radical journal of health

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Editorial Perspective

One Small Step

WITH this issue we complete four years of crowded life. As we begin a new volume we would like to share with you some of our experiences, some positive and some not so, in producing this journal. Also, we would like to collectively recollect how we began and why we launched a health quarterly at all in the first place.

As in any such venture, we too had some broad objectives in mind when we began. These objectives were evolved in response to a need many of us felt for such a platform in the context of the time. In the course of four years these objectives have themselves been re-examined — which we believe is a positive development. No journal can hope to survive without being conscious of changes in its milieu. At the same time it cannot afford to adapt itself too rapidly to every movement in its reference fabric. This creates a certain tension, the nature of which may be different for mainstream publishing and for the alternative media. *RJH* has generally been able to cope with this tension and work within it. Often some of the changes we make are mooted by pragmatism, and may not appear to further our goals. And this is why we are very much aware of the need to reflect on whatever has happened to us. This is not so much an exercise in self-criticism as a process of sharing our problems — which we are sure many other similar journals have experienced — and learning to deal with them.

In 1983 many of us independently began to feel the need for a forum for discussion and analysis of health issues from a left, marxist perspective. For one thing, since the 70s diverse groups with differing political and ideological perspectives had began to work in health as part of 'development' activities. Individuals in these groups through their work and exposure to ground realities had become sensitised and come to feel the need for a substantial radical critique of health. Also, political activists through their involvement in or exposure to health issues of working people had been forced to realise the importance of health in all its aspects to the practice of politics. Yet another factor was the emergence of the people's science movement, which although it had not at that time taken health as a major focus of its activities, had generated a sharp awareness of the need to critique establishment science including medicine.

What did we understand by a marxist approach to health and medicine ? As the editorial perspective in the first issue of the periodical pointed out, we meant an "analytical approach which takes a historical materialist and dialectical view of the health of people and the medical care system in a given social order." From this standpoint health was considered a part and consequence of economic, political and socio-cultural development of society. That is, "the problems of health and health care system reflect the problems of the dialectic of production forces and production relations and the broader social order based on it." At the same time we also acknowledged that there did not exist "one single marxist analysis — an all correct perfect line so to say of health and medicine." What the periodical hoped to do was to facilitate a continous interaction at the level of praxis amongst the different trends within the marxist movement.

However, we also agreed that there were other approaches or strands of analysis which had contributed to a radical understanding of health and health care. One such was the Illichian which locates problems not so much in the socio-economic formation as in the bureaucracy and in the centralising tendency of capitalist development, faulting rather the trends towards industrialisation and urbanisation rather than the socio-economic system that engenders it. Similarly, the women's health movement in the west had pioneered the critique of the ideological structure of health care and the medical establishment and in doing so had rewritten in many ways the history of medicine. These we felt, would contribute to the development of marxist analysis of health.

But why did we need a separate journal for fulfilling these objectives? Couldn't existing left — journals or health periodicals serve the purpose? This was indeed an important issue since we did not want to merely add to the large number of periodicals unnecessarily, and secondly, many of us though not all, had our introduction to health issues in forums such as the **medico friend circle** which published some kind of periodicals. As the first editorial made clear, while other health periodicals would always remain useful in introducing individuals to a critical perspective on health, it may not be possible for them, or even appropriate, to initiate and continue a debate with a coherent political perspective, such as a marxist one. While the richness of the interaction between ideological perspective could not be underemphasised, the development of a marxist approach to health through these journals may not be feasible. As for other left oriented journals like the ***Economic and Political Weekly***, it was felt that since they covered all aspects of the analysis of society, it would not be possible for them, nor may they be so inclined as yet, to devote space to discussions and debates on health issues.

Thus was launched with great trepidation, the first issue of the ***Socialist Health Review*** in June 1984. In that one year not only had a collective of health and political activists from various parts of the country been formed, but we had also collected a small fund to cover costs through individual donations and pre-publication subscriptions. The response certainly surprised us and after the first few issues we were quite overwhelmed — we now have very few, a dozen perhaps, of the first issue on 'Politics and Health' and a few more

of the other issues except the second one, on Women and Health, and that was because it was reprinted with the help of a donation from a friend and well-wisher.

But even then, in spite of our euphoria, we recognised that if this response indicated anything at all, it was the need for such a periodical. And also that our survival was in equal parts due to the support of our readers many of whom encouraged us in several ways by recommending ***SHR*** to others, collecting subscriptions, sending donations and most importantly, writing enthusiastic letters to us and other factors, not the least of which was our 'discovery' of our first printers, **Omega**, who shared our burden in producing the journal, not only because they were such professionals, but because of their philosophical and ideological orientation.

For the first two years, ***SHR*** had a comparatively smooth run — there were of course financial problems, 'administrative' as well, because there were so few of us wanting to do so much (!) and other day-to-day troubles. (On one occasion, the production of our issue was held up because of a transport strike, and for the moment whatever the nature of the demands of the strikers, we certainly did not feel very sympathetic!) Then came the problems in our third year.

We can't help wondering at this point if this isn't quite typical of this kind of publishing. And is there a lesson in all this? That unless the skeleton structures for functioning are formalised in the first few years, the natural decline of enthusiasm in the later years will affect the activity drastically. We did try to do this with the ***SHR***. For instance, it was decided that the topic for each of the four issues would be decided well in advance. The editorial perspective, whether written by one of the collective or a 'guest', had to be circulated nine months in advance of the issue date. This would give enough time to organise a good collection of articles on a particular theme. This is how we have been functioning more or less, until recently and we hope to revive it very soon.

There were of course, many critical comments, perhaps the most important one, after the first issue, that ***SHR*** read too much like a 'high brow' journal. That is, the articles assumed a degree of familiarity with marxist analysis which may not exist among most readers. This led to the use of marxist terminology without explanation which sounded like jargon. This was a serious problem — either we could decide that those who did not have a grounding in marxist analysis were not our target readership and so we could not cater to their needs, or, we could attempt to 'dejargonify' the articles and in fact introduce the marxist approach to social analysis through the discussions on health issues. Almost unanimously we opted for the latter. We have attempted various ways of getting over this problem by trying to use a minimum of marxist terminology without damaging the analysis, and by presenting a mix of articles, some of which were more rigorously marxist than others. (Sometimes of course, we wonder if we have fallen between two stools because we receive our share of criticism on this count from both groups.)

Together with other problems, we discovered that for some reason we could not register the journal under its name. Of all the near-***SHR*** names we proposed, we were allowed to use the ***Radical Journal of Health.*** In January 1986, at a meeting of the collective, it was decided to set up a trust, which happily we could name the **Socialist Health Review Trust** to undertake the publication of ***RJH*** as one of its activities. We also decided to collect a corpus fund, introduce a life subscription and raise our subscription rate marginally. So far we had been subsidising the journal through donations collected in the first year or so but we could no longer do so. Moreover, this was also the time when **Omega** ran into a variety of problems and could no longer print ***RJH***, which meant that our cost of production would also go up. Fortunately we found friends again, in the shape of **Bharat Printers,** Bombay and the ***Economic and Political Weekly*** who undertook to print the periodical and typeset the matter and produce layouts respectively painstakingly, at reasonable cost, bearing with all our now haphazard time schedules. With this issue the journal is now back with **Omega** and may this be the last word on the subject!

