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.

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(*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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