family planning, control of communicable diseases and ESIS. The other programmes follow a different sequence of priority in each state. The per capita per annum state health expenditure (inclusive of water supply) for Maharashtra and Gujarat works out to Rs 48 and Rs 35 respectively.

Thus the priority and pattern of expenditure for various health programmes is not very different from that we have seen for 'plan expenditure' for the country. Of course, it must be noted that Maharashtra and to some extent Gujarat are the better performing states vis-a-vis the health sector.

Role of State Health Sector

In the foregoing analysis we have seen that within the health sector two programmes stand out prominently—water supply and sanitation and family planning. Ironically both these programmes are not perceived by the people as health programmes. For the general population health care is synonymous with curative services and this does not have a very high priority with the state.

Why do water supply and sanitation and family planning feature as high priority programmes? Water supply itself has high priority with people, may be even greater than medical services, but this is not the reason why it is so heavily funded.

The role played by imperialist agencies is very crucial in understanding this. If one lays threadbare the development programme expenditures of the state it is clear that those programmes which receive financial support through various imperialist agencies, such as bilateral (USAID, ODA, DANIDA, etc), multilateral (World Bank, WHO, etc) or private (Ford, Rockefeller, Population Council, etc), get into the state's priority list. The Indian state, being part of the world capitalist system (though backward), is greatly influenced by it in its policy and programme making. Thus water supply and family planning and a few selected communicable diseases (malaria, earlier small pox, now measles and even AIDS) get top billing in the state's resource allocation. If one goes through the CFRA or RBI Finance Reports of any year and looks up the section on international debt the correlation between plan

priorities and public finances and foreign debt becomes clear. Power projects, transport and communication, industrial infrastructure, mining projects, irrigation projects, water supply schemes and population control projects are the major areas of international debt financing. These areas also happen to be the ones that take the cream of our plan public finances. These are the very areas in which India lacks technological skills and has to rely on multinational corporations. This is too good to be a mere coincidence. If one were to list all the significant water supply schemes and the population control projects in India there would not be a single project that did not receive foreign finances (see RBI, 1984).

This nexus does not exist only at the international level but also within the country between the state and private capital. In a capitalist state the government (the functional form of state) is a functionary of capitalism—its role is to protect and strengthen it. Thus the state's behaviour, even with regard to the health sector programmes, is a function of private capital. The state's financing patterns of various health sector programmes are primarily the fulfilment of the needs of private capital. At the time of Independence the Indian state lacked any significant health structure. The Indian bourgeoisie was not prepared to enter this 'social sector' and therefore it allowed the state to develop this sector. And today when a bare minimum of health infrastructure has been developed and is functional the bourgeoisie, following the footsteps of its western allies, has stepped in a large way in the health sector. In fact, in the next three or four years large financial investments by the corporate sector in health care have been planned.

Further the curative health care sector, which has priority with the people and which forms the *raison d'etre* of the entire pharmaceutical and medical equipment industry (overwhelmingly controlled by the private sector, especially MNCs), has received a very lukewarm attention from the state. This is because the entire private practice of medicine thrives on curative services. It is the life-line of the private health sector. Private practice of medicine, which looks after three-fourths of the population falling ill, has never been controlled by the state. It has been given a completely free hand to operate and amass surplus.

Most of the doctors who get into private practice are trained at public institutions run entirely through public finances. Thus the state is directly responsible for creating an exploitative private health sector. The state is also a very large buyer of drugs from the private drug companies. The state provides tax concessions for running private hospitals under the grab of 'public trusts' that are referred to as 'voluntary hospitals'. (According to the Directory of Hospitals in India Maharashtra state does not have a single private hospital. Jaslok, Breach Candy, etc are listed as 'voluntary' hospitals!).

Thus we may conclude that the state's health expenditure which has been gradually increasing over the years, grows in an unhealthy direction, is urban-biased, anti-poor and above all is invested for the health of private capital.

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Appendix-I
Health Expenditure During British Rule 1870-1939
(Rs million - annual average)

Category of Health Expenditure	Decade						
	1870-79	1880-89	1890-99	1900-09	1910-19	1920-29	1930-39
Central & Provincial Govt. Medical and Sanitary	6.2 (0.03)*	7.3 (0.04)*	11.6 (0.05)*	14.1 (0.06)*	23.0 (0.10)*	52.1 (0.22)*	57.0 (0.21)*
Military Medical	4.2	5.5	7.1	8.2	6.3	NA	NA
Municipal Water Supply Conservancy, Drainage, Hospital, etc	8.1 (0.04)	10.5 (0.05)	17.3 (0.08)	26.9 (0.12)	40.3 (0.18)	75.5 (0.32)	67.7 (0.25)
District and Local Boards Sanitation & Hospitals	— —	— —	2.8 (0.01)	4.3 (0.02)	6.7 (0.03)	15.8 (0.06)	20.6 (0.08)
Total Health Expenditure	18.5 (0.07)	23.3 (0.09)	38.8 (0.14)	53.5 (0.20)	76.3 (0.31)	143.4 (0.60)	145.3 (0.54)
Total Govt. Municipal, District, etc. Expenditure	589.7	798.8	1026.7	1265.2	1679.6	2677.9	2651.4
Per Cent Health Expenditure of Total Expenditure	3.14	2.92	3.78	4.23	4.54	5.35	5.47

(Figures in brackets are Rs per capita per annum expenditure on health at current prices).
* includes military medical expenditure.
Source: Statistical Abstract of British India, relevant years: quoted in "The Politics of Health in India" by Roger Jeffery, California University Press, Berkeley, 1987 (forthcoming).

State in Medical Care

sujit k. das

The nature of state intervention in medicare has been determined by two factors the demand of the people on the one hand, and the ruling classes' urge to acquire legitimacy and credibility on the other. Often enough policies which have been a consequence of the pressures brought to bear by the working class, have subsequently adapted to benefit the interest of the dominant class effective medical care to the poor, can never, the article contends, be provide by a state geared to the interests of capital accumulation.

MODERN societies, without exception, view certain basic health care services as commodities to which every member of the society should be gauranteed access, regardless of their ability to pay. This general proposition seems widely shared among nations, whatever their cultural and political complexions; vastly different approaches, however, have been adopted for acting on that precept" (Reinhardt, 1982).

Reinhardt's statement reflects a somewhat universal value; but, besides approaches, the understanding and interpretations of the general proposition he mentions also differ widely. Though it has long been established that 'basic health care' includes food-cloth-shelter-safe water-sanitation, etc, as popularly understood in India it actually means medical care, i e, medical intervention to prevent and treat diseases. That is why the Indian state maintains a large number of institutions where a citizen, dying from some disease, may claim free life-saving medical aid. There is no state agency which provides free food to a citizen dying from hunger or for that matter clothing, shelter, etc, to the similarly deprived. Neither is there any demand on the state from any quartor to arrange for such provisions. In fact, conceptually it is yet to be accepted that the basic elements of health care should be provided free to the pauperised people; to each according to his ability—is the motto; one should earn his living—is the precept. Emergency situations, e g, disasters like floods, earthquakes, accidents, etc, of course, make exceptions. In contrast, universal-free medical care by the state is not only welcome but such provision is actually there and more is being demanded.

The endeavour to provide medical care for its members by human society is as old as any other social activity. state, religious institutions, voluntary collective efforts—all have played their part. Modern societies, enriched by modern scientific knowledge, have turned their attention to basic health care with, as Reinhardt says, vastly different approaches. In the socialist countries, state intervention is almost comprehensive in all aspects though the citizens contribute in varying proportions to its financing. In the developed capitalist countries state intervention in the matter of safe water supply, education and sanitation is quite significant and, though food-clothing-shelter remains as yet an individual responsibility, various social security schemes help the pauperised citizens and guard against death from deprivation. As regards medical care, approaches are different. In the US there is no direct state intervention and the semblance of a free market is sought to be preserved, but with the introduction of medicare (for aged) and medicaid (for poor) programmes and financial support to other agencies, the financial contribution of the state has, steadily in the last two decades, come to bear the largest share in the national health care expenditure. United Kingdom's National Health Service is somewhat unique and rather incomparable among the capitalist countries as it is run entirely with state revenue. Other countries heavily depend on different kinds of insurance systems with heavy state and employer contributions. In Canada medical care is almost totally state care.

Among the developing and under-developed countries, the trend is similar. Pressure on the state to provide for more and more health care is put from all corners—deprived classes, liberal section, political forces and international community—albeit from different motives. Accordingly state health care is expanding more rapidly than private sector health care. The Indian scene may be reviewed in two categories—non-medical health care and medical care.

The debate in the wake of WHO's call 'Health For All' has brought about a change in the concept of non-medical health care. It not only includes food-clothing-shelter-safe water-sanitation-pollution-free environment, etc, but is also held to be dependent on education, economic security or effective employment, women's equality, social justice, political control over economy, etc. For all these factors, the supreme role of the economy is indisputable. The market economy does not care for the achievement of all these health determinants for the broad masses. Clearly, the private sector of the economy cannot be induced to work for equitable distribution of non-medical health care, nor can such health care be achieved through individual efforts. Its realisation depends entirely on the political direction of state policy and its effective implementation. In other words, non-medical health care for the masses depends entirely on state intervention for the development of new economic relations conducive to equitable distribution.

Why State Medical Care?

State intervention in medical care depends not so much on the economic structure of the social formation; all societies appear to agree on the state's increasing role in providing universal medical care. The extent and magnitude of state intervention depend primarily on political commitment and then on the level of development of the state as an institution and on the degree of its dominance over social activities. In India,

the operation of preventive medical intervention, e g, national disease control and eradication programme, routine immunisation, etc, is almost exclusively in the hands of the state. Free curative services operated by the state effectively reach only a few selected target groups, e g, government employees, including the armed forces, organised labour force (ESI), and the socially powerful minority in both urban and rural areas. The rest of the population depends upon various kinds of private and corporate services. All concerned people agree that the services are inadequate and effective curative services do not reach the largest section of the people in need. A variety of prescriptions have been offered as remedial measures and these should be considered in their political and economic dimensions.

It is often argued that liberal philanthropic welfare has given way to capitalist welfare measures, e g, medical care which is intended to contribute towards maintaining reproduction of labour; state medical care, like education, is actually a part of the social wage of the labouring class. This argument appears to be relevant in the context of an advanced capitalist economy where the role of skilled and highly skilled labour is significant and capital's stake in developing that kind of labour is high enough to justify large state allocations to medical care in order to maintain the health of the labour force. In the drive for accelerated industrialisation in USSR and China, state policy accorded priority to maintaining the health of the labouring force by organising medical clinics in each factory complex (Deacon, 1984; Wilenski, 1979). But this argument is not sufficient to explain the Indian situation. Labour in Indian industry and agriculture is mostly low-skilled and unskilled and the reserve force is so abundant that its continuing health and quality cause the least worry to the capitalists. There is as yet no evidence to suggest a linear co-relation between productivity and improvement of the health status of the people. Even in the case of the ESI, the apathy and neglect of the state as well as of the employers indicate that they are more interested in something other than the protection of the workers' health. On the other hand, the argument that the entire state medical care service is entended to earn legitimacy for the ruling classes and the existing social order and to secure credibility for the state as the benevolent friend of the poor appears to be more plausible. It will be evident if the real state of affairs prevailing in the operation of the state health service is reviewed.

State authorities never tire of proclaiming that the state service is free and is meant for the poor. Actually, both the principle and practice are otherwise. In principle—legal, constitutional and otherwise—state medicare is not meant for the poor alone. By policy the access is universal. Both the millionaire and pauper have equal rights to claim free state service. Not only that, the population groups who enjoy exclusive access to reserved medicare schemes, e g, CGHS, ESI, railway, armed forces, public undertakings, big industries, etc, also receive free treatment from state hospitals without restriction. Even foreigners are freely entertained as a routine. What happens really is that the larger portion of effective state medicare is cornered by the socially-economically-politically powerful sections who, in addition, are exclusive recipients of other medicare projects not accessible to the poor. That the real objectives of state policy are compatible with this situation is evident from the fact that state medicare infrastructure is concentrated in the urban areas; that provision of high cost medical technology, e g, C T Scanner, Echodiagnostics, cancer-therapy, intensive care, surgical super-specialities, etc, which have little relevance to the major medical needs of the poor (TB, leprosy, enteric disease, bacterial and parasitic infections, etc), is rapidly increasing; and that the state frequently spends large amounts for high cost treatment of dubious outcome for the VIPs. An example: state medicare in West Bengal is fairly well developed compared to other provinces. But even after the devastating experience of the enteric disease epidemic in 1984, the government is unable to provide for cheap oral rehydration salt packages to the chronically afflicted population on account of stringency of funds which does not impose any constraint, however, on the expansion of high cost technology proceeding as per schedule in the metropolitan hospitals frequented by affluent clientele. Secondly, state service is far from free for the poor. Supply of the needed essential drugs is grossly inadequate and people have to purchase these as a routine. In the urban and semi-urban hospitals it is now customary to engage at the patient's own cost an additional care-taker in order to obtain minimum necessary caring services. The practice of some form of payment as premium to the doctor or hospital worker for the privilege of admission in a free bed is still rampant in most of the provinces. Quite frequently such premiums ae obligatory for investigative, surgical and similar services. It should however be kept in mind that even with the premium, state service, on the whole, is much cheaper than the market product both for the poor and the affluent.