The journal has touched upon a variety of issues some of these have become the focus of debate. But others which had been consciously raised with a view to generate discussion, such as the issue of the socio-economic roots of the prevailing practice of witch hunting in tribal region of Maharashtra, failed to elicit much response. We have come to realise that the 'objective conditions' have to be right even for initiating debates — they need to be live and day-to-day concerns. While theoretical issues do get a response the debate does not continue for very long. This may also be due to the fact that academic interest in health issues may be of recent origin in India.

To any retrospective reader it may appear that the ***RJH*** has glossed over three health issues which have been very much the focus of public attention in the years of our existence : pharmaceuticals, the Bhopal disaster and the campaign against amniocentesis and sex determination techniques. Although we did carry a couple of articles on Bhopal, we have not had a sustained focus on it. Similarly, while the ***RJH*** has published reports and discussion pieces on pharmaceuticals, it is only in our last volume that we have carried substantive articles on the drug policy or for that matter an entire issue on pharmaceuticals. We have done a little better on the amniocentesis campaign our very second issue carried an article on the topic and a recent number did as well; but nevertheless, we did not in a major way, contribute to the ongoing struggle to obtain a ban on the technique. Perhaps this needs an explanation of sorts.

Early on, it was felt that we did not need to publis'something' on every issue, unless we had something to say (

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25. Opinion and correspondence in "Watchdog" column in *Cape Times* March 20, 1985; March 26, 1985; April 2, 1985; April 9, 1985. The law permits new schemes to spend a maximum of 14 percent on administration, and established schemes, a maximum of 10 percent.

26. Navarro V. Commentary : The public/private mix in the funding and delivery of health services : An international survey. *Am. J.Public Health*, 1985; 75: pp1318-1320.

27. Barney Hurwitz, past chairman of the Representative Association of Private Hospitals, commented that there was probably as much overcharging as undercharging given the complicated billing system. "Killing off the paymaster." *Financial Mail* November 29, 1985, p 37.

28. 'Take them off the drip.' *Financial Mail* June 7, 1985, p 31.

29. 1985 *Hospital and Nursing Yearbook for Sourthern Africa*. Cape Town: H. Engelhardt and Co., 1985, p155.

30. Barney Hurwitz, managing director of Clinic Holdings, quoted in 'Take them off the drip'. *Financial Mail* June 7, 1985,p 32.

31. Rand Mines Corporation Health Department. *Annual Medical Report* for 1984 p 15.

32. Watt J M, Derzon R A, Renn S C, Schramm C J, Hahn J S, Pillari G D. the comparative economic performance of investor-owned chain and not-for-profit hospitals. *N.Engl. J.Med.* 1986; 314 pp 89-96.:

33. *See e.g. essays in McLachlan G & Maynard A. The Public / Private Mix For Health: The relevance and effects of change.* London : Nuffield Provincial Hospitals Trust, 1982.

34. 'Doctors win when it comes to fees'. *Cape Times* February 26, 1986.

35. 'Taking them off the drip'. *Financial Mail* June 7, 1985, p31.

36. De Villiers Commission of Inquiry into private hospitals and unattached operating theatre units in the Republic of South Africa, 1974. Cited in Thomson E. The private hospital industry in the greater Cape Town area. *S. Afr. Med J.* 1984; 66 : p19.

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41. 'Killing of the paymaster' *Financial Mail* November 29, 1985 , pp 36.

42. 'Medical aid near collapse'. *Cape Times* July 7, 1985.

43. *Financial Mail* November 29, 1985, op.cit. pp 37

Continued from page no. 2)

other than what was already being written about. We were in no competition with fraternal journals which were focussing on these issues. And most of the ongoing debate on the three issues, whether in the mainstream or in the alternative press were themselves major contributions to the radical critique of health. There was another perhaps more important reason. For all of us on the collective the ***RJH*** was the second or third area of activity. That is all of us at different levels with different groups were already very much involved with these issues. The other forums, such as the **medico friend circle, the All India Drug Action Network, The Health Services Association and the West Bengal Drug Action Forum, Kishore Bharati,** women's groups and others, were putting in a tremendous effort to generate a public debate on critical problems in these areas. By tacit consent we decided to put our energies into these for a rather than in brin out substantial material in the ***RJH.***

What now? Do we still feel that the journal can fulfill a need? Have we contributed to the development of a marxist debate on health care? Certainly things have changed much since we began. For one thing the last four years have seen an upswing in the interest in and awareness of health issues. Interestingly the three issues we mentioned above have been both a cause and consequence of the changing situation. During this period we have also seen a large number of health periodicals, some occasional, some regular, emerge. Also, publications encompassing a broader canvass of social analyses have begun to devote more space to health issues.

We do not attempt here to answer these questions. Because we really have no means of evaluating the ***RJH*** qualitatively. We invite you, our readers new and old, to give us your feedback. Because after all the whole point in starting this journal was so that it could provide a forum for participating in the evolution of a radical, marxist critique of health. In the meanwhile we will continue to do our bit as best as we can.

So here comes a fifth year of ***RJH!***

Padma Prakash

Health Care Beyond Apartheid

Economic Issues in Reorganisation of South Africa's Health Services

max price

The consequences of apartheid for health policy in South Africa are profound. Racial differences in health status and the allocation of health care reflect the inequalities of power and wealth produced by the political economy of apartheid. Furthermore, health policy is itself instrumental in furthering apartheid goals. It might be tempting then, to rely on the demise of apartheid and subsequent democratic redistribution of power and wealth to redress the fundamental inequalities in the provision of health care. Yet, as has been seen in Zimbabwe for example, radical political change is not sufficient in itself fully to transform the health services. Likewise in South Africa, it will require more than the mere removal of apartheid policies to attain health for all. This article analyses the economic organisation of health services in SA, so as to identify various structural obstacles to the provision of health care for all, which could well survive the demise of apartheid. The article analyses the proposed options for reorganising the economic structure of the health services to decide whether they make economic sense and to indicate the likely consequences of particular choices. It does not assess the political possibility of their implementation.

The article is abstracted from the author's Master's dissertation to the London School of Hygine and Tropical Medicine, published in full in ***Critical Health****, March 1987.*

IN 1944, in South Africa (SA) the Gluckman commission proposed the establishment of a comprehensive national health service. Few of the commission's recommendations were implemented. However, while not committed to the principle of a national health service, the Nationalist government steadily increased its control over the health services during the 1960s and 1970s. Since the late 1970s the trend has turned towards greater privatisation. This has recently been accelerated by the state's current fiscal crisis, combined with escalating health care costs. There are also strategic political and ideological reasons for the change in the state's policy towards increasing the number of people who use private sector providers. This trend has been supported by various private sector organisations, think-tanks, companies and professionals. On the other hand, there is also a growing concern about the inadequacy of the present health services amongst some professionals and political organisations, many of whom have called for the establishment of a national health service. Thus the debate on the choices to be made regarding how the health services should be financed, has again flourished.

Not surprisingly, it is often emotive, and positions are taken primarily because they are in line with the broader ideologies of the authors. But more importantly, when economic arguments are marshalled, they are frequently confused. Choices are crudely defined, since the options of 'privatisation' and 'nationalisation' are presented as if they were each a single uniform phenomenon. On closer examination however, it will be seen that the nature of each is more complex, and defined by a range of possible combinations rather than one essential feature. The choices in the economic reorganisation of the health services, therefore, comprise a series of options which should be examined discretely.