Medical Care vs Non-Medical Care

Official versions of state policy, expert commentators and the WHO strategy for Health For All—all in quest of better health for the people—emphasise non-medical health care and preventive intervention and underplay medical care. As a long-term strategic approach this cannot be disputed. But a good deal of ambivalence and many contradictions appear in the field of practice. The strategic approach takes into consideration only the conventional measurable indices of health, e g, mortality, morbidity, disability, water supply, sanitation, etc, on the one hand and the proportion of doctors, paramedics, beds, drug consumption, etc, per unit of population on the other, in determining the efficacy of health care service. But medical care serves a prime need which cannot be quantified or statistically measured.

Healers have been venerated and honoured since the infancy of human society for the vital function they perform both at the individual and social levels; they respond to human distress. Most of minor illnesses treat themselves; people learn to tackle a good number of everyday physical ailments themselves; when people seek a healer it is a response to more than the mere physical illness but includes added factors of apprehension, fear and helplessness which compound the distress. The healer propounds an explanation of the causation of ailment (however weird), prognosticates, takes charge of the battle, relieves the patients of their helplessness, applies his technology (however primitive and absurdly ritualistic) of diagnosis and treatment and emerges triumphant when the self-healing ailment heals itself. The entire episode restores confidence and balance to the sufferer and his kinfolk, enabling them to again face the adverse world with renewed courage—the unknown enemy is now known and conquered and the healer, the weapon to tackle the enemy, is there. Even when the healer fails, he allays distress, offers comfort and finally legitimises death, the most fearful enemy, by performing rituals intended to ensure a comfortable after-life for the dead. This is one of the most vital psycho-social functions for mankind to adjust to environmental adversity in the struggle for survival and progress. Biologically potent therapy came much later, only recently. In fact, as late as in 1980, Oliver Wendell Holmes wrote that, except for opium and wine, "if the whole *materia medica*, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind—and all the worse for the fishes". Modern doctors also perform the same psycho-social function, only they are immensely more successful owing to the remarkable development of potent preventive, life-saving, curing and relief-producing technology of medical science. But distortions of this very achievement have developed, influenced by economic and socio-cultural transformations. Modern medical care generated tremendous mass demand and was rapidly transformed into a commodity attaining its characteristic features. Doctors rely more and more on the infallibility of technology and are at the same time getting enamoured more and more of its commercial return. Time for consultation is now priced and cannot be wasted for demystifying, caring and personal attention. Drug industry, flooding the market with useless drugs, makes skyhigh profit so that access to essential drugs becomes dear for the poor. The very expansion of medicare services gave birth to bureaucratisation and de-personalisation. In short, while the demand for more and better medical care is increasing, escalating prices are pushing it out of the reach of most people.

Medical care continues to be one of the most pressing felt-needs of all societies. Medical care renders credibility to any health care service and ensure people's acceptance of it. China's post-revolutionary health policy is a case in point. Policy makers understood that in order to ensure mass participation in the public health programmes, the people's felt-need of medical care must somehow be met and they rapidly set up a comprehensive organisation to serve even the people in remote, inaccessible areas. To improvise, they requisitioned the services of the indigenous system of medicine. The point is to provide for some form of medical care to all regardless of standard and quality which could come later. The Chinese health system is now so organised that a citizen of a remote village is assured of the most sophisticated treatment, if needed, in an urban centre.

In our own society, preaching and practice differ. While almost everyone harps on the priority need for non-medical health care, in practice expansion of medicare service goes on unabated. Government health centres, established to provide comprehensive health care, have over the years turned into centres of curative service. People, who persistently deprecate the growing trend of setting up sophisticated diagnostic and curative centres, never fail to rush there for their own needs. The reason for this is not far to seek. Medicare needs of Indian people are so urgent and enormous that they overshadow all other needs. And their priority cannot be over-emphasised. Though it is well-known that availability of safe water is the final answer to the massive problem of diarrhoeal diseases, the instant need of the diarrhoea-stricken dying child is curative intervention and not safe water. To save the life of their dear ones, the poor risk further pauperisation, the extremely poor risk destitution. Medical care is a commodity which never fails to find consumers who cannot afford it.

To sum up, medical care is the most important felt health need of the people; medical care is the pivot of health care service; medical care adds credibility to health care programmes and ensures people's interest; medical care meets needs of the people which, though not quantifiable, are indispensable in acquiring strength to fight against adversities. And whatever role is assigned, on paper, to medical care, it will continue to play the dominant one in health care service. People's demand for more and better medical care will never diminish.

Medical Care Delivery

How then to ensure a certain standard of effective medical care to the people? At present the delivery of medical care is operated through three channels with some overlapping. Firstly, free care—through government and non-government hospitals and clinics. Secondly, indirectly paid care—through various medicare schemes for employed people, e g, ESI, government employees' medicare, corporate employees' medicare and insurance schemes. Thirdly, directly paid care—through open market which includes a few voluntary institutions. The system, as underlined earlier, has failed to provide medical care to the poor. That is why pressure on the state to provide for the deprived is mounting. The state, on the one hand, is not in a position to disclaim such responsibility for obvious political compulsions; on the other, it cannot really provide for a minimum standard of effective

medicare for the deprived population without jeopardising the existing exploitative economic order. To find the way out, several prescriptions have been offered as remedies. The ICSSR – ICMR report recommends a 6-tier organisation from the smallest unit at the lower level covering 1,000 persons operated by two part-time voluntary health workers. The required cost has been worked out to be very low, e g, Rs 30 per capita per annum. The entire scheme appears to be not only simplistic but idealistic as well. It also offers universal access for affluent and poor alike; allows private market to thrive; does not provide for guaranteed emergency care and rests on the premise that both the higher echelons of administration and the providers are imbibed with the spirit of selfless public service. Several other prescriptions include (a) people should be taught and trained in demystified principles of medical care so that they can take health in their own hands, (b) indigenous and non-allopathic systems should be adopted to develop an alternative cheaper culturally acceptable medicare for the poor. None of the alternative schemes suggests dismantling of the sophisticated modern medicare merrily operating in the market. Parallel existence of inaccessible and costly high grade and free low grade services devalues the latter and breeds demand for the high grade one. The poor are already aware of the virtue of modern medicine. True, owing to poverty, they have to go for the cheaper alternatives most of the time, but that is no indication that they love these alternatives or have reconciled themselves to using them for ever. Government experiment in West Bengal illustrates the point clearly. Government appointed homeopath and ayurved practitioners are in a few health centres. It is a common scene in those centres that they spend their days without patients while people throng to the allopathic counter even when the latter is attended by only a pharmacist. The most repugnant feature of the alternative prescriptions is the common objective that each is aimed at lightening the burden of the state. People should be made to realise that they are responsible for their own ill health and therefore must learn to take care of health hazards by themselves. Hence the slogan "people's health in people's hands". Or they ought to remain satisfied with traditionally superior, culturally compatible indigenous medicine with a few doses of cheaper but holistic homeopathy here and there. In any case, they should not bother the state for more costly modern medicare. The modern medicare system will be there but only for the privileged and affluent as usual. The alternative schemes have a common virtue. They spare the state large expenditure and at the same time see to it that its image is not tarnished.

For this purpose, a number of issues, e g, cultural compatibility, self-sufficiency, demystification, etc, have been broached in order to confuse the problem which is essentially economic. In fact, the chief contribution of modern science is to demystify the secrets of the universe—natural and biological. At the present level of knowledge, the ancient medicines stand almost totally mystified, while modern medical science has been able to demystify the phenomenon of ill health and health care to such an extent that even illiterate people now can acquire an insight into the socio-economic and biological dynamics of physical disease and its management. Self-help is another utopia. It has long been abandoned by humankind since the introduction of division of labour in social production. By no stretch of imagination does it seem advisable to consider creation of self-sufficient human beings producing their own material, biological and cultural necessities by themselves or immediate communities.

The development of state intervention in medicare has two driving forces behind it. Demand of the people on the one hand and the ruling classes' urge to acquire legitimacy and credibility on the other. V Navarro describes the relationship precisely. 'Social demands of labour' include increase of social wages, the comprehensiveness and levels of which depend on the strength of working class pressure; 'social demands of capital' include measures to smooth down and cushion the dislocation, uncertainty and dis-welfare created by the process of capital accumulation, e g, social security and health care. Navarro explains, "there is no single-factor explanation of social policy... there is no clear-cut dichotomy between the social needs of capital and the social demands of labour. Any given policy can serve both. Indeed, the social policies that serve the interests of the working class can be subsequently adapted to benefit the interests of the dominant class... the 'bias of the system' has always insured that these policies can be deflected to suit the capitalist class. Indeed, history shows that concessions won by labour in the class struggle become, *in the absence of further struggle*, modified to serve the interests of the capitalist class" (Navarro, 1976). Several spanners have been thrown into this convenient process of concession and legitimacy—fast rising cost of modern medicare, increased demands from all sections of population, increased awareness of the discriminatory distribution of state services, effect of the international slogan of Health For All, increased trade unionism among the employees of the state health services, etc, to name a few. Mere slogans and superficial measures now fail to contain dissatisfaction. It is now realised that provision for a minimum standard of medicare for all entails a magnitude of expenditure sure to undermine other state priorities determined by the ruling classes. Hence the urge and campaign for cheaper alternatives. Noteworthy is the fact that the alternatives are prescribed for only the poor. The state cannot afford to alienate the privileged classes.

What the Poor Must Demand

Underplaying of the role of medical care should stop. Such underplaying ignores the felt-need of the people. Rakku's story revealingly demonstrates that Rakku risked further pauperisation for the elusive life-saving medicare for her child; seeing the government auxiliary-nurse-midwife on her way to the city hospital, "she suddenly felt resentment towards this woman. She wondered why as a health worker she did not have

medicines for helping sick children. Why did she only have injections [vaccines] for healthy children and advice to mothers to stop having more children! Here was her child dying and this woman could not help her" (Zurbrigg, 1984). Valuable scientific advice about safe water, personal hygiene, immunisation, balanced diet, etc, do not cut much ice with the Rakkus.

Effective medical care to the poor will never be and cannot be provided for by a state geared to the interest of capital accumulation; nor can it be provided by collective humanitarian urge. India has a long tradition of philanthropic, charitable, humanitarian effort to provide medicare to the poor and such efforts have increased through the recent spurt in voluntary agencies' activities in the health field, but this has hardly made any ripple on the health scene. The deprived people will have to earn medical care; it must be demanded from the state.

A. State medicare should be exclusively reserved for the large indigent population, i e, people living below a predetermined income level. Other existing schemes of medicare be similarly reserved for the existing beneficiaries. Affluent people be left to fend for themselves. Semi-affluent people be assisted to develop their own medicare facilities through insurance system, as is prevalent in the developed countries.

B. To operate this scheme, the population will necessarily be divided into economic categories as has been for the rural rationing system. In marginal situations and in the case of exigencies persons from unauthorised categories may be entertained in the state institutions but in exchange of a price, not free.

C. Eventually other related functions will have to be modified and rationalised. For example, state expenditure on medical education will be steadily reduced to that optimum level necessary to train personnel destined for state service.

A host of objections and problems will come up in the course of implementation of this scheme. It has been argued that such a scheme is discriminatory, is not fesible and works against humanitarian principles. Surely it is discriminatory but it is a reverse discrimination in favour of the poor aiming to abolish the present discrimination and introduce equitable distribution. The feasibility of such compartmentalised service has already been established. Several such medicare services, e g, ESI, armed forces, railway, etc, have long been functioning. In Andhra Pradesh such compartmentalised public distribution service for foodgrains is being operated for the entire state. About humanitarian principles, the less said the better.

Is this scheme another alternative to meet the medicare needs of the poor? Will the state concede this demand if only its rationality and feasibility are established? The prudent answer is NO. This scheme is founded on the premise that no scheme of equitable distribution and social justice is implemented by the state in an exploitative, class divided society. A few sporadic benefits may be realised from time to time through class struggle to produce only some palliative effect. The demand under this scheme is entirely different. It does not call for some concession for a particular group. It is not only a demand exclusively for the deprived classes so that they have a concrete slogan to struggle for and organise, but also calls for restructuring of the entire medical care system of the society. Moreover, the prospect of earning an exclusive right will provide the necessary urge to struggle for it and, once achieved, the poor will be equally zealous in guarding it. Likewise, the danger of exclusive control of a state apparatus by the poor is apt to invite strong opposition and resistance. The present beneficiaries of state service will oppose it as they stand to loose an existing privilege. The controllers of the state exchequer will oppose it as it only entails increased allocation for the poor but opens up a possibility of establishing a system of accountability of the providers to the recipients. When this inevitable opposition comes, it instantly identifies the real beneficiaries, exposes the nature and utter inadequacy of the present system; it shatters the humanitaring camouflage of the state; it makes a dent in the legitimacy of the present order. In other words, this scheme envisages conflict and polarisation of the contending forces. It may act as a nexus for class struggle.