The effects of the system of apartheid on health and health care have been extensively researched and debated. These studies have focussed largely on those aspects of the health services that fall under direct government control — viz. the public health sector. There has been very little research or debate on the health service as a whole and in particular, its economic structure. Recently, however, this debate has flourished.

Although for most of the 1970s the government seemed to view the provision of health services primarily as an obligation of the state, and seemed to tolerate the private sector with some suspicion and a good measure of control, the recession and fiscal crises of the late 1970s and 1980s have resulted in a dramatic shift of attitude:

> Curtailed by the lack of resources, especially financial, ... a more active process of privatisation of health services is indicated. Dr. Francois Retief, Director General of the Department of Health and Welfare, 1985. [2]
>
> We will have to guard against being compelled to move away from the free market system. (The Minister of Health and Welfare in parliament, March 1984.) [3]
>
> Health authorities must not be seen as an infinite source of health facilities and medical care. More people should be able to make use of private health facilities as their economic circumstances improve. (Dr. M.H. Ross, Department of Health and Welfare, 1982.) [4]

The government appointed the Browne Commission of Enquiry into the Health Services in the Republic of South Africa in the early 1980s. Although it has recently submitted its report, this is not yet published at the time of writing. Since 1980, SYNCOM (PTY) Ltd, a private sector 'think-tank' organisation, has received several commissions to research the future of health care services in SA from the Pharmaceutical Society of SA (PSSA) and the Health Strategy Group (HSG). The HSG is composed of the Medical Association of SA, the Dental Association of

SA, the Chemical Manufacturers Association of SA PSSA, the Propriety Association of SA, the Representative Association of Private Hospitals, and the SA Nursing Association. In August 1985, the department of health convened a meeting at which representatives of the HSG, industry, academia and the public sector deliberated on the options for privatisation of health care. Out of this, four working groups were established which presented their consolidated report in February 1986.[5]

Between August 1985 and June 1986, the South African Medical Journal (SAMJ) carried 14 letters, an editorial and an opinion column on the subject of whether or not a National Health Service (NHS) would be appropriate for S A. So the future economic organisation of health services in South Africa is very much on the agenda.

The 'Ideological' Arguments

Much of the debate simply reflects participants' vested interests and ideological tendencies, with little attempt to explore the consequences of proposals honestly and rationally. For example, one opponent of NHS, in a letter to the South African Medical Journal (SAMJ), claimed, "They (the advocates of NHS) are simply advocating socialism", as if that were sufficient reason for his opposition. Far more disturbing though, is the following allegation by SYNCOM about a report it prepared for the HSG in 1982 (known as the SYNCOM III report): "The draft to the final report contained chapters on the future role of the Associated Health Service Professions, on the changing scientific paradigm, and on the need to shift the incentive in health care from the curative aspects to primary health care with emphasis on life styles and prevention... It was unfortunate that most of these chapters and observations had to be deleted, since they were perceived to clash with vested interests."[7] And, on the other side of the debate: "In our view, the right to health implies provision of health services which are free, ..."[8] There may be good reasons why some or all people should not have to pay for health care at the point of service, but this has to be argued and the consequences examined, and certainly does not derive automatically from the premise that health is a right.

The examples of these arguments which follow are given in order to illustrate my contention that they are confused because of the analytic approach they adopt. The substance of the arguments will only be assessed later, since the point here is only to justify the presentation of an alternative analytic framework.

Although presented with many minor variations, most of the arguments for privatisation are covered in the report of the four working groups on privatisation and deregulation, and may be summarised as follows:

1. As the demand for health care, and health care costs escalate, the government and taxpayer will not be able to afford the health care bill. Privatisation reduces the costs to the state of health care because:

(a) Privatisation shifts this burden from the public sector to private individuals. The implication is that because private health care is not provided free, patients have to pay for it and therefore they carry the costs, not the government.

(b) If people have to pay for health care, the tendency to overuse health services can be reduced considerably.

(c) Since all parties are agreed that a minimum level of health care must be provided for the indigent, the aged, the chronically ill etc, where necessary the government should subsidise the individual, not the institution. This is claimed to be cheaper for the government because private providers in a competitive market are more efficient than bureaucratically controlled, non-competitive public providers.

2. Privatisation permits a range of levels of health care to be offered by providers. This not only increases consumers' choice of provider, it also permits discrimination, or rationing of health care along non-racial lines, thus depoliticising the issue.

3. People attach more value to services for which they have to pay.

Argument 1(a) is concerned with the possibility of raising funds by making private individuals pay to use health services, thus easing the burden on the state. Yet, hospitals do not have to be privately owned, nor do doctors have to be in private practice for this to occur, since such charges could quite conceivably be made for publicly owned services. Thus this argument relates to methods of paying for health services (public versus private sources of funds), not the pattern of ownership of services (the provision of services by private, independent health workers and facilities).

Arguments 1(b) and 3 are concerned with reducing the demand on the health services, using fees as a disincentive to patients so that they do not use the services 'unnecessarily'. These incentive effects on demand for health care depend on the use of user charges, third party systems of payment and other factors all related to the methods of financing health care, not the pattern of ownership of health services. For example, if patients have 100 per cent health insurance, then there is much evidence that their demand for health care increases, regardless of whether they are being treated in the private or public health sectors.

Just as public facilities can charge for their services, public funding can be used to pay private providers, as is suggested in argument 1(c). This argument is obviously concerned with a different sense of privatisation, viz, multiple private owners of health services rather than private sources of funds.

Argument 2 is about rationing scarce resources and the consequences for equity. Privatisation here refers to a particular pattern of ownership, viz., multiple providers; a particular method of financing, viz., private payment via

'user charges' or voluntary health insurance; and a particular form of remuneration of providers, viz., on a fee-for-service basis. Only with such a combination can the quantity and quality of service be varied according to how much a patient is willing to pay.

Much of the confusion in the debate on privatisation results from the failure to separate out three distinct aspects of privatisation: (1) private sources of funds; (2) payment of providers on a fee-for-service basis; and (3) private ownership of services. More generally, it is necessary analytically to recognise three distinct components in the economic organisation of any particular health service. These components are: (1) Methods of financing health services, i.e. how funds are raised to pay for health services; (2) Methods of remuneration of providers; and (3) Patterns of ownership of the health services.

When we turn to the international literature to throw some light on the debate about the economic organisation of health services, we find similar confusions arising from the same analytic failure to disaggregate the components of the economic organisation of health care as was found in the South African debate. Two examples are examined here to illustrate this.

Debate About Private Practice

In an article entitled 'Private Medical Practice: Obstacle to Health For All' Roemer identifies the following problems associated with private practice: (1) perverse incentives leading to unnecessary investigation and treatment, and escalating health service costs; (2) inequity resulting from the inability of lower income patients to afford fees to cover treatment costs; and (3) maldistribution of medical manpower caused by doctors' attempting to maximise their income by moving to areas where demand is high, i.e. where there are large numbers of people who can afford private medical fees.[9]

But are these problems endemic to private practice or do they apply to a particular form of private practice? If the latter, how can we identify what it is precisely about that form so that it can be selectively altered? I will take the problems Roemer identifies in turn.

1. The problem of perverse incentives and escalating costs arises because, in the health care market, the supplier is an important determinant of demand and therefore perfect competition fails. This problem may be aggravated when the provider is reimbursed on a fee-for-service basis, such that the more expensive the investigations and treatment, the more the provider benefits. As I will show later if private practitioners were paid on a capitation basis, whether by the patient directly or by the government or other third party, the perverse incentives would disappear although ownership of the services would remain private. In other words, the problem needs to be analysed by focussing on the method of remuneration of the provider since this is not inherent in the pattern of ownership (i.e. private practice).

2. Unequal access to health care due to inability to afford fees is mainly a problem for poor people who do not participate in any risk sharing scheme. In Western Europe, where 90 per cent to 100 per cent of the population are covered by social security, the inability of the poor to afford the fees of private health care is largely solved. (This is not to say, of course, that non-fee costs, utilisation, quality of care or distribution of burden of financing is equitable.) Again, the point here is that the criterion in this discussion, equity, relates specifically to the method of financing, rather than to the institution of 'private practice'.

3. The maldistribution of doctors in favour of the urban rich again depends primarily on the method of financing. For example, if private, self-employed doctors were paid an adequate fee-for-service by the government on behalf of the poor (i.e. by subsidising the individual), they might move to areas where they could maximise the number of patients per doctor. This could produce a reasonable distribution of doctors. The maldistribution of private practitioners is more accurately attributable to whether private or public sources of finance are used, than to how they are reimbursed, or the pattern of ownership.

Thus we can only make sense of Roemer's criticisms, given a strict definition of 'private practice' as entailing self-employed providers, dependent on fee-for-service for their income, where the fees are paid by patients with no risk sharing arrangements or third party payment systems. Roemer probably intended this definition. However, as the responses to his article exemplify[9], others may not accept such a strict definition and the different meanings of 'private practice' (e.g. direct payment by private individuals, competing privately owned practitioners, etc.) are one source of confusion in the debate. Yet this could be readily overcome by making one's definition explicit.

The more serious criticism though, is that the discussion fails to recognise that the economic organisation of health care (in this case, private practice) has three analytically distinct components viz. financing, remuneration and patterns of ownership. The failure to disaggregate the institution into its component parts masks the fact that judgements made about the institution as a whole, are in fact the result of judgements about one or other component of the institution. It is this failure to apply evaluative criteria to the separate components individually that results in much of the confusion that surrounds debates about the pros and cons of different ways of organising health services.

One way in which authors frequently deal with the conceptual difficulties that arise, is by apparently restricting their discussion to the first component — the financing of health services. However, their failure to identify the other two components often results in the de facto inclusion of the latter under a discussion of 'financing',

and the same confusion recurs. Zschock, for example, categorised the possible ways of financing health services as follows:

(a) Public and quasi-public sources — general tax revenues; deficit financing (including foreign loans); sales tax revenues; social insurance; lotteries and betting.

(b) Private sources direct financing of health care by employers; private health insurance; charitable contributions (including foreign grants in aid); direct household expenditures for health; communal self-help.[10]

Although these categories appear to relate only to financing, the discussion that follows this classification suggests otherwise. For example, with respect to general tax revenues, Zschock argues that "to increase significantly the proportion of general tax revenues allocated to health care ... would imply a movement towards increased socialisation of the health sector by providing free or low cost health care services for most or all members of society."[11] Yet there is no necesary connection between the extent of government funding (a financing issue) and the socialisation of the health sector (which concerns patterns of ownership, if socialisation means the extent to which health workers are employed by the state). Public funding very frequently goes to the private sector directly as fees (e.g. Medicare in the US), or as subsidies to social security, or as capitation fees to GPs. The methods of remuneration, the patterns of ownership of the health services and the various combinations of financing methods are all separate questions.

Social insurance or social security is another example of confused debate. Some authors do attempt to distinguish different forms which social security systems might take, e.g. direct (employing health workers and owning facilities) and indirect (paying independent private practitioners and facilities), multiple or single providers. [12,13,14] Abel-Smith makes the point that the many problems attributed to health insurance are not intrinsic to health insurance as a system of financing services, but to other associated features — e.g. in Europe, the fee-for-service remuneration system, and in Latin America, the separation from the ministry of health and the competition among the many social security schemes for scarce personnel.[15] Thus analysing social security as a method or source of financing is confusing unless the point is to show that very little can be said that is true of social security systems in general. Once again, the analysis would be facilitated by disaggregating the three components.

An Alternative Framework

The left hand column of table 1 sets out an alternative framework for the analysis of the economic organisation of health services. This has firstly been divided into its three component parts. Secondly, within each component a number of possible methods are identified. The methods within any component are not mutually exclusive, and frequently occur together in the same organisational form. For example, private health insurance may require co-payment and thus the method of financing includes user charges. For the sake of continuity with the conventional taxonomies, the table attempts to indicate the links between the categories used in this analysis and conventional categories (in the right hand column). Also in the right hand column are the institutional forms which usually manifest the particular method of financing, or remumeration, or pattern of ownership.

Increasing Finances For Health Care

In the debate on health care financing in SA, privatisation has most frequently been supported on the basis of the claim that it will result in more funds being made available for health care. The argument, typical of that common in the international literature, usually runs something like this: The level of resources that a government can raise and devote to health services will always be less than is required to meet the health needs of the whole population. (Indeed, even if the whole GNP were allocated to health, this would not meet the total needs). If, however, there are individuals or groups of individuals who are willing to pay more for better health services than can be provided through the public health sector, this should be encouraged because it can release the public funds spent on these individuals. Thus total resources allocated to health services can be increased, and public health expenditure can be concentrated on the poorer members of society.

This type of argument in favour of privatisation depends on a number of assumptions which are only valid under certain conditions. The following discussion identifies the conditions under which each assumption would hold, and shows that these do not obtain in SA at present. It suggests how these conditions would have to change in order for privatisation to make economic sense as a means of increasing the total financial resources devoted to health care.

First Assumption: Public and Private Methods of Financing are Independent

The first assumption is that the increased expenditure by other sectors (private individuals, medical schemes, employer- provided services) releases public expenditure that would have been spent on the beneficiaries of those sectors. Thus, for example,

> (The private sector) is self-perpetuating and independent of government finance. ... (it) is therefore not to be considered a drain on public funds. (Submission from Hoffman Hospital Group to the Browne Commission Enquiry.