Then again, what happens in the unlikely event of the state conceding this demand? An exclusive state medicare service will necessarily render the situation conducive for the deprived classes to exercise control over it. The essence is control. Without control there is no participation. They only participate meaningfully who weild power and authority. The very exclusiveness will generate demands for guaranteed service, accountability of the providers, uniform and better standards, more state allocation for medicare—in other words, struggle for control. Struggle for control will soon make it apparent that without eventual control over the state itself, nothing could be achieved or sustained. It will soon be apparent that the fundamental problematic is political and economic. Without political control no change in the economic order is possible. Without economic change, provision of non-medical health care will remain elusive. This situation is not peculiar to health care. The same situation prevails in the other sectors of state policy, e g, education, housing, agriculture, etc. The same discriminatory practice operates under cover of universal eligibility. It cannot be reversed without political control. The way to achieve political control is struggle. It may also begin in medical care.

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The Irreversible Welfare State: Its Recent Maturation, Its Encounter with the Economic Crisis, and Future Prospects

Goran Therborn and Joop Roebroek

This article describes the influence of the current economic crisis on the welfare state in the advanced capitalist countries. The authors discuss how, under the surface of welfare state growth, the political relations of force have changed in favour of those social forces advocating fundamental reappraisal of the welfare state over those supporting its maintenance or extention. It is argued that, as long as democracy prevails, the welfare state is an irreversible major institution of advanced capitalist countries. While the building of a majoritarian anti-welfare state coalition seems impossible for the forseeable future, the authors do not rule out significant cuts in welfare expenditure in some countries and specify some of the economic and political preconditions for such cuts.

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RARELY in the modern history of advanced capitalism has there been a major institution that is so much talked and argued about with so little knowledge as the welfare state. Very little is known—in the sense of being digested by prevailing social scientific as well as political knowledge—of (*a*) the recent developments of the welfare state, (*b*) its part in the current international crisis, and, consequently (*c*) the future prospects of the welfare state. Given the severe space limitations of this paper, what will be attempted here can be no more than a modest contribution toward some enlightenment in these three problem areas.

Welfare State in Contemporary History

History is the mother and teacher of the future. Any attempt at an analytical understanding of future options and possibilities, therefore, has to start from a historical grasp of the present. Here we will concentrate on two aspects: the location of contemporary welfare states in state history, and the socio-economic size and ramifications of current welfare states.

Public social insurance, public health, and social care have at least a century-old history. The major international theoretician and architect of public welfare arrangements, William Beveridge, made his epochal contribution in the 1940s, and the accompanying economic theory got its major statement in 1936 wth Keynes' *General Theory*. This is common knowledge, but for an understanding of the present—and of the future—it is quite inadequate.

In fact, the welfare state as we experience it today is an outcome of the 1960s and the 1970s. In a long time perspective, the extraordinary changes, little theorised and little even noticed, of the sixties and seventies stand out.

In the relatively uneventful years of 1960-1982, overall public expenditure on the average grew by 24 percentage points in our ten selected countries. The combined effects of the two World Wars and the 1930s with its, sooner or later, ensuing turn of economic policy orientation (the arrival of Keynesianism) brought an increase in public expenditure of 16 percentage points between 1913 and 1949. In the 1950s, during the unprecedented boom, the average increase was 1.4 points, compared with 8.4 in the 1960s, and no less than 14 percentage points between 1970 and 1981.

The accelerated growth of Western states after 1960 has mainly been due to welfare state growth. In other words, the welfare state has been *the* major factor in the growth of state involvement in the life of the people it governs. No other force is comparable to it. The rather limited proportion of welfare commitments in the growth of the Danish and Swedish states is most probably in part a statistical artifact, hiding an increase in the number of public employees working in the welfare administrations of the ordinary state apparatus.

This silent change has also meant a major internal transformation of advanced capitalist states. In their everyday activities, Western states have changed from being mainly apparatuses of armed forces, bureaucratic ordering, and public transport and communication into predominantly institutions of transfer payments to households, public education, and public caring and social services. In short advanced capitalist states have in their everyday routines become welfare states. In Belgium and the Netherlands, welfare expenditure in the sense above occupied more than half of all public expenditure by 1960 (1, pp 88, 93). In Sweden this jump occurred between 1966 and 1968 (2,3). By 1981, all advanced capitalist states devoted more than half of their public expenditures for welfare state purposes, even the United States and Japan (1, pp 70). With regard to terms of public employment, in the Scandinavian states employees in education, health care, and social care now comprise between two-thirds and three-quarters of all public employment (4). (The actual figures are 62 per cent in Sweden (1981), 68 per cent in Denmark (1981), and 76 per cent in Norway (1980). All figures except employees in public enterprises operating on competitive markets.) In the Netherlands in 1977, about 57 per cent of all government and government-subsidised para-statal personnel were occupied with

teaching, caring, and other social and medical services (5). (From the total of the "kwartaire sector" (5) have been subtracted private practitioners of medicine, dentistry, and physiotherapy as well as personnel in private child care.) In brief Western states have (largely) become post-bureaucratic welfare states.

Socio-Economic Ramifications of Welfare State

We have seen that the contemporary welfare state is not an elderly institution, susceptible to the ailings of old age. On the contrary, the developed welfare state is a very recent phenomenon, better characterised by the sometimes extravagant vitality of youth. In our time, the welfare state has also become a major institution of advanced capitalist societies. One expression thereof is the significance of the welfare state as a source of income. Between one-fifth (Japan) and one-third (Netherlands and Sweden) of the sum of the household income derives directly from the state. Calculated in terms of income recipients, the significance of the welfare state is even greater. By the late 1970s, old age pensioners and public employees together made up more than half of the voting-age population in Britain and Sweden, and close to half in Germany. In the United States, public employees plus recipients of social security and of social assistance constituted about 35 per cent of the adult US population in 1975 (6).

In the Netherlands, old age pensioners and public employees are not so many—roughly 30 per cent of the electorate in 1981 (7,8). On the other hand, given the massive failure of Dutch capitalism to provide employment the total number of people receiving their main income from the state is huge. In 1983, 49 per cent of all income recipients below the general pension age of 65 got their income from the welfare state, 27 per cent as receivers of social benefits and 22 per cent as public or para-public employees (9, p 320).

Welfare State and Economic Crisis

The current, now ten-year old, international economic crisis has, of course, affected the parameters of the welfare state. However, from the discrepancy noted earlier between the dramatic growth to maturity of the welfare state and the relative lack of attention to and comprehension of it, we should expect another lack of fit between real developments and the foci of prevailing public discourse. This is in fact the case. Ideologically and politically, the welfare state is currently under heavy attack. This phenomenon is most briefly summarised in the election of the militantly right-wing liberal regimes of Thatcher and Reagan, seconded by several other governments, most wholeheartedly by the Lubbers Cabinet in the Netherlands, and in the retreating positions of the Mitterrand government, of the US Democrats, the Dutch and the Danish Social Democrats, and the disarray of the British Labour Party. In social science, the way the wind is currently blowing is most directly left from the strongly increased influence and assertiveness of anti-Keynesian economics. But major social institutions can hardly be knocked down by rhetoric alone, either from electoral platforms or from academic chairs. Let us take a look at a few facts about actual developments.

Developed capitalist welfare states remain subordinated to the business cycles and the structural crises of the international capitalist economy. The current crisis has shown that generous systems of social security in themselves provide no security against unemployment. But anti-welfare statists cannot "have their grain ground" here; there is no *inverse* relationship between social policy extension and unemployment. The evidence is contradictory (Table 1).

Economic growth has become a weak predictor of unemployment, only a quarter of the variation in unemployment at the end of 1983 can be accounted for by the economic growth between 1978 and 1983 ($r^3 = 0.25$). Between the size of social expenditure (from which education has been excluded here in order to accentuate the more controversial social security aspect) and low unemployment there is a small negative relationship ($r^2 = 0.11$); as there is between social expenditure and economic growth ($r^2 = 0.12$). In other words, only one-ninth and one-eight, respectively, of variations in unemployment and in economic growth may be statistically accounted for by the extension of public social commitments.

Briefly and crudely summarising a long argument (which is developed and sustained empirically at some liength in reference 10), contrary to the McCracken Report (11) and other conventional wisdom, states can maintain a low level of unemployment even in the face of a deep international crisis, provided there is a deeply institutionalised commitment to high employment. But general Keynesian demand management is not enough; a compatible monetary policy and/or an extensive selective labour market policy is also required. And a crucial factor is non-market control over employment, whether through extensive public works and retraining as in Sweden, public subsidies as in Norway, public industrial employment as in Austria, publicly supported paternalism as in Japan, or public control of immigration in an immigrant-dependent economy such as that of Switzerland.

Combining the extension of social security commitments and institutionalised full employment commitment, Scheme I shows the typology of welfare states with regard to both employment and social security. Commitments to social security and commitments to full employment thus vary independently of each other, something that must be brought into the centre of the welfare debate and analysis. We may give our typologised countries descriptive labels:

1. The strong welfare state (Sweden), highly committed to social security and capable of preventing mass unemployment, even in the face of a deep worldwide economic crisis and a low rate of national economic growth (12).

2. The soft welfare states (Belgium, Denmark, Netherlands), generously committed to social security, but unable to control their labour market.

TABLE1: UNEMPLOYMENT, ECONOMIC GROWTH, AND SOCIAL EXPENDITURE[a]

	Unemployment	Economic Growth[c]	Social Expenditure[d]
Australia	9.5	1.8	12.8 (1980)
Austria	4.2[e]	1.8	24.1 (1980)
Belgium	14.9	1.5	32.6
Canada	11.1	1.6	15.5
Denmark	(10.6)[f]	1.6	29.0
Finland	6.2	3.8	23.3 (1980)
France	8.8	1.8	23.8
Germany	7.8	1.5	26.4
Italy	10.0	2.1	22.7
Japan	2.6	4.3	12.5
Netherlands	14.0	0.7	29.1
Norway	2.8	2.5	21.0
Sweden	3.4	1.5	(31.9)[g]
Switzerland.	(0.4)[h]	1.5	9.4 (1979)
United Kingdom	13.1	1.1	19.0
United States	8.4	1.8	15.0

Correlations: Spearman's rank order correlation
between unemployment and economic growth, r = 0.50
between unemployment and social expenditure, r = 0.35
between economic growth and social expenditure, r = 0.34

Because of the less than perfect comparability of the data, differences in unemployment rate of 0.5 per cent or less and of social expenditure of 1 per cent or less have been left out of consideration. Since the Swedish figure was lower in 1980 than 1981, Belgium alone is topranking in social expenditure.

Notes: a The selected countries are meant to be exhaustive of all advanced capitalist countries, except the smallest—Iceland and Luxembourg. New Zealand has been left out for lack of reliable employment data.
b Standardised rate of unemployment as percentage of the labour force in the fourth quarter of 1983. Data for Denmark, from Det Okonomiske Rad *Dansk Okonomi* December 1983, p 52 Direktoratet for Statens Indkob, Copenhagen 1983. For Switzerland, from *OECD Observer* 127, March 1984. The remaining countries from OECD *Quarterly Labour Force Statistics 1984*, p 76, Paris 1984.
c Average annual growth of GDP 1978-1983, in per cent. Data for 1982-1983 from *OECD Observer* 127, March 1984. For 1978-1981, from OECD *Economic Outlook* 33, July 1983, p 160.
d Public expenditure for health, social and welfare services (transfers, public consumption, capital expenditure, exclusive of education) as percentage of GDP in 1981 prices. From OECD *Statistical and Technical Annex*, Report No SME/SAIR/SE 83.02, pp 31-69. OECD, Paris, 1983 (unpublished).
e Third quarter of 1983.
f Non-standardised rate for 1983.
g The original data source had no final consumption and capital expenditure for social and welfare services. The latter have been assumed to be of the same size in relation to social transfer payments as those in Denmark. This will be seen as a conservative estimate.
h Non-standardised rate for 1982.

3. The full-employment oriented medium welfare states (Austria, Norway), giving priority to employment policy.

4. The states of socio-economic mediocrity (Finland, France, Italy, United Kingdom), distinguishing themselves neither in social nor in employment policy.

5. The full-employment oriented market states (Japan, Switzerland), dedicated to maintaining full employment but with limited commitments to social security.

6. The market-oriented states (Australia, Canada, United States) where, in spite of significant welfare state developments in recent years, the market is unequivocally given the upper hand in income as well as in employment determination.

The world of advanced capitalism is a world of wide variations in public and in individual life chances (1).

Real Impact of the Crisis

Table 2 shows that the average yearly growth of social security expenditure declined in almost all western countries under review (except in France) between 1975 and 1981. However, up to and including 1981, social security expenditure continued to grow at a respectable pace. There were considerable yearly variations, but with the exception of Italy in 1977, the United Kingdom in 1977 and 1980, Australia in 1979, New Zealand in 1980, and Sweden in 1984, in no country was there in any year an overall absolute decline, although there were declines in individual programmes, most often in family benefits (1).

For developments after 1981 we will have to resort to national data of various kinds. The Reagan administration has concentrated its cuts on the means-tested programmes for the poor, but social security (old age, disability, and survivors) benefits grew in real

SCHEME 1: A TYPOLOGY OF CONTEMPORARY WELFARE STATES[a]

Social Security Commitment[b]	Full-Employment Commitment	
	Institutionalised	Non-institutionalised
Major	Sweden	Belgium Denmark Netherland
Medium	Austria Norway	Finland France Germany Italy United Kingdom
Minor	Japan Switzerland	Australia Canada United States

Notes: a Data from Table 4 (social expenditure) and the analysis of economic and labour market policies in reference 10;
b The procedure of trichotomisation of social security commitments has been guided by a search for significant break points such that the difference between the lowest scoring country of one group and the highest scoring country of the group below should be larger than the difference between the lowest and the second lowest country of the same group.

terms by 15 per cent between 1980 and 1983, and hospital insurance (for the aged) grew by 25 per cent (13, 14). In Britain under Thatcher, public expenditures on social security and personal benefits grew from £ 25.336 million in fiscal year 1978/79 (under Labour) to £ 28.444 million (in 1978 prices) in fiscal year 1982/83 (15, 16). In the Netherlands, net public transfers to households (net insurance premiums paid) grew from an average of 3.3 per cent of national income in 1976-1980 and 4.6 per cent in 1981 (when the Social Democrats took part in the government) to 5.0 per cent in 1984, exclusive of the growth caused by the rise of unemployment (and of unemployment compensation) (9, p. 157).

But figures do not always tell the whole truth. The welfare state expenditures are still growing, but this is not to deny that painful cuts and redistribution measures from labour to capital and from the poor to the well-to-do are being made by governments. This is true not only for right-wing liberal regimes, but also for coalition governments with social-democrat participation. The measures are nearly the same in most Western countries: (a) changes in indexation of benefits, implying less than full compensation for price increase; (b) more strict entitlements to benefits, such as unemployment insurance and taxed paid services; (c) certain tendencies toward privatisation, e.g., a relative increase in number of beds in private hospitals compared with public hospitals, and accommodation of public-controlled services, especially in the sector of health services, to the private sector; (d) a tendency toward de-individualisation of rights on social insurance and restrengthening of the "family breadwinner principle" in entitlements to social insurance; (e) rationalisation, especially in the health services; and (f) shifting costs: less redistribution over the public budget and more emphasis on direct payments for services and insurance premiums. In Belgium, the Netherlands, and the United Kingdom these measures are accompanied by a discussion about a more fundamental reappraisal of the system of social security on the basis of actions taken by the government.

TABLE 2: ANNUAL GROWTH OF THE EXPENDITURES ON SOCIAL SECURITY[a]

	Percentage Growth		
	1965-70	1970-75	1975-81
Australia	5.3	15.6	2.8
Austria	6.4	5.8	4.6
Belgium	9.1	10.5	5.1 (1975-80)
Canada	11.5	12.9	3.3
Denmark	9.0	6.6	4.5
Finland	10.7	9.5	5.5
France	5.0	6.6	7.4
Germany	5.5	8.6	2.0
Italy	8.2	6.5	3.9
Japan	10.4	12.3	8.6
Netherlands	11.6	8.3	4.5
Norway	15.3	8.0	6.2
Sweden	10.2	9.6	4.4
Switzerland	8.9	10.4	2.7 (1975-79)
United Kingdom	5.3	6.3	3.9
United States	9.3	9.9	3.7
Average	9.4	9.2	4.6

Note: a Calculated from reference 1, in constant 1970 prices. Expenditures on health, temporary sickness, pensions, unemployment, family benefits, and other transfers.

With regard to the welfare state as a whole, the real impact of crisis policies has so far been marginal and unable to break the trend of growth. But it is worthwhile to investigate if these policies reveal recent changes in the political relations of force.

Welfare State and Political Relations of Force

The explosive growth of the welfare state in the sixties and early seventies is accompanied on the political plane by a strengthening of the position of labour *vis-a-vis* capital. This is the effect of wide-ranging social processes that have undermined partriarchy and the family control over production, challenged clientelist and religious forms of social control of production and class division, increased the scarcity of labour on the market, and diminished the dependence of the propertyless upon the labour market for their support (17). This development resulted in a compromise of the main political actors, wherein the welfare state provisions occupied an important place.

What happened to the political relations of force from 1975 onward? In most countries the crisis policies cracked the existing compromise. To answer the question more carefully, we have made, for a selected group of Western countries, a more thorough analysis of government social policy in the crisis.[6] (The analysis is based on materials from the project *The Political Future of Social Security: Political Demands and Social Relations of Force*, financed by The Commission for Research on Social Security (COSZ) of the Dutch Ministry of Social Affairs and Employment.) As a first result, we present two schemes. Scheme 2 contains an overview of the points in time at which a "crisis statement" is given, the "first significant cuts" are carried out, and the discussion about a more "fundamental reappraisal" of an important part of the welfare state, the system of social security, begins. Scheme 3 reveals the composition of the government at these points in time.

At the time of a "crisis statement" (and also of the "first significant cuts"), with one or two exceptions (Netherlands and Sweden) the social democrats formed a coalition government (in Belgium with the confessional and liberal parties) or took a dominant position within the government. Second, discussion about a more "fundamental reappraisal" of the system of social security and the launching of plans in that direction took place exclusively under right-wing governments. In the two countries where the discussion was advanced and the governments proposed plans for the reappraisal, the right was, in a relative sense, best represented in the governments that announced the "crisis statement" and carried through the first "signifi-

cant cuts." In the three countries where the discussion was started by conservatives and liberals (Denmark, Germany, and the United Kingdom), social democrats were defeated in an election after a (long) period of governmental power and were sent back to the opposition. These developments indicate that under the surface of a relatively unbroken growth of the welfare state, a change of the political relations of force has taken place: a development that needs more attention with regard to the future of the welfare state.

This shift in the relations of power should not be understood as an exclusive effect of changes in electoral favour. It is a more structural development not only of social and political relations, but also of social and political moods. It is a field of forces in which political parties, labour unions, employees organisations, and other organisations try to influence decisions that are made within the government, the parliament, and other organs. In this field one can, in general, distinguish two fronts with regard to the welfare state: on the one hand the organisations and forces that advocate a fundamental reappraisal of the welfare state, and on the other hand the organisations and forces that stand for maintenance and, where necessary, further extension of the welfare state. The first front is composed mainly of the conservative, the liberal, and larger or smaller parts of the confessional parties, the employers' organisations, and sometimes middle-class organisations. The other front is made up of the social democratic, communist, and other progressive parties, the labour unions, and organisations of consumers of services and recipients of benefits. The development in the relations of force since 1976 indicates a shift in the direction of domination from the "maintenance front" to the "reapparaisal front" (Scheme 4).

SCHEME 2: THE POLICY OF WELFARE: A SEQUENCE OF ACTIONS

	Crisis Statement[a]	First Significant Cuts[b]	Fundamental Reappraisal[c]
Austria	1983	—	—
Belgium	1976	1980	1983
Denmark	1980	1980	—
France	1982	—	—
Germany	1975	1977	—
Netherlands	1978	1980	1983
Sweden	1980[d]	—	—
United Kingdom	1976	1977	1983

Notes: a "Crisis statement" refers to the moment that the government announces that the policy of welfare cannot be continued without changes.

b As a criterion for "first significant cuts" we use three standards. First, two quantitative standards: an annual growth of expenditures on social security of less than 2 per cent and/or a decline in the annual growth rate of more than 3 per cent. Also a qualitative standard: the changes in a quantitative sense are the result of obvious alterations in policy. This estimation is based on materials up to and including 1983.

c "Fundamental reappraisal" refers to the statement by which the government takes the initiative for a possible fundamental change of the social security system as a whole. This is usually done through the setting up of a public commission of investigation with far-reaching tasks.

d In Sweden the "crisis statement" was made by the incumbent bourgeois government in 1980. After the reelection into office of the social democrats in September 1982, the social cuts that followed the "crisis statement" were redrawn and did not take effect.

SCHEME 3: THE POLICY OF WELFARE AND THE COMPOSITION[a] OF THE GOVERNMENT

	Crisis Statement	First Significant Cuts	Fundamental Reappraisal
Austria	left	—	—
Belgium	coalition	coalition	right
Denmark	left	left	—
France	left	—	—
Germany	left	left	—
Netherlands	right	right	right
Sweden	right	—	right
United Kingdom	left	left	right.

Note: a Here we use a threefold distinction: "right" (conservative-liberal-confessional), "coalition" (social democrats in a balanced coalition with one of the right-wing parties), and "left" (a government dominated by social democrats).

We can come to the more general conclusion that the resistance to significant changes within the welfare state, even when there is domination by the "reappraisal front", is so strong that a fundamental reconstruction of the welfare state is excluded. Even in the Netherlands, it is not obvious that the defeat of the trade unions in December 1983 weakened the position of the "maintenance front" to such an extent that the announced reconstruction of the social security system will be carried through.

Future of the Welfare State

On the basis of the evidence given earlier on the socio-economic ramifications of the welfare state, and further sustained by the record of the effects of the welfare state upon the economic crisis, we conclude that the welfare state is an irreversible major institution of advanced capitalist countries. Or, to be more precise. It is irreversible by democratic means. The size of the population benefiting from the welfare state ensures that as long as democracy accompanies advanced capitalism, the core of the welfare state is safe. This goes against a great deal of hopes on the right and fears on the left. But it is not enough. We have seen above that the welfare state is a variable, not a fixed, entity; an assessment of its possible future will have to pay attention to possible variations. Our general analytical perspective involves two fundamental causes of welfare developments: socio-economic tendencies and socio-political relations of force.

The major push ahead of the welfare state is the aging of the population of advanced capitalist countries, except that of Belgium. The aging of the population means not only more pensions and more old-age services, it also means a great increase in health care. For the Netherlands, it has been calculated that for the period between 1981 and 2000, a growth of expenditure (for pension benefits, nursing homes, old people's homes, old people's welfare work, and medicines) of

more than 20 per cent is needed to maintain existing standards (18).

A second push for welfare state expenditure derives from unemployment. Currently, almost all predictions point to an enduring rate of massive unemployment among two-thirds of advanced capitalist countries, which have failed since 1975-76 to maintain more or less full employment. This means the establishment of a virtually permanent pool of unemployed. Except in Belgium, existing unemployment insurance is not geared to handling long-term and permanent unemployment. Under existing political conditions, permanent mass unemployment is likely to produce mounting pressure for economic provision for the long-term unemployed at a level above that of social assistance.

A third major pressure for increased public social commitments may be expected from population concerns. In most Western European countries the current rate of reproduction is negative, and it may be expected that procreation-stimulating social policies will be adopted. The Sweden, this is already a consensual issue.

Fourth, the number of single mothers is likely to increase. Particularly in countries with current high unemployment and low rates of female participation in the labour force, this implies an increasing demand for social assistance.

One significant alleviation of the pressure is the visible tendency of expenditure for public education to decline because of demographic changes in Western populations. For the Netherlands, this means a possible decline of expenditures between 1981 and 2000 of 20 per cent while maintaining the existing level of education (18, p 86).

The fiscal constraints of social policy are not absolute givens. They are to a large extent politically defined and affected by policy outcomes. The enduring crisis does not mean a permanent depression, as shown by the current upturn in which a growth rate of 2.5 pr cent is forecast in 1984 for the European Community and 4.5 per cent for the OECD as a whole (9, p 19). A provisional calculation by the OECD Secretariat for the seven major Western countries estimates that, because of declining needs for education expenditure, a constant GDP share of welfare state expenditure could ensure a 0.7 per cent annual growth in real social benefits till 1990 (1). One the whole, and by and large, there seems to be little reason for doubt that the current level, or even a moderately higher one, of social welfare commitments is payable.

However, there are at least two qualifications to be made here. Pensions insurance schemes in many countries are very sensitive to lower rates of growth and/or to high rates of employment. In some countries revisions have already been made, and further ones are not unlikely. Second, some countries have already incurred large financial deficits in their public sector. The mounting interest burden of this debt and the narrowed policy margins of big structural deficits are most likely to constrain furture social policy. This holds, above all, for Italy and Belgium, but also to a lesser extent for Denmark, the Netherlands, Canada, and Sweden (16, p 27).

SCHEME 4: CHANGES IN THE RELATIONS OF FORCE BETWEEN THE "MAINTENANCE-FRONT" AND THE "REAPPRAISAL FRONT"[a]

	Domination Maintenance Front	Balanced Relations	Domination by Reappraisal Front
Austria	1975-1982	1983-present	
Belgium		1975-present	
Denmark	1975-1980	1980-1982	1983-present
France	1975-1982	1982-present	
Germany	1975-1977	1977-persent	
Netherlands	1975-1977	1977-1982	1982-present
Sweden	1975-1980 1982-persent	1980-1982	
United Kingdom	1975-1976	1976-1979	1979-present

Note: a This overview has been made on the basis of electoral results, changes in the composition of governments, actions to economise, and the results of confrontation between both fronts.