> (P)rivatisation of health services ... would lead to considerable savings in terms of demands made on

Table 1 : Three Components in Economic Organisation of Health Services and Available Options

Components of health service organisation and options within each component	Conventional categories and Institutional form usually taken
A. Methods of Financing:	
Public Methods of Financing:	
Taxes - General	Income, company, property taxes
- Sales tax, import/export duties	Sales tax, tariffs and duties
- Charging out costs to those who generate them	Motor vehicle licences and compulsory third party insurance
	Taxes on tobacco, alcohol
	Workmen's compensation contributions from employers
Deficit financing	Deficit financing and foreign loans
Foreign Aid grants (bilateral/multilateral)	Foreign Aid grants (bilateral/multilateral)
Lotteries and betting	Lotteries and betting
Public, Quasi-public or Private Financing Methods:	
Employer & employee contributions (other than general taxes)	Direct provision of, or payment for health services by employer
	Payroll taxes
	-National health insurance
	-Social security, compulsory health insurance
	-Private health insurance
	Charges related to generation of costs
	eg. workmen's compensation
Private Methods of Financing:	
Charitable contributions	Frequently from wealthy families, firms, religious groups
Private health insurance	Private health insurance
	Direct household expenditure
User charges	Direct household expenditures— for treatment and drugs etc.
	Co-payments — proportion of total costs, deductibles, excess above ceilings, for excluded benefits
B. Reinmbursement of Providers	
Fee-for-service	Private practice
	"Indirect " social security (eg as found commonly in Western Europe)
	Private health insurance
	Direct household expenditures
Capitation /pre-payment fees	Health maintenance organisations
	National Health Service "contract arrangements" with GPs (eg Britain)
	Community based/cooperative financing (eg Brigade level health care, China)
Salaried/budget allocation	Government provided health services
	"Direct" social security systems (eg as found commonly in Latin America)
	Employer provided health services
Others eg. bonus systems, merit award	
C. Patterns of Ownership	
Predominantly public owned health service (other sectors very small)	eg National Health Service (UK), small private sector, small or no quasi-public sector.
Multiple sectors, Many private providers as well as public and quasi-public sectors	Public sector as well as one or more social security schemes and/or employer providers and/or self employed practitioners
Community owned health services	Community financing [16]

the central coffers (Report on Privatisation and Deregulation of Health Care in S. A., 1986 — hereafter referred to as the Report on Privatisation.)

However, the private sector is not, at present, "self - perpetuating and independent of government finance." For, the public sector subsidises the private sector in numerous ways.

Tax concessions: Under corporate tax law, the contributions paid by employers are tax deductible, and the contributions paid by individuals are abatements under individual tax provisions. In 1982, medical schemes' income from contributions was approximately 54 per cent of total private health expenditure (26 per cent of total health expenditure) of which at least one-third is subsidised by the state, i.e. the real cost is 50 per cent more than what employers and employees pay. [17] This loss of tax r ue (at least R337 million in 1982), was equivalent to 1 er cent of total public sector health expenditure, and more than twice the total amount spent on preventive ser. ices.

Subsidies For Medical Education: The major share of the costs of medical education is borne by the public sector. This is a form of 'human capital' investment by the state. When the doctor is employed in the public sector, it may be assumed that his/her salary undervalues his/her output by an amount equivalent to the return to the state on its investment. When a doctor is either self-employed or employed by another sector, the additional value accrues to him/her and to his/her patients. This value is an effective subsidy to those sectors from the public sector.

Estimates of the cost to the state of the undergraduate training of a doctor vary from R36, 000 [18] to R100, 000. [19] 937 doctors qualified in 1985, half of whom will eventually work in private practice. This is equivalent to a state subsidy of R47 million (2.4 per cent of public expenditure) to the private sector, excluding the costs of post-graduates' training.

Subsidised Use of Public Facilities: Publicly financed facilities are usually available to private sector patients (especially for sophisticated tertiary care), but also frequently for routine care under private doctors. Most patients requiring emergency admission are admitted to public hospitals regardless of their income and whether or not they are covered by medical aid. These patients are charged at less than the running costs of maintaining the beds (i.e. ward costs), let alone the full costs of investigation and treatment. In 1984/5, in the Cape, the average daily cost for an in-patient at a teaching hospital was R130.14, for which the maximum fee of R45.00 was charged. (In provincial non-teaching hospitals the costs and maximum fees were R55.45 and R36.00 respectively.) [20] Thus the government is subsidising the non-public sectors.

Other Forms of State Subsidisation: The government, as one of the largest employers' pays employer's contributions so that its own employees will have medical aid coverage, and be able to use the private sector providers. Many other forms of subsidy would be too complicated to measure — e.g. the costs of training nurses and other health workers, the cost of research, drug testing and control, and other parts of the health service infrastructure which benefit private sector, and public sector patients alike.

Thus it is not at all clear that the private sector does indeed release public resources for use on services for those who cannot afford private health care.

It is likely that the individual who uses the private sector providers costs the government more in subsidies than is spent by the government on individuals who depend on the publicly funded services. [21] The subsidy to the private sector therefore, distorts public sector resource allocation in favour of those who are already the most privileged. However, there is no theoretical reason why subsidisation of the private sector cannot be reduced.

The state could quite conceivably withdraw tax concesions; it could charge private patients the full cost for the use of public facilities; doctors who leave the public sector could be obliged to pay an additional tax on their earnings, etc. Withdrawing all subsidies may raise the costs of private health care so high that demand is transferred to the public sector. The costs of meeting this demand may therefore reduce the net savings to the state.

Nevertheless, the assumption that other sectors release public resources which can be directed to higher priority services, often ignores the many ways in which the public sector subsidises other sectors, and the distortive effects this has on public sector resource allocation.

Second Assumption: Only Private Sector Services Can Raise Funds from Private Sources.

The second assumption in the argument that privatisation increases total funding for health services, is that publicly owned services are financed from public sources of funds, and privately owned services, from private sources which would not otherwise come into the health sector. As the Report on Privatisation expressed it, "Privatisation seems to imply a shift towards health as a personal responsibility and feel and unlimited access to health care as a privilege."

Yet this assumption fails to separate, and distinguish between, private ownership of services and private sources of finance. Privatisation of ownership is only one way of getting private individuals to finance their own health care. For, user charges can be a method of financing public sector providers just as it is for the fee-for-service providers. Publicly owned services need not be financed entirely from taxation, but can draw on other methods of financing as well, e.g. social security, health insurance and user charges.[22]

Third Assumption: Political Pressure for Public Funding Will Not Decrease.

The third assumption is that the existence of a private sector would not inhibit or depress the amount raised by public methods of financing and allocated to health care. Yet, in the presence of other methods of financing from private sources, and alternative private providers, it is likely that the people with political influence (usually the relatively wealthy, urban dwellers with regular employment), will not be dependent on the publicly financed services. There is a strong chance, therefore, that they would not lobby either for increasing the tax effort or for allocating a greater proportion of public expenditure to the health services.

Thus privatisation has been seen as a way of offering urban middle-class blacks access to racially integrated medical care of better quality than is available in the public sector. This has been motivated precisely by the belief that it defuses the political pressure from this articulate group to improve public health services for blacks in general, which would be extremely expensive. And as the Report on Privatisation concludes, "There is likely to be an overall saving to the taxpayer." Yet this may be one of the greatest dangers of privatisation, and may result in little increase in the total resources allocated to health care, and a decline in public sources of finance for the health services.

It is possible, though, that if a future democratic government were committed to providing the best public service the country could afford, that the existence of the private sector would not reduce the political pressure for raising public finances, and therefore total finances could be increased by permitting other sectors to operate and raise funds. Roemer's research in Latin America, for example, suggested that there was no decrease in the allocation of public funds to health services with the growth of the social security systems there. The overall level of resources available was indeed increased, and he argues that money that would otherwise have been spent on the costly and inefficient private health sector (if it had been spent on health at all) was channelled into the more efficient social security sector. At the same time, governments were able to devote larger proportions of their expenditure to deprived rural areas.[23]

The economic organisation of the health services should ensure that, for any given total expenditure, the health outcome is maximised. The concept of 'efficiency' encompasses both (1) financial efficiency and (2) economic efficiency.

Financial Efficiency

Financial efficiency is a measure of the proportion of total expenditure that is spent in the direct 'production' of health care. If system 'A' produces the same output of health care as system 'B' but at lower cost, then 'A' is more efficient, financially, than 'B'.