Socio-Political Forces of Welfare State Demands and Defence

At least one major social force behind the welfare state is growing and is likely to become more active and demanding in the future: that is old people, the "senior citizens." They are growing in numbers, and they are becoming more vital and active because of the combination of increased longevity and reduced retirement age. The aged are also by far the most important beneficiares of the welfare state. Pensions and health care of the aged make up the bulk of social security expenditures in all countries. As the French specialist Anne-Marie Guillemard has said: "The welfare state is, first and foremost, a 'welfare state-for-the-aged'" (19). The demands of the aged are likely to grow for social, cultural, and recreational services, and the aged are likely to be vigilant with regard to their pension rights and level.

Another interested welfare state defender is the group of welfare state employees. Their number is unlikely to grow in the near future, but it is quite significant already, between a quarter (in Sweden) and a tenth (United States, Germany, and Italy) of the economically active population (20). This is a well organised and highly articulate category of people. Welfare state employment has been especially important for the emancipation of women, who usually occupy most of these jobs. Large-scale attacks on the welfare state are therefore likely to meet with resistance from articulate women, even those outside welfare-state employment.

Finally, the labour movement is in modern times the major political protagonist of the welfare state. In countries with high unemployment, the labour movement is currently being weakened, and tendencies to division between private and public employees are appearing. However, even after some recent setbacks, the labour movement in most advanced capitalist states is

located on a historically high plateau of strength and acquired rights (17).

Precondition of a Right-Wing a Roll-Back

We have given a number of reason for our conviction that the welfare state is irreversible by democratic means, and also for our belief that in the foreseeable future even successful cuts and restrictions will not change its fundamental base. However, countries already vary in their line-up for or against the existing welfare state and further variation cannot be excluded. On the contrary, there are strong grounds to expect a further divergence among advanced capitalist states over the coming five to ten years. This divergence derives mainly from the divergent impact of the current economic crisis, in particular with regard to unemployment. The enormous differences in the rate of unemployment (shown by Table 1) are likely to have an enduring, diverging impact for two reasons. First, all OECD estimates indicate that these differences will remain for the rest of the 1980s (21). Second, and also an explanation in part for the first reason, contrary to pre-crisis predictions or fears, mass unemployment has not led to massive socio-political upheaval. Mass-unemployment Netherlands remains as calm as low-unemployment Sweden.

Before going further, however, a major qualification has to be made. Politics and policy are not amenable to scientific prediction. Rather than expecting their specific predictions to come true, political scientists would do well to adopt as a major law of politics the title of a book of stories by Andre Maurois, *Toujours l'inattendu arrive* (always the unexpected happens). We should formulate all of our predictions as conditionals: "if *a*, then (probably) *b*."

The fundamental precondition for a significant right-wing roll-back of the welfare state is a division, a demoralisation, a decomposition, and an at least partial political marginalisation of the broad coalition of socio-political forces that supported and sustained the welfare state expansion in the 1960s and 1970s. The building of a socially majoritarian anti-welfare state coalition, dedicated to capital accumulation and to private business ideology seems impossible in the foreseeable future. The best evidence for the latter assertion is given by the comparative class analysis of Erik Olin Wright. Wright combines the scientific commitment of Althusserian Marxism with post-orthodox theoretical sophistication and the large-scale empirical surveys of American Big Science. His results indicate that even in the United States, about 60 per cent of the labour force has at least a minimum of pro-labour or working class consciousness. In Sweden the corresponding figure is 90 per cent (22, 23).

What then are the preconditions for a division, demoralisation, decomposition, and partial marginalisation of the welfare coalition? First, high unemployment and/or other kinds of worsening in the condition of labour, incurred under a government in which the major left-of-center party takes a significant part. The record of the successful low-unemployment countries strongly suggests that such a major policy failure is not primarily due to the openness to and force of the international economic system, but to half-hearted, contradictory, or adverse policies. The electoral defeats of British Labour (in 1979), of the US Democrats (in 1980), of the Danish Social Democrats (in 1982), and the Dutch center-left (in 1982) fit into this pattern, as does the current defensive of the Mitterand regime. However, the original division and demoralisation of the forces of the left and the center-left have to be reproduced for the right to be able to make significant inroads into the welfare state. There are a number of possibilities for this reproduction, which are not mutually exclusive.

Second in our list of preconditions, and the strongest and most reliable mechanism for reproducing division, demoralisation, and decomposition of the left, is a dualistic scoio-economic development. A dualistic economy and society—a dynamic, well-off sector and a stagnating or declining sector of low-wage or unemployed misery—is the medium-term goal of the new right, consciously or unconsciously. And the fact is that some advanced capitalist societies are beginning to take on those features earlier held to be characteristic only of Third World societies. Thus in Britain, an increase of unemployment from 5 per cent in 1979 to 12 per cent in 1982 was accompanied by a slight increase of consumer expenditure, measured in constant prices (24). The US economy grew by 7.6 per cent between June 30, 1983 and June 30, 1984, but unemployment was still 7.1 per cent at the latter date (25). The more a dualistic economy and society is created, the stronger the roll-back pressure on the welfare state. The current upturn of the international business cycle is likely to produce significant dualistic effects even in societies and politics not so extreme as those of Britain and the United States. The economy is also beginning to grow again in Belgium, Canada, Denmark, and the Netherlands, but mass unemployment and the misery of the unemployed remains.

Managing a dualistic economy and society by democratic means is largely dependent, however, on the character of the political system. This is our third variable: the more elitist the political system, the easier a right-wing attack on the welfare state. One important measure of elitism is the prevailing electoral turnout. In this respect, the Western democracies currently fall into three groups (26).

1 The exclusive democracies, with an electoral turnout of about 50 per cent of eligible voters: Switzerland and the United States.

2 The reduced participation democracies, with a 70-85 per cent participation rate: the United Kingdom, Japan, the Netherlands, Finland, Denmark, Norway.

3 The full participation democracies: the remaining countries.

Elitist politics, reinforced by first-past-the-post electoral systems, mean that Thatcher and Reagan were elected into office by less than a third of the electorate.

Finally, there are policies reproducing left-wing

defeat. We began our list of variables conducive to right-wing attacks on the welfare state by indicating the fateful effects of anything less than whole-hearted commitment to full employment in the period 1975-1982. We will end it by listing a set of policies most likely to ensure the reproduction of the dominance of the right. From the point of view of the right, the policies may be read as goal targets.

1 Disunity between trade unions and the political parties representing labour. The greater the disunity, the greater the chances of a right-wing roll-back. This is partly a question of institutional structure—the extent of elitist middle-class character of the party, which is thereby starkly distinguished from the unions. The US, British, Dutch, and French cases indicate this. But it is also something that is affected by policy, as exemplified by the *Schulterschluss* between the Social Democratic Party and the unions in Germany after the eviction of the Schmidt government.

2 Concessions from a weak position in the hope of reciprocity. Givebacks of collective-bargained wages and other benefits in a weakened position are likely to produce mainly internal division and demoralisation, and unlikely to bring forth equivalent concessions from the counterpart. This tactic has been pursued by some US unions—that of the steelworkers above all—and, en masse, by the Dutch unions, seconded by the Dutch Labour Party. The main effect of this is likely to be a strengthening of the self-confidence and assertiveness of the political right and of the employers. The West German unions and Social Democrats have, after losing office, opted for another tactic, the result of which is more respect for the concerns of labour.

3 Selective social policies. There is a dilemma in social policy between general and selective policies. In order to be effective and truly general, general policies have to be high in transfer payment and in quality of services. This makes them very costly and also tends to reduce their redistributive effects. On the other hand, selective social services tend to be or become of lower quality, and selective social policies are or become very vulnerable to political attacks, since the set of beneficiaries is restricted. Therefore, the more selective (geared only to the poorest) the social transfers and social services, the more likely they are to be subject to roll-back attempts. Thus, to the extent that left-of-center parties and trade unions adopt selective social policies, e g, in the form of "basic" services and transfers plus optional superstructures, the more likely it is that the level of the "basic" provisions will become the object of attack.

4 Decentralised labour policies. The strength of the labour movement, and of the welfare coalition as a whole, rests on its numbers and its unity. To the extent that policies are adopted that are not based on those assets, the right and the anti-welfare state coalition will gain. This implies that the more collective bargaining is decentralised, and the more specificities of private and public sectors, of industrial branches, and of enterprises are opted for in the current period, the stronger will be the position of capital, and of the anti-welfare state forces.

The welfare state has become a major and irreversible (by democratic means) feature of advanced capitalist societies. The current discussion of the welfare state crisis is little more than an ideological fad, which serious researchers cannot take seriously. On the other hand, a divergence of Western welfare states is likely to take place in the foreseeable future. The failure to maintain full employment that began in 1975 is likely to have enduring effects. Further, the reactions to the earlier failures diverge. The West German labour movement seems to have learnt from its past, whereas in the Netherlands, for example, we see strong left-of-center forces heading for further defeats. However, we would rather end by saying that the future remains open. As political human beings, we are committed to full employment and to social security.

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Sex Determination Tests

A Survey Report

THE practice of prenatal sex determination followed by selective female foetus abortion is one of the most striking examples of how advances in science and technology are employed for the furtherance of women's oppression. Although this inhuman practice has been in existence in India for many years, it is only last year that anything like an organised and sustained mass campaign against it became a reality. While Bombay has been a principal centre of the campaign, it has now also spread to other cities, including some small towns. A concrete manifestation of this positive change has been the formation of the Forum Against Sex Determination and Sex Pre Selection.

The collective efforts of several women's groups and other voluntary organisations, spearheaded to some extent by the Forum Against Sex Determination and Sex Pre-Selection, have yielded some notable results. Two private bills concerning this issue were introduced last year—one in Parliament and the other one in he Maharashtra legislature. This goes to prove that both the Union and the state governments were forced to take note of the issue because of the growing popular protest. The bill in Parliament is yet to come up for discussion. Nevertheless, the minister of state for health and family welfare did convene a meeting in New Delhi last December to discuss the issue. The Maharashtra government formed a committee in September last to study the problem and suggest a set of corrective measures. The private member's bill in the legislature came up for discussion in the 1986 winter session at Nagpur, but the same was withdrawn following an assurance from the government that the committee was still studying the problem and that, on the completion of the study, the government would itself initiate appropriate action in the matter.

As part of its activities, the state government-appointed committee commissioned me for the Foundation for Research in Community Health (FRCH), Bombay, to conduct a short study of the prenatal sex determination tests and female foeticide in Bombay city. The study was conducted in November 1986 with the objective

a) Determining the extent of the spread of sex determination tests and female foeticide in Bombay city;

b) Finding out other related aspects of this practice; and

c) Knowing the views and perceptions of the doctors involved in this practice.

Fifty private gynecologists, chosen randomly but with a view to covering the entire city and the suburbs, were interviewed in person during the course of the study. Some of the important findings of the study were:

1 Eighty-four per cent of the gynecologists perform amniocentesis for the purpose of sex determination. These doctors together perform on an average 270 aminocentesis tests per month.

2 Some doctors have been performing aminocentesis for the past 10-12 years. But a majority of the doctors (over 85 per cent) have started performing these tests in the last five years. On the one hand, this shows that Bombay is one of the first urban centres where SD tests and female foeticide started. On the other hand, it is evident that the debate that took place in the early 80s had a significant anti-publicity effect.

3 Only very few (upto 5 per cent) of the aminocentesis tests conducted are done for the detection of genetic defects.

4 Seventy-five per cent of the doctors interviewed said that over 50 per cent of the women who come for the tests belong to the middle class, whereas 85 per cent of the doctors said they do not get women from the lower classes for SD tests.

5 It is generally believed that it is only women with four or five daughters who go in for SD tests and female foeticide. But the study showed that the proportion of women going for SD tests when they have four or more daughters is quite small and that a majority of the women coming to the SD clinics are mothers of two or three daughters. Significantly enough, 24 per cent of the doctors said that 20 per cent of their patients had only one daughter. Thus, it appears to be a growing trend among the public to go in for SD tests in the second pregnancy itself, if the first issue happens to be a girl.

6 About 30 per cent of the doctors said that in nearly 10 per cent of their cases, the women already had one or more sons when they came for SD tests. This findings explodes one more myth that only those women go for SD tests who have no sons and only daughters. This trend moreover, appears to be on the ascendancy.

7 A majority of the doctors contacted in the study see SD tests and female foeticide as a humane service to women who do not want to have any more daughters. Some doctors also fee that SD tests and selective abortion of female foetuses are a good method of promoting family planning and controlling population growth in the country.

8 Six out of the 50 doctors said that they also perform chorion villus biopsy for sex determination.

—Sanjeev Kulkarni

Isolate Apartheid Health Care

THE Anti-Apartheid Movement in Britain has been campaigning for the isolation of the racist apartheid regime in all areas—political, economic, cultural and sporting for 27 years now. It has been realised that the policies of apartheid in segregating health care in South Africa and the inaction of the authorities in the face of rampant malnutrition and preventable disease amount to state-directed genocide against the country's black majority.

Recognising this and that health is an emotive issue which effects everyone and that everyone can therefore relate to, in 1979 health workers within the Anti-Apartheid Movement joined together to form a Health Committee. The mandate was to use health as an issue to educate people about apartheid and to mobilise health workers to support the international boycott. Since then Health Committee members have researched the health situation and produced campaigning leaflets, documents and a newsletter on health in South Africa. We have travelled up and down the country speaking at meetings and mobilising people in the struggle against apartheid.

Health and Liberation our newsletter is produced quarterly and covers the latest update on health in South Africa as well as news of our campaigns in Britain.

Exchange of medical skills in knowledge between Britain, South Africa has gone on for many years. British nurses are recruited to work in South Africa, lured by the prospects of sun, sea, sand and higher wages. The need for them lies in the racist ruling that black nurses may not care for white patients. Thus whilst black nurses, unemployed are relegated to the Bantustans, white British nurses are recruited to make up the shortfall of staff for the whites-only hospitals.

Many medical students go to South Africa for three months 'elective' period as part of their training and many doctors go to work there for short periods. These people are attracted by the regime's publicity that pathology can be seen in South Africa at a more advanced stage than elsewhere in the world. This is true, but it shows the true callousness of the regime that it can use the misery of the nation's black majority—created by their denial of facilities for the prevention and early detection of disease—as a way of attracting people to break the international boycott and make up the shortfall in doctors which has arisen through the denial of adequate places for training African people as doctors. To all these groups of health workers we have directed specific campaigns not to go to South Africa to work or on lecture tours.

Our international work to gain the expulsion of South Africa from international medical bodies began in 1981 when the Medical Association of South Africa (MASA) applied to be readmitted to the World Medical Association. A major international campaign was conducted with extensive briefing documents circulated covering the medical treatment of Steve biko and the inability of MASA to address itself to the collaboration of doctors with the security police and the inequalities in and fundamental issues behind health care in South Africa. International opinion was mobilised against MASA. The campaign culminated with MASA's readmission solely on the basis of the voting system which is loaded towards the United States. However all the African countries resigned, the WMA lost its consultative status with the WHO and in 1983 the British Medical Association withdrew. The WMA was thus left as an impotent and unrepresentative body.

A similar campaign was conducted at the International Planned Parenthood Federation which ended with South Africa's resignation in July 1986, and currently we are campaigning for South Africa's expulsion from the World Psychiatric Association and the International Dental Federation.

Another important facet of the struggle against apartheid is direct material solidarity with the liberation movements. With this in mind we established the Medical Aid Campaign for Southern Africa to collect money for medical supplies for the ANC and SWAPO. We have sent a large amounts of books and drugs to the ANC hospital in Tanzania at the Solomon Mahlangu Freedom College and to their clinics in Zambia and Angola.

Over the coming few years, the struggle in South Africa will be reaching its most crucial stage and with this comes an ever more urgent need for concerted international action to gain the total isolation of the apartheid regime and the final victory against the forces of racial and national oppression in South Africa. Health workers throughout the world must unite with this goal to contribute in a small way to the final victory.

Rachel Jewkes
Secretary AAM Health Committee

Towards Rational Therapy

THE Prescription Guidance and Information Services (PGIS) of LOCOST is an educational effort to promote awareness about the correct use of medicines. PGIS is therefore for the benefit of both prescribers as well as patients. Two main aspects of PGIS being proposed are:

(1) Information dissemination to doctors who write prescriptions and
(2) Guidance to the patients regarding the correctness and use of medicines prescribed in a particular condition.

The objective here, is to help the patient, the end user of medicines to know the correctness of the medicines prescribed. the PGIS will give comments on following aspects of prescription: correct medicine for a particular diagnosis, adequacy of the treatment, the uselessness or harmful effects of any medicine, the side-effects of the medicines required, the dosage, alternatives available both in terms of cost, quality and nature of medicines, etc. Wherever possible, other aspects of the therapy will also be explained. This will

help the patient by developing an understanding regarding the treatment given to him/her. This will also equip the patient and relatives or friends to question and to ask for more information from prescribers in future. Thus the ultimate aim is to build up consumer awareness and initiative to bring about a change towards more rational therapy.

LOCOST is aware of the limitations of PGIS: Personal examination of the patient may not be feasible, the scope of PGIS may not cover all diagnostic situations as also the fact that a large number of 'successful' treatments may not be touched, and so on and so forth. The service may not be useful for the patient as it will take at least 10-15 days to give a balanced view on the prescription. However, queries by doctors for information can be attended to faster. LOCOST is keen on not encouraging legal battles between the patient and the doctor. PGIS is a beginning, a collective effort to facilitate awareness, education and action. Action towards more rational therapy and towards conserving scarce resources of patients as well as that of the community.

LOCOST is also prepared to facilitate prescription medical audits of hospitals, dispensaries and community health projects, if so requested. You may be a like minded doctor, a patient or a person simply interested in social change. Contact: *Prescription Guidance and Information Service (PGIS)*LOCOST, Ist Floor, Premanand Sahitya Sabha Hall, Opp. Lakadi Pool, Dandia Bazar, Baroda 390 001.

Miracles and Profits in Sickness

A NURSE who focussed a small research project for a post-graduate university course on a private food allergy clinic managed to achieve a relatively high mark from the tutors involved, and it was also considered worthy of publication in a scholarly journal. To her amazement the doctor whose clinic had been studied objected to the publication, not because of any feared damage to his professional reputation, but because of certain implications seen behind the student's work—especially the open discussion of the sordid subject of money.

There are a number of diseases where medical science has not discovered or developed a method of entirely halting their progress and treatment is limited to controlling or alleviating the symptoms, but not the spread of the disease itself. These conditions typically attract imaginative mirage "cures" which are difficult to get, expensive, or both. The cure is often proclaimed as some commonplace naturally occurring substance—igonred by modern western technology—which, according to anecdotal claims, has been used for years in a remote part of the world. Sometimes the product or treatment method is a secret which cannot be disclosed to the general public, but you can always buy bits of the magic. Whatever the story, evaluation by independent scientific workers will prove fraught with snares and delusions.

If some unfortunate person whose name has publicity value falls ill, (s)he may be treated with the remedy and live happily ever after. Recently a former pop singer, hitherto not widely known but nonetheless of some public interest, fell ill; and her symptoms were attributed to multiple allergies. Personal friends and a sympathetic section of the public expended much good will, time and effort in what appeared to be a good cause. The patient was flown to Dallas, USA, to Dr Rea's Environmental Unit, but her luck did not continue; voluntary funds of sympathisers at home dried up and she was not shown returning home in triumph. She returned as she had left—on a stretcher with an oxygen mask attached to her face, as she inhaled the only unpolluted vapour she could tolerate.

It has been said that "A fool and his or her money are easily parted"; sadly many patients would seem to be fools, if judged by the large sums of money they seem willing to pay for treatment of very doubtful value. Maybe it doesn't matter what treatment patients have if their belief in it is enough to effect a cure, but the long-term consequences of 'miracles' have also to be considered.

What happens when the dream fades, when the symptoms return or new ones come in their place? The despair and frustration must be magnified, as the patient has once again to struggle with a handicapped identity. Having attended an unorthodox clinic the patient may not only be financially broke but, more difficult to repair, psychologically damaged by the disappointed dreams offered by modern medical messiahs.

It costs a lot of money to run private clinics, and to pay attractive salaries to people who remove themselves from incremental ladders in the NHS, and need financial incentives to get involved in work that is of doubtful validity within scientic medicine. It is not difficult to find private practitioners from various disciplines who will quite readily remove NHS equipment and surgical supplies to "get their clinic started." When they are challenged about this exploitation of the health service, one is reminded that the patients who attend the private clinic cannot be treated by orthodox methods and as they are paying their NHS contributions it is all OK. While a hospital porter may get taken to court for removing flowers from a tip outside the hospital, the consultant who sends a junior nurse down to surgical stores to collect an expensive piece of equipment is able with impunity to 'transfer' the hospital instruments to the private clinic and reap the benefits from the fee-paying customers.

Doctors and nurses who work in private clinics using untested methods which are either innocuous or dangerous, are prostituting themselves by capitalising on the dignity and prestige afforded by their medical or nursing qualifications. It is indefensible to take advantage of the trust patients place in health care practitioners, and to make financial gain out of their vulnerability.

—Virginia Scott

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Towards a Left Critique of New Drug Policy

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The long awaited new drug policy has prompted this piece so that RJH-readers may get some systematic idea about this issue, especially its economico-political aspect, albeit in a summary form. For a detailed treatment of the basic issues involved in the drug policy, readers may refer to some of the sources at the end. A special issue on Pharmaceuticals and Health is being planned in December, 1987 and will carry a substantial left analysis of issues in drug policy.

THE NDP represents a typical example of the 'new' thinking in the ruling class circle and the new method of functioning. First about the latter. A lot of show was made about consulting various experts and of giving a hearing even to the representatives of the All India Drug Action Network. (AIDAN). But all this facade meant nothing in practical terms; or perhaps the drug industry used 'tonic-M' much more liberally this time. The NDP was suddenly announced in a hurriedly convened press conference; bypassing the Parliament. The 'policy' consisted of only a breif statement amounting to about 1500 words—That's all!! When a lack of a detailed draft was criticised by all analysts, the government came out with a somewhat detailed 19-page announcement. When one reads this pamphlet a little carefully, it is clear that it was written *after* the 'policy' was announced. The press statement of the December 18, 1986 was not a summary of a policy document since no such document was ready the then.

For example, the press statement of December 18 says that. "A National Drug and Pharmaceutical Authority will be created. This authority will be an apex body which will have representation from all the concerned agencies including those from the industry. Among other things, it would go into the question of rationalisation of existing fomulations in the market including the banning of formulations of harmful nature. . ." When one looks for an elaboration of this point in the detailed policy announcement, to one's utter dismay and shock there is not even a mention of "representation from all the concerned agencies" nor of "banning the formulations of harmful nature"!! To release a brief statement to the press and then to prepare the main text is a mockery of the norms of even bourgeois democracy. The deletion of these to small concessions (announced in the press statement,) given to the movement for a Rational Drug Policy was perhaps on account of bowing to the pressure exerted by the drug industry to scrap these concessions. To silently drop certain measures already announced is shocking indeed.

The earlier policy of 1978 was based on the report of the famous Hathi Committee which had at least a few Members of Parliament (though there were no representatives of the concerned trade unions and of consumers.) The policy-making was done this time entirely by bureaucrats and technocrats. The Drug Consultative Committee of the Parliament was not involved. The content of this NDP is therefore as bad as its flimsy form. None of the issues central to the Drug Policy have been seriously considered except the ones related to profits and production increase. All the important issues have been adequately highlighted by different science and health groups, some of which were dealt with by the famous Hathi Committee more than a decade back. Instead of making progress beyond the Hathi Committee there has been a regression right from the basic stage. It is, therefore, not much of a surprise that the content of the policy is also reactionary.

Freer Hand to Multinational Companies

The drug industry in India in under the domination of the MNCs. The various ill-effects of these MNCs have been adequately proved by different studies—commercial exploitation of Indian consumers through transfer-pricing; huge outflow of capital through repatriation of profits in different forms, drain on the foreign-exchange account; huge social waste on account of extravagant selling expenses, disinformation of doctors, insistence on brand-names, production of irrational and hazardous drugs when the same drugs are not allowed in their parent country, etc. It is because of these ill-effects that the Hathi committee had recommended nationalisation of these MNCs. The Hathi committee's recommendation did not include confiscation (i e, nationalisation without compensation) or worker's control along with nationalisaton. But even this radical bourgeois recommendation was not accepted by the Indira government.

The New Drug Policy has on the contrary given further concessions to the MNCs. "For the production new bulk drugs, and drugs produced for exports, there will not be any restrictions on the MNCs, even though it is well known that MNCs tend to import penultimate products from their parent-companies at extravagant prices and hence are responsible for a drain on the Indian economy even for foreign exchange account. Production of penicillin, amoxycillin, cephalexin etc, has also been completely decontrolled except for FERA companies." But the hitch is, there are now only 3 FERA companies; the rest of the MNCs have now become 'Indian' because they have diluted their foreign-equity to less than 40 per cent as per the FERA. Out of these eight a further six have announced their intention to dilute their foreign-equity to less than 40 per cent, so that like in other ex-FERA companies, the foreign share-holders would continue to take all the policy-decisions but the company would now be legally counted as Indian. Thus a couple of restrictions applicable to the FERA companies would now be applicable to only two companies. There has been a demand to put all the ex-FERA companies is a separate category and not to treat them on par with the rest of the Indian companies. But under Rajiv Gandhi's leadership, such a demand has not been accepted. Self-reliance is no more a serious slogan.

Increased Rates of Profit

Under the New Drug Policy, the drugs have been recategorised as category I and II. Category I would consist of those drugs which are required for various national health-programmes; and category II would consist of 'other essential has not been published. The whole aim of this exercise is to reduce the total number of drugs under price control. Only those drugs belonging to these two categories would be under price control. The prices of the rest would be 'monitored'; but they would be out of the price control basket. Going by the list prepared by the National Drugs and Pharmaceutical Development Council (NDPDC), three years back, this list of "essential drugs" would consist of around one hundred drugs, instead of the required number of around two hundred. Today, about 360 bulk drugs are under price control; the majority of these would now join the category of decontrolled drugs.