With respect to methods of financing, financial efficiency refers to the difference between the gross and net yields of a particular method of financing. This relates primarily to the cost of administering the collection and allocation of funds. Other measures sometimes considered are the difference between actual and hypothetical gross yields and reliability or stability of a source.

The protagonists of privatisation claim that public methods of financing are financially inefficient. For example, in its conclusion, the Report on Privatisation and Deregulation in SA claims that, with privatisation, "more funds would be available for the direct delivery function through a reduction in regulations, interventions and central decision-making".

Yet there seems to be little evidence to support this. The government spends 0.34 per cent of tax revenues on tax collection, and 0.9 per cent of public health expenditures administering financial allocations to the health services.[24] Most medical schemes, on the other hand, spend between 6 per cent and 10 per cent of their income from contributions on administration, i.e. calculating and collecting contributions and processing claims. [25] There are also numerous examples of overcharging by private hospitals, since it is difficult for medical schemes to check the bills and there is little incentive for patients to check them, even if they are informed enough to do so. This reduces the efficiency of this method of financing, since it results in more being spent with no increase in output.

This evidence is compatible with the findings of two recent international health care expenditure surveys. Commenting on them, Navarro concluded that western industrialised countries with the greatest government funding and administration of health services have the greatest population coverage and the lowest administrative costs.[26]

There are no estimates of the costs of collecting user charges either in the public or private sectors. However the relative costs will largely depend on whether the user charges are flat rates, or are related to the costs of providers (as with fee-for-service providers). This will therefore be covered in the next section (on the efficiency of different methods of remuneration).

(a) Private fee-for-service hospitals: Many of the arguments presented in the South African literature in favour of privatisation, are based on the belief that competitive providers motivated by profit and dependent on fee-for-service for their income, are financially more efficient than non-profit, government-owned services where facilities have fixed budgets. These arguments also reflect a faith in the power of the free market to prevent higher costs and excessive profits being passed on to the consumer in higher prices.

A criticism frequently made about the financial management of public sector hospitals is that "public hospitals in South Africa do not operate on a true costing system and

nobody actually knows what it costs ... to keep a patient." This criticism is valid. However, it does not follow from this that these hospitals are managed inefficiently, and the lack of cost data means that no accurate comparisons have been made. There is therefore no good evidence to suggest that private hospitals are more cost effective than public hospitals.

Indeed, one might expect the reverse. For, firstly, there can be little doubt that the flat rate fees charged by public sector facilities, even when applied on some sort of means tested basis, are cheaper to administer than the user charges in the fee-for-service sector. For, in the latter, the need to calculate charges for each item (drug, investigation, use of equipment etc.) for each patient individually, makes billing complicated and costly.[27]

Secondly, most of the hospitals which operate on a fee-for-service basis are profit making enterprises. As the director of one of the Rembrandt group of hospitals said, "We came onto the scene in 1983 purely for business reason — we didn't do it for charity. We see the medical services industry as an area of growth." [28] The profit obviously accounts for some of the difference between the gross expenditure on health in the private sector, and the net amount actually spent on activities which improve health.

At a fairly crude level of analysis, there is considerable evidence suggesting that fee-for-service hospitals are more expensive for less output. Comparisons are hazardous because one is not comparing like with like. For example, the costs per patient-day in public hospitals may include the costs of training personnel, of treatment, drugs, etc, but generally exclude capital expenditure, while for fee-for-service hospitals, ward costs exclude medicines and treatment, but include amortisation of capital expenditure. There is usually no training of medical staff in private hospitals. The quality of care and of the 'hotel' functions may differ. Furthermore, many of the most expensive treatments are available only or mainly in public hospitals (e.g. cardiac surgery, neonatal intensive care) because these are not covered by most medical schemes, or they are not profitable. The following comparisons must therefore be treated with due caution, though the order of difference seems so large that it is doubtful that the direction would be altered by the net effect of these biases.

In the Cape, the Groote Schuur teaching hospitals had an estimated daily average cost per unit of R108.37, and an average for all Cape provincial and aided hospitals of R63.43. In the Transvaal, in 1983/4, the median cost per patient day of 69 provincial and provincial-aided hospitals was R63.27. [29] Compared with this, fee-for-service hospitals are estimated to cost R100 per patient per day for ward costs alone (hotel and nursing services), before the costs of any doctors fees, theatre costs, investigations, drugs etc. are added. [30] On the other hand, in some private sector industrial hospitals, which are non-profit, with salaried health workers, and which do not have to compete with other providers (as employees are obliged to use the services provided), the average cost per patient day in 1984 was R30.61, inclusive of all drugs and treatment. [31]

Table 2 : Comparative Costs of Specific Curative Health Services in Public and Private Sectors 1984.

	Cost to Cape Provincial Administration	Cost to private patient at medical aid rates
GP Visit	R 10.00(a)	R 39.50(b)
Obstetric Confinement	R 567.00(c)	R 850.00(d)
Herniorraphy (5 day stay)	R420.00(e)	R 990.00(d)
Pneumonia (5 day stay)	R 420.00(e)	R 700.00(d)

Notes:

a. Cost per patient seen at Cape Peninsula Day Hospital includes investigation, minor procedures, day theatre cases, district nursing and medicines.

b. GP visit and average medical aid pharmaceutical cost of R30 per patient.

c Cost per confinement at Peninsula Maternity Hospital, including complicated obstertrical cases and neonatal ICU facilities.

d. Uncomplicated normal medical aid patient.

e. Cost to the Cape Provincial Administration of a 5 day stay in Victoria hospital (a non-teaching hospital).

(Source: Frankish J, Thomson E, Budlender D, Zwarenstein M, Dorrington R, Bradshaw D. *Privatisation of Health Services— Who Benefits?* Unpublished. 1986.)

A more comparable and accurate analysis of costs in the public and fee-for-service sectors has been made by Frankish et al (Table 2).

In the light of the above, it is interesting to note the findings of a recent study in the United States, which compared the differences in the economic performance of matched pairs of 'for-profit' and 'not-for-profit' hospitals. While there were no significant differences in patient-care costs, the total charges and net revenues per case were both significantly higher in the 'for-profit' hospitals due to higher administrative overhead costs. The author concluded that 'for-profit' hospitals generated higher profits through more aggressive pricing practices rather than higher operating efficiencies. [32]

The imperfections of the market, in the case of health care, have been frequently discussed in the literature [33] and cannot be reviewed here. It may be concluded, however, that the evidence available suggests that the profit motive, and the competition of multiple fee-for-service private hospitals are no guarantee of greater financial efficiency. Indeed, such an economic structure is probably less efficient.

(b) *Effects of Methods of Remuneration on Efficient Use of Personnel Resources:* Doctors in SA have jealously guarded their monopoly over the right to diagnose and treat, and 'primary health care nurses' have only been allowed to perform a limited range of tasks in certain prescribed circumstances. There is adequate evidence from all over the world that, in both developing and developed countries, other health workers can perform many of these functions at lower training and salary costs. Yet South Africa's present inefficient system will not change as long as doctors earn more for seeing patients themselves, as occurs in a fee-for-service system. If, for example, doctors were paid a capitation fee, then it would be in their economic interests to employ cheaper health workers to perform the tasks for which they are competent, so that their own more expensive skills could be used more efficiently, while covering a much larger population.