Even those which would continue to be under price control, would fetch a higher profit-rate than hitherto. According to the Drug Price Control Order (DPCO) of 1979, category I consisted of life-saving drugs which were allowed a 40 per cent 'mark-up;' category II consisted of 'essential but not life-saving' drugs with a permissible mark-up of 55 per cent and category III consisted of 'useful drugs, new drugs' with a 100 per cent mark-up. The rest, mainly consisting largely of quite useless drugs could earn unlimited profits. The NDP has now two categories with a "Maximum Allowable Post-manufacturing Expenses" (MAPE) a new term for 'mark-up'—prescribed as 75 per cent and 100 per cent respectively for these two categories. (Readers may note that 'mark-up' or MAPE includes manufacturer's profit plus costs and profits of transport, and sale.) This hike in mark-up would cause a price-rise in life-saving and other essential drugs in these two categories by 12 per cent to 25 per cent according to the government's own admission. Many essential drugs are not going to be included in these new categories I and II and hence would be decontrolled. Their prices would increase 'as much as the market can bear'. As a result the prices of essential drugs would rise much more than this official estimate. According to the Secretary of the Indian Medical Association, which is otherwise a conservative body, the drug prices would rise by 60 to 300 per cent.

Unnecessary Price-rise

Many of the leading national dailies have refrained from criticising head-on this increase in mark-up. Many of them have called it as a 'sensible' step. If one takes the arguments of the drug industry, uncritically, this step appears sensible indeed. But this increased mark-up and consequent price-rise in unjustified on three accounts:

a) The drug industry argues that the earlier mark-up of 40 per cent and 55 per cent was 'unremunerative' This assumes that the cost-price as given by the drug industry is not fictitious. The cost calculations furnished by the industry to the Bureau of Industrial Costs and Prices (BICP) are considered as trade-secrets and are not available for scrutiny by any other public body. Let these figures be published and be verified by other experts in the field. The study quoted by industry sources to show that the earlier mark-up was not remunerative was done by the National Council of Applied Economic Research (NCEAR) but was funded by the drug industry. Let there be an independent study by a public body to determine the real costs of manufacturing. It is only then the question whether the existing mark-up is genuinely inadequate can be meaningfully discussed.

b) It is true that the wholesaler stockist claims 8 per cent of the selling price as his commission and the retailer a minimum of 11 per cent. These selling costs are in addition to transport and sales-promotion costs. This leaves comparatively limited profits for the manufacturers when the mark-up is 40 per cent (i e, when the selling price is to be upto 40 per cent higher than the manufacturing costs. This calculation, it may be noted, assumes that the manufacturing costs have not been fictitiously jacked up.) If this is the situation, the real solution in order to increase manufacturing profits is to reduce the costs and profits of distribution and marketing. The wholesaler's margin should be reduced to 3 per cent as in the case of other sectors. Secondly, the promotional expenses can be drastically reduced. Giving free samples, gifts to doctors, dinners after 'scientific seminars', etc, etc, are huge social-wastes which need to be stopped. But the Indian state is not in a position today to control the profiteering of even a section of the commercial bourgeoisie (the stockists). That is their problem. The left should ask why should the people pay the price for the timidity of the Indian state? Similarly, high-promotional expenses are "necessary" for monopoly capitalism, but the left has to ask—" why should the people pay for these necessities of monopoly forms of competition'? In case of the MNCs, these promotional expenses were as much as 33 per cent of the costs as per the data collected by the Lovraj Kumar Committee.

c) Today drugs are costly because they are available mostly in the form of drug combinations. Most of these drug combinations consist of an essential drug and one or more unnecessary or useless or even harmful ingredients. For example, popular analgesic brands like Aspro, Anacin, Powerin etc, etc, consist of aspirin as the essential ingredient and in addition one or two unnecessary ingredients. The price of aspirin is 3 to 5 paise, whereas that of these irrational brands two to four times as much! AIDAN has, therefore, demanded that all such irrational drug combinations should be banned and that only rational, essential drugs be made available under generic names only. If there is a sufficiently strong movement which makes the government accept this demand, then prices of a overwhelming majority of drugs would be drastically reduced. (Prices of single-ingredient drugs will not be reduced much.) A rise in mark-up if, and to an extent genuinely necessary, can be allowed only if this above demand is accepted. In such a case, the price of aspirin would be increased by one or two paise but since there would no more be any costlier irrational brands (Aspro, Anacin etc.) available at all, the consumer's expenses on analgesics would still be much less. This demand of AIDAN has no been accepted by the government because the movement is not strong enough.

This demand is not a socialist demand in itself since it does not question the very existence of the capitalists in the drug industry. All it says is that "you earn a reasonable rate of profit by selling really useful drugs and not a lot of junk in addition." The World Health Organisation and other such

non-socialist bodies have also been advocating the sale of only rational, essential drugs under generic names. The problem is, the people's movement, the health movement is not strong enough today to force the government to discipline and control the parasitic, antiquated interests like those of the stockists, or the monopoly-interests in the drug industry. Though monopoly capital as a whole is in the dominant position in India, a control over their reckless profiteering *in one sector* is possible even within bourgeois bounds if the people's movement is strong enough. This has been achieved to a certain extent in Bangladesh due to the combination of public pressure, historical accident and populist initiative by the government. A similar thing can happen in India also.

Delicensing and Indigenisation

According to the industry, licensing means a lot of unnecessary beaurocratic interference (which also breeds corruption) with the "freedom of enterprise". But this is an antiquated, 19th century thinking. That "free-market economy" leads to repeated small and big crises which are too painful for the people and hence inconvenient to the capitalist class as a whole and therefore, capitalism needs to be regulated at least to a certain extent has been proved in theory and in practice over and over again the world over. It is true that some of the licensing procedures and other governmental regulations are too cumbersome today and they also create another parasitic layer of administrative beaurocracy which sometimes harasses the individual capitalists or other citizens for its own corrupt interests. Thus a regulatory mechanism which has evolved historically to smoothen to a certain extent, the anarchic function of capitalism is not doing its job properly.

The solution to this is not to abolish the regulatory mechanism itself; but to simplify it, to make it more efficient and functional. But under Rajiv Gandhi's leadership, there is not even a concern for overall planning in the interests of the capitalist class as whole. The new 'modern' policy-makers have been yielding in an *ad-hoc* manner to the purely sectional interests of the Indian and foreign monopolists or sometimes to the purely sectional interests of other sections of the capitalist class. This is at the expenses of the working-masses and also at the expense of the long-term interests of the Indian capitalist class as a whole. The policy of delicensing in the drug-industry by the Rajiv-regime is a case in point.

Before the announcement of the NDP, the Rajiv regime had delicensed 82 drugs which means any company can produce any of these 82 drugs to any extent without prior permission of the government. Now according to the NDP, this policy is to be 'progressively extended'. The reasons given for this policy are: to remove unnecessary hurdles in the way of the industry, so that there will be abundant production of those drugs which are in short-supply. But in reality the consequences would be quite different:

a) Many of the essential drugs have been in short-supply today not because of the licensing system (a few exceptions apart) but because they were under price-controls. The drug industry could get a much more higher rate of profit in the production of decontrolled drugs and hence it concentrated its efforts on the production of these high-profit though mostly useless drugs. Of the 94 drugs delicensed, 75 so far (even before the announcement of the NDP) have been open for all sectors for production. But the MNCs and big companies by and large neglected their production. In the NDP, except for about a hundred drugs, all the rest would have no price-controls and hence the drug industry would continue to neglect these 100-odd priority essential drugs and would continue to concentrate on the rest. The shortages of priority essential drugs would continue so long as the non-essential, useless, irrational drugs are allowed to be produced and moreover are allowed higher-profit rates.

In case of certain essential drugs the existing capacities are today underutilised because the drug-companies have not been interested in a 40 per cent or 55 per cent mark-up. But now that the mark-up on these drugs has been increased to 75 per cent and 100 per cent, the drug-companies may now fully use their existing capacities. In the short-run therefore, there may be increased production of some of the essential drugs. This should not be interpreted as "success of the delicensing policy". In the long run, newer capacities would be developed for the decontrolled drugs more than those for the priority essential drugs.

b) Whatever limited planning that exists in capitalism requires that the planning authorities can intervene to stop/reduce or encourage the production of certain drugs or to intervene to balance the growth of different types of companies in different areas. Delicensing would mean the drug production would be entirely left to the chaotic market forces. The government would not be able to do anything about it, nor would it be able to threaten the monopoly companies with the stick of the licensing authority if these companies indulge even in brazen malpractices to fleece the consumers.

Delicensing would not be applicable to FERA and MRTP companies. But now legally there would be only two FERA companies and only a couple of Indian drug companies would be counted as MRTP companies since now the limit for inclusion in the MRTP list has been raised to Rs 100 crore by the Rajiv-regime.

The deleterious impact of delicensing can be congertly visualised since 12 drugs in March, 1983 and 82 more in June, 1985 have already been delicensed. As a result, a number of monopoly companies have registered capacities for production of many delicensed drugs in quantities which are 3 to 10 times the targets for the seventh Five Year Plan! Generally, most of these capacities are not utilised by the MNCs. Registrations are made primarily to preempt competition! For example, Duphar Interfram had 39 registrations in 1980-81; but utilised only 18 of these; in 1984, it acquired eight registrations but used none of these. The government cannot do anything about the chaos thus produced.

The ex-FERA companies would now more easily push out other companies and this would, amongst other things, push up the import-content of drug-production in India. A study of production of 8 drugs by MNCs after delicensing has shown that the import of these drugs has increased substantially. For example, Boots produced 20 tonnes of Ibuprofen and imported 4 tonnes in 1980-81, whereas by 1984-85, the imports of this drug by Boots increased to 62 tonnes but indigenous production by Boots increased to only 51 tonnes.

Delicensing would, therefore, lead to a further control by

the monopolies over the Indian drug industry and a further chaos with all the ill-effects for the people as well as for the balanced development of the Indian capitalist class as a whole.

Probably in order to stave off criticism on the forecasted increased import of drugs due to further delicensing the government has announced in the NDP, a scheme if 'indigenisation'. The NDP lays down that in cases where the import content of a product is more than 20 per cent, the drug companies would be required to submit an annual plan of how its production is going to be indigenised. This is a very loose formulation. Suppose, a foreign company unnecessarily imports, say codene, and prepares a costly, irrational cough mixture by adding a number of unnecessary ingredients to it so much so that the imported essential ingredient comes to less than 20 per cent of the total cost then, this new restriction of 'indigenisation' would not be applicable to this product. Thus vital, essential ingredients can continue to be imported in large guantities. Secondly, there is no time-limit given for 'indigenisation' nor any punishment specified if the companies do not observe in practice the plan of 'indigenisation'.

What is in fact needed, and is technically, definitely possible, given the developed technical capacity of the drug-industry in India, is more or less a complete indigenisation in say three-five years and rapid, drastic reduction in the current rising drug-imports (Rs 198 crore in 1984-85!) Sudip Chaudhury (see references) amongst others, in his detailed study, has shown that this is technically very much possible. The Indian state, because of its class-character is not able to take this step even today. On the contrary, during the last five-six years (even before the Rajiv regime), it has been forced to give more and more leeway to MNCs. The NDP is yet another example that Rajiv Gandhi's leadership has considerably accelerated this proces.

Broad banding

This is another measure to "remove the unnecessary hurdles in the growth of the industry." Broad-banding means that if a drug-company gets a permission for the production of penicillin, then now it can produce all types of penicillins and chemically related analogues like ampicillins and the like. The companies would not be required to take separate permission from the drug controller for a new formulation once the basic type has been allowed. If such broad-banding is done for single-ingredient bulk drug only, then it is a sensible step within the chaotic capitalist economy because companies can produce in the same plant, chemically related products in changing quantities depending upon orders they receive without asking for a licence each and every time. This can enable them to fully utilise the production-capacities they have built.

But the NDP allows broad-banding of formulations also. This means that if a company has a licence to produce a mixture of say three types of analgesics or vitamins, it can change their proportion or change a bit the chemical structure of one or more of its ingredients and sell the 'new' product under a new brand name. Earlier, the companies had, at least, to undergo the formality of applying and getting a permission. Now there will be a totally uncontrolled growth of all sorts of irrational drug-combinations sold under a range of newer brand-names. It would become more or less impossible to monitor the prices of the new formulations in order to check price-rise. Monitoring the quality of drugs would also be a mammoth task for the government since it is impossible to check the ingredients qualitatively and quantitatively if we have over 50-60,000 formulations.

Quality Control

The NDP seeks to make Good Manufacturing Practices a statutory requirement. This was quite an overdue step. But the problem is, there is no mention of qualitatively improving and strengthening the existing too weak, too ineffective and corrupt drug-regulatory authority. The statutory requirements would, therefore, remain on paper.

The NDP is to make a compulsory certification system for quality-control from 'recognised institutions'. This means, now there will be specified institutions for this purpose. Whether such institutions would be private or public has not been mentioned. Going by the Rajiv regime's trend towards privatisation, it is likely that privatisation will take place here also. The data with private laboratories is considered trade-secrets and generally it is impossible to get these data to find out whether a particular private company has been doing its job honestly or whether like the notorious Chemical Labs involved in the JJ Hospital death-scandal, the private laboratory is giving false reports. Though many public authorities tend to be as secretive, public laboratories can be more accountable with increased public pressure. In case of private laboratories, it is their constitutional bourgeois right to keep their trade-secrets confidential.