Effect on Financial Efficiency of a Multi-sector Pattern of Ownership.

(a) *Wage inflation:* The competition between sectors for fixed resources forces up wages in both the public and private sectors. Comparing salaries of professionals in the public sector in 1984, the median salary (before tax) of male doctors was 26 per cent higher than engineers, 39 per cent higher than lawyers, but only 4.5 per cent less than doctors in the private sector. [34] As one private hospital managing director said, "We just take a lead from the government hospitals. When they increase their rates we simply add a bit more on to get the staff." [35] This is unrelated to productivity, and hence is purely inflationary and is financially inefficient.

(b) *Duplication and Economies of Scale:* In 1974, the de Villiers Commission found that there was a lack of planning, especially between provincial and private hospitals — an excess of beds had been provided in certain urban areas, resulting in too low a rate of occupancy in provincial hospitals as well as private hospitals. [36] But this is not merely the result of poor coordination. It is the inevitable consequence of access to different providers being restricted to different groups in the population (the rich and the poor) when these groups overlap geographically. Thus there will be many areas where both public and private facilities overlap merely because they are not open to all the people who live near them. If this results in the failure to achieve economies of scale, then average costs are high, and the arrangement is financially inefficient.

Economic Efficiency

Economic efficiency, as opposed to financial efficiency, is concerned with the allocation of resources in socially optimal ways. The reality of finite resources means that more of health care entails less of something else, and within the health sector, more of one type of health care means less of another. Optimal economic efficiency occurs when the marginal rand produces equal benefit, no matter where in the economy it is spent. In a free market, the price mechanism may equilibrate supply and demand in a way that reflects individuals' relative evaluation of alternative combinations of resource allocation. However, in the health care market, the price mechanism fails to achieve economic efficiency for several reasons: the presence of monopolistic providers (e.g. doctors); consumers are not well-informed and have difficulty choosing between alternatives; providers influence consumption more than consumers; there are significant externalities such that the social benefits exceed the sum of the individual benefits (and therefore willingness to pay); and unequal income distribution results in monetary prices reflecting different marginal utilities at different income levels. [37]

Consequently, other mechanisms are needed (some of which may also use prices as signals to providers and consumers) to promote efficient resource allocation. Broadly speaking, these mechanisms act either on the providers to influence the supply of health services, or on the consumers, to influence the demand for health care.

The efficient allocation of resources therefore, depends inter alia on: (1) The ability to control allocation on the supply side — determined largely by the pattern of ownership of the services. (2) The ability to control demand for health services, i.e. to limit demand for each kind of service to levels that are socially optimal — dependent on the methods of financing and remuneration.

There can be little doubt about the economic inefficiency of resource allocation in a country where heart transplants are being performed while the vast majority of the population suffers from vaccine preventable diseases. This failure to allocate resources to where they will achieve the greatest health improvements for the maximum number of people, occurs because the economic agent, the decision maker, is split into parts with independent allocation systems. The result is that the benefits and opportunity costs of a given allocation are borne by different parts of the system. Put another way, even when the marginal rand spent by different parts of the system produces highly unequal benefits, no transfer of resources occurs between the separate parts of the system, in favour of those sectors where they could produce a greater marginal benefit.

The present system prevents the optimal allocation of resources in two ways. The first is the racial and geographic fragmentation of the public health service and the division of control over total health care spending between many sectors (government, medical schemes, employers, private individuals). The other is, of course, the control of public health services, by an undemocratic minority government. For such a government, the present policy may be 'rational' in the sense that it serves the interests of that government. Thus even if there was a single authority controlling all health resource allocation,

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in the absence of a democratic government, health policy would be unlikely to benefit the maximum number of people.

Yet, assuming that in the future there is adequate democratic control over public health expenditure, if private expenditure is significant, it will continue to produce inefficiencies since private individuals do not suffer the opportunity costs of withdrawing trained personnel and technology from the public sector. The effects on the public sector could be minimised, though, by removing any subsidy to the private sector. Then, if private individuals were willing to carry the full cost of, say, haemodialysis, public sector resources would not be diverted and the optimal allocation of public expenditure need not be reduced (although the economic efficiency of *total* expenditure would still be suboptimal).

The determinants of demand for health services are multiple and complex. Financial incentives are clearly only one group of determinants. Furthermore, it is difficult to say what the appropriate level of provision for any particular service is. However, in terms of economic efficiency, the quantity provided is optimal when it costs what society is willing to spend on it, i.e. the value society places on it relative to other possible uses of those resources.

When the economic organisation of the health services does not have adequate mechanisms for limiting demand to the level for which resources have been allocated, demand will exceed its optimal level, drawing in more resources and resulting in economically inefficient resource allocation. This also means that cost escalation cannot be controlled.

(a) Economic Efficiency and Methods of Financing: Third party methods of payment frequently result in economic inefficiencies and cost escalation. If individuals had to pay the true marginal costs of medical care, they would allocate their resources according to how they valued each, which would ideally reflect the relative cost-benefit of each. A collection of individuals, in the form say, of the state (ministry of health), or an insurance group, should allocate their collective resources the same way. However, having paid their insurance contributions, individuals who no longer have to sacrifice more in the short term for demanding more expensive curative care, will demand more than the value of that care to them (the problem of 'moral hazard'). Assuming, for this example, that the provider faced no financial incentives either to provide or withold treatment,(s)he will attempt to do what is best for the patient personally. To serve the patient's interests well,(s)he will administer additional care as long as there is some net benefit to the patient.

Yet this may be excessive from society's point of view since the same resources could have achieved greater overall welfare had they been used for some other purpose. In the long term, costs will escalate, with aggravated distortions and growing economic inefficiency.

(b) Economic Efficiency and Methods of Remuneration —Problem of Perverse Incentives: In the example above, it was assumed that the provider was interested only in what was best for the patient. However, given firstly, that the provider is the main determinant of demand for investigation and treatment, and for secondary and tertiary care, and secondly, that the patient can afford almost any fees either personally or through risk sharing arrangements, the fee-for-service system offers financial incentives to the provider to perform more investigations and treatment than are necessary or justifiable. This is the problem of "perverse incentives."[38] In Brazil, for example, doctors and hospitals receive the highest fees from private patients, slightly lower fees for patients on social security, and the lowest for indigent patients (paid by the government). The rates of caesarian section in primiparous women in 1981 were 75 per cent in private patients, 40 per cent in insured patients and less than 25 per cent in indigent patients.[39]

Usually the interests of the income maximising practitioner will not be in conflict with those of the patient — the marginal investigation may indeed increase the certainty of diagnosis. Furthermore, other non-financial incentives such as status, career advancement, medical ethical principles and regard by peers may protect the patient's interests. However, all these incentives work in the same direction as the financial incentives, encouraging the doctor to 'do more' rather than less, with little regard to the economic costs to society. Thus the system of fee-for-service remuneration aggravates the problem of efficient resource allocation and results in the dramatic cost escalation.