The government does not want to spend money on increasing the number of public laboratories upto the required number whereas it is willing to squander money on all types of useless or anti-people projects. Hence the move towards privatisation. This must be stoutly opposed. At the same time, as a measure of rational utilisation of existing resources, public bodies like laboratories in research-institutions, universities, etc, can be entrusted to a certain extent, this task by fortifying these facility-centres with the needed extra equipments and personnel. This would obviate to a certain extent the need to build new facility-centres from scratch. Whether the existing system can do this is a moot point even if socially, it is quite a viable propositon.

Medical Issues

Health and science groups in India have identified the following key-issues from a medical aspect as part of a rational drug policy; none of which find a place in the NDP.

i) Preparation of a priority essential drug-list and a comprehensive rational drug list for India. Production of drugs to take place in accordance with only these lists and no other.

ii) To assess quantitatively the drug needs of the Indian people on the basis of a study of prevalence of the disease-pattern in the country and to plan the production accordingly.

iii) To completely and immediately ban all the irrational and hazardous drugs. Only drugs as specified in (i) to be allowed.

iv) Complete abolition of brand-names and replacing them

with generic names, with the company's name in the brackets; for example, "Penicillin-V (Alembic)".

v) Stopping the 'disinformation' of doctors and consumers by drug companies. Continous compulsory reeducation of doctors and relevant education of consumers by state medical authorities.

vi) Strict check on the unethical marketing practices by the drug companies; a ban on incentive-schemes and on giving samples and gifts to doctors by drug companies.

vii) Adequate supply of drugs free of charge to poor people through the government set up. Rational utilisation of the existing budget and increasing it rapidly to the adequate level.

vii) To stop the continuing colonial heritage of step-motherly treatment being given to the non-allopathic systems of medicine; to encourage research in these systems with financial and other support. At the same time to disallow the commercial production of any drug by any company unless it is accepted as scientifically proved (effective and safe) by appropriate bodies. Encouragement to ayurveda does not meant that Richardson-Hindustan be allowed to avoid taxation or to get other concessions by naming its Vicks Vaporub as herbal medicine! To enact that medical practitioners would use only those medicines or therapies in which they have been adequately trained by recognised institutions.

The NDP talks about only the standardisation of non-allopathic drugs and preparation of standard formulary for non-allopathic systems of medicine. There is no serious research policy nor any attempt to curb production of irrational (may be hazardous also) medicines under the name of ayurveda of the misuse of these medicines.

ix) All medical research on human beings must be statutorily required to confirm to the 1975 Helsinki (Mark II) Declaration. This should be strictly followed in case of contraceptive research also.

None of these medical demands have been accepted. One may conclude that the NDP is only a pricing and 'liberalisation policy' with no concern for rationalty or people's health needs. The foregoing account shows that as an industrial policy also, it is clearly reactionary and anti-people.

Selected reference material

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3 *Issues involved in Drug Policy*, Prepared by Pondicherry Science Forum, pp 56, Price Rs 6.50, Chennai Books, 6, Thayar Sahib Street, II Lane, Madras 600 022.

4 *'Manufacturing Drugs without TNCs'*, Sudip Chaudhury, *EPW*, Vol XIX, Nos 31-33, August 1984.

5 S Singh, *Multinational Corporations and Indian Drug Industry*, Criterion Publications 1985.

Medical Officers—The 'New Middle Class'?

I WAS a little bit surprised by Sujit Das's rather sharp response (Organising doctors: a difference in approach, *RJH*, Vol I:2) to my critical comments (*SHR*, Vol II:3) on his article and my separate piece on 'Organising Doctors' in the same issue.

Das feels that my remark that his article is a "shamefaced defence of the interests of the doctors" is a rude one. The dictionary-meaning of "shamefaced" is "bashful, shy, retiring, modest. . ." and has no rude connotations.

I am not sure whether I should go into a detailed debate about the questions of terminology raised in the second paragraph of his response. Some people including Das may find it irrelevant. I would only point out that a mode of production is a relatively stable set of relationship consisting of a specific intertwining of productive forces and production relations and which reproduces itself over and over again. Petty-commodity relations by their very nature cannot constitute a mode of production (a stable, self-reproducing mode) but must disintegrate over a period of time; general practitioners would, over a period of time, more and more be replaced by hospital-owners-capitalist doctors on the one hand, and the wage-earning doctors on the other hand.

Now about the central issues: The main difference in approach according to Das is:-

1) "Phadke wants to organise doctors towards the end of fulfilling the tasks set by his own lofty ideal" Das, however, believes that "such idealistic approaches have never helped".

I plead guilty to his first charge; I would only hasten to add that the "lofty ideal" is not my personal invention. All those who believe in scientific socialism from the point of view of human liberation believe in a "lofty ideal" of a revolutinary charge. His second charge is however, a little off the mark. I have not taken any idealist approach. I have started with a "materialist analysis of position of doctors", and have then tried to point out the contradictory class-location of medical officers—medical officers being one important layer within the category of wage-earning doctors. Based on this materialist dialectical analysis, I have questioned the existing strategy of organising this new middle class "*mainly* on the basis of their trade-union demands" (emphasis added).

2) Das disagrees with my critical attitude towards doctors: It is, of course, true that a socialist health system cannot be run without doctors. But it is also true that a revolutionary socialist transformation in the medical system cannot be *initiated* by a new middle class organised mainly on trade union demands. Such a change can only come (as a part of a broader revolutionary transformation) through revolutionary coalition within and outside the health system in which medical officers as a *social layer* may or may not participate. It should be the attempt of marxists to bring at least a section of this new middle class to the side of the revolutionary programme; and my contention is that this cannot be done by organising them mainly on their trade union demands. Upholding the interests of medical officers as wage-earning health-workers is not enough. Scientific socialists have to be critical about their interests as officers. There has to be an independent platform clamouring for a revolutionary-change in the 'health-system'. Such a platform will take a dialectical approach to the contradictory interests of medical officers. It is not necessary that the majority of the new middle-class comes to the side of the revolutionary programme. There is a more numerous other section of doctors (junior doctors) and much more numerous paramedics who are more likely to come to the side of a revolutionary programme in the field of health. Those medical officers who do not join such a platform today will have to accept and implement after the revolution, the programme chalked out by this platform. Das, however, disagrees basically with my characterisation of the medical officers as part of the new middle class. For two reasons—the first reason is rooted in his misunderstanding of the concept of the new middle class. I have explained my understanding of this term at some length in my note '(Organising Doctors; Towards What End?)' and it should be clear to anyone that I have not 'adopted this formulation' of identifying "the highly skilled wage-earners of advanced capitalist society as new middle class." For me, their position as new middle class is not due to their "skills" but derives from their role as officers. Das's second reason is that "by no stretch of imagination could India be labelled as an advanced capitalist society;" and the new middle class is a product of advanced capitalist society. India is, of course, not an advanced capitalist society like the West, but yet we have monopolists like Tatas and Birlas. In certain sectors, we do have signs of advanced, monopoly interests; and the new middle class (executive engineers, foremen, supervisors, medical officers all those who perform the function of the labourer as well as that of capital as officers) is very much a reality in India.

3) Das disagrees with me on empirical grounds also. ("I have not found these doctors, as a class, performing the function of capital, of supervising, extracting work from the paramedics. . .") The problem is tht Das continues to talk about "doctors in service" as a homogenous category,

whereas I have distinguished between doctors with hardly any administratively supervisory or executive function, e g, the junior doctors on the one hand, and the medical officers who have to perform these functions on the other. If one goes to any Primary Health Centre, one would immediately come across a series of executive, supervisory tasks over the work of the paramedics that the medical officer has to do. It is because of their status as 'officer' that the MOs at PHC get well-built quarters or bungalows (though no such accommodation has been built in many new PHCs;) whereas the junior doctors share one room amongst 2-4 doctors. The MOs get a salary which is higher compared to that of the junior doctors though junior doctors are many a times clinically more competent and are more overloaded with work. The MOs can be compared with the parademics also. The salary and the facilities that the medical officers have, are more than would be explained purely by their training if we compare them with the paramedics (like the ANMs). It is because of their dominant position as officers that many medical officers illegally earn money with impunity through private practice. Medical officers *as wage-earners* have many problems and that is why they have been unionising. But marxists, scientific socialists should not point out only to their problems but also must bear in mind their status as officers.

Contrary to Das's assertion, I have not 'discounted trade unionism as such', nor have I said that doctors should behave as if the world around is not commercial. I only wanted to point out the fact that Das has not given any class-characterisation of doctors though the title of his article raises this expectation and though he raised this question in the text also. Instead, the article gives an account of the problems faced by the doctors without looking at their contradictions and hence becomes a kind of a one-sided defence of the interests of doctors.

—ARS

(*Continued from page 77*)

responsibilities to serve the needs of the dominant class. Total state control is a hightened level in the process of socialisation. On the other hand, at the present moment it is obvious that total state control is not equivalent to people's control. Our conception of people's state or proletarian state has received a jolt from the experience of the socialist countries. People's participation also remain elusive without sharing in power. A rethinking is perhaps in order to conceptualise people's control in political and organisational terms.

But then it is also on observable fact that total state control or major state control, in whatever form, have brought about more equitable distribution of health care among the people. Its contribution in human values has proved to be immense.

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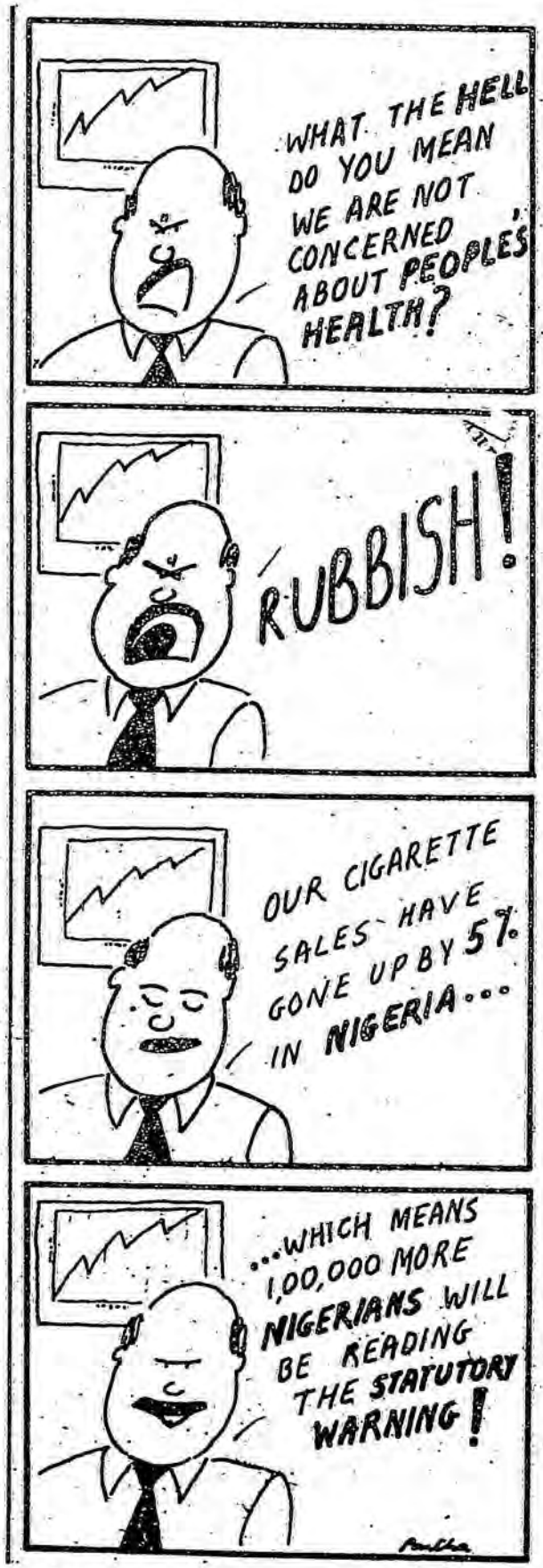
—Smarajit Jana



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"When one individual inflicts bodily injury upon another, such injury that death results, we call the deed manslaughter; when the assailant knew in advance that the injury would be fatal, we call his deed murder. But when society places hundreds of proletarians in such a position that they inevitably meet a too early and an unnatural death, one which is quite as much a death by violence as that by the sword or bullet; when it deprives thousands of the necessaries of life, places them under conditions in which they *cannot* live—forces them through the strong arm of the law, to remain in such conditions until that death ensues which is the inevitable consequence—knows that these thousands of victims must perish, and yet permits these conditions to remain, its deed is murder just as surely as the deed of the single individual; disguised, malicious murder, murder against which none can defend himself, which does not seem that it is, because no man sees the murderer, because the death of the victim seems a natural one, since the offence is more one of ommission than of commission. But murder it remains."

—Frederick Engels

(From *The Condition of the Working-Class in England,* 1892)