By contrast, the incentive effects of remuneration by salaries and capitation fees do not have the 'perverse' effects that occur with fee-for-service, with its consequences for cost escalation and economic efficiency. In prepaid (capitation) group practices the providers undertake to cover part or all the costs of treatment that a patient may require during the next year (or other period of time). This creates financial incentives not only to keep patients healthy in the first place, but also to limit unnecessary or excessively expensive tests, drugs, referrals etc. Saward and Fleming, for example, have shown that prepaid group practices can be more cost-effective than fee-for-service systems, largely because of lower hospitalisation rates.[40]

In S.A, as in most other countries, per capita expenditure on health care has escalated in real terms. One source (in the Report on Privatisation) estimates that real per capita expenditure by the state increased by 13.5 percent from 1975/6 to 1984/5 (i.e. 1.4 per cent annually, compounded). On the other hand, average Medical Aid premiums (which approximate per capita expenditure by medical schemes) have increased 500 per cent from 1975 to 1986 compared with an inflation rate of 387 per cent over the same period

(a real annual increase of 2.3 per cent compounded), i.e. more than 1.6 times the per capita rate of increase of public expenditure. [41]

Another source puts the increase in total (public and private) real expenditure on health (not per capita) at 26.5 per cent from 1978 to 1982 (or about 6 per cent annually compounded). Over the same period medical schemes' total real expenditure increased by 31.3 per cent (or 7 per cent annually compounded). Some of the factors that have contributed to cost escalation over the decade have been demographic changes e.g. aging white population, urbanisation of blacks, increasing income and sophistication of patients, increased coverage by medical aids (membership has been increasing by about 20 per cent in five years), increased provision of services, increasing costs of high technology equipment combined with a falling exchange rate, recession and poverty. All these trends are likely to continue. The economic organisation of health services ought to be able to contain costs at appropriate levels. Yet, there is evidence that in both the private sector and public sectors, the structure aggravates cost escalation and does not provide mechanisms for its control.

An increase in expenditure on health care is not in itself a bad thing, especially since the proportion of the GNP devoted to health care is relatively low (4.9 per cent), compared with most industrialised countries. Yet the following quotes indicate that, in the private sector at least, the cost escalation is due to the inability to limit demand to socially optimal levels i.e. to growing economic inefficiency.

In 1985, John Erntzen, chairman of the Representative Association of Medical Aid Schemes of S.A. (RAMS), said that as a result of increased claims: medical aid schemes throughout the country are on the brink of collapse ... (T)here is evidence that doctors are offering more services, often unnecessary, to make a living. ... RAMS has also found that doctors charge more and offer less services at any given consultation. ... (T)he man-in-the-street also insisted on a lot of treatment because he felt he was entitled to it because of his medical aid membership. [42]

He also claimed that, while medical tariffs in 1984 were an average of 4.4 per cent higher than in 1983: (y)et we have found that our claims costs for 1984 rose much higher than this: up 19 per cent on 1983 for general practitioners and 25 per cent for specialists. This can only suggest that more services are being performed (per beneficiary). Those doctors who rely on medical schemes for their income see our members on average 25 per cent more than those doctors contracted out." (Tony Leveton, executive chairman of Affiliated Medical Administrators [43].

And, in the Report to the Department of Health on Privatisation and Deregulation in SA, it is claimed that the "disproportionate increase (in private medical expenditure) can most likely be ascribed to an overuse of health care facilities in the private sector due to the present structure of Medical Aid Schemes".

These are exactly the obstacles to economic efficiency that are created by the inability to contain excess demand due to the moral hazard problem of third party methods of payment, and the perverse incentives effect when suppliers who influence demand are reimbursed on a fee-for-service basis.

This report to the department of health recognised that "the present triangular arrangement (consumer-provider-funder) is highly inflationary" and that, in such a system, "with state subsidy to individuals, the results could be disastrous." Yet its answer was that, " to overcome this, prepaid cover for health care should be market-oriented," so that people could attain the kind ofcover they require. But this is a *non sequitur*. For, no amount of market orientation will alter the inflationary triangular arrangement. The report goes on to say that the members of the four working groups that produced the report could reach no agreement because of strong vested intreests", and that this "requires much further detailed study once the principle has been accepted." (One might have thought that such a study should precede acceptance!)

Thus, on the one hand, they are unable to accept the logic of their own arguments because the conclusions would conflict with"strong vested interests". On the other hand, since they refuse to question their assumptions about the efficiency of private sector health care, any observed inefficiencies in the present system are regarded as the indications that further privatisation is required. As we have seen, the real problems are the fee-for-service method of remuneration and the dependency on health insurance as a method of finance.

These are not the only obstacles to limiting demand to socially optimal levels. Any mechanism that lowers fees below their marginal cost may result in `excess' demand. And, as was suggested above, even when there are no perverse incentives (such as with salaried doctors), supplier induced demand, and hence costs, are difficult to control. These latter problems occur in the present structure of the public sector, since the doctor does not have to carry the costs of the quantity of care (s)he provides, and the opportunity costs of such care frequently exceed the marginal benefits. However, in the public sector, where total expenditure is constrained by a predetermined budget, suitable management mechanisms could be developed to control the supply of services and thus control costs.

Any changes in the economic organisation of health services designed to meet the objective of greater economic efficiency, must clearly move *away* from these methods of financing and remuneration by introducing selective user charges; by reinbursing providers on a capitation fee or salary basis; and by making providers bear some of the cost of the demand they induce. In the public sector, manage-

ment systems will be required to ensure that resources are directed towards those communities and types of health care that produce the highest marginal benefit.

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17. For every R1 contributed, 50c is paid by employers, most of whom are companies. The company tax rate is 50 per cent, thus the company effectively pays only 25c and the government pays the other 25c (through loss of tax revenue). The employee pays the other 50c. The lowest rate of individual taxation is 16 per cent (the highest rate on the marginal Rand is 50 per cent). Even if all employees are assumed to be on the lowest rate, the effective government subsidy is: 16percent X 50c = 8c. Therefore the total minimum subsidy is: 25 + 8 = 33c in the rand.
18. Calculated from figures given in reply to a question in the House of Assembly. *Hansard* February 27, 1986, column 256. "The estimates are based on the subsidy formula used for calculating the 1986subsidies" i.e. they are not based on calculations of cost.
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21. The total value of these government subsidies, divided by the number of people who benefit from them (approximately 20 per cent of the population who use the private sector providers), is likely to be more than per capita public sector health expenditure. The tax concessions alone, which equal at least 17 per cent of the public health budget, benefit only about 16 per cent of the population (the proportion covered by medical schemes). If the whole public sector health budget were distributed evenly over the whole population; the per capita expenditure would be less than the amount of the tax subsidy to private sector users.
22. The Chinese system comes fairly close to this arrangement. At secondary and tertiary levels of care, there is only one sector providing care and this is charged for. The methods of financing used to pay these charges depend on whether the patient is a government employee, a commune or brigade worker, a factory worker, a dependant of a worker, or not covered by any risk sharing arrangement in which case (s)he must carry the full cost privately. Prescott N & Jamison D T. Health Sector Finance in China. *World Health Statistics Quarterly*, 1984, 37(4): pp387 - 402.

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Continued from page no. 2)

other than what was already being written about. We were in no competition with fraternal journals which were focussing on these issues. And most of the ongoing debate on the three issues, whether in the mainstream or in the alternative press were themselves major contributions to the radical critique of health. There was another perhaps more important reason. For all of us on the collective the ***RJH*** was the second or third area of activity. That is all of us at different levels with different groups were already very much involved with these issues. The other forums, such as the **medico friend circle, the All India Drug Action Network, The Health Services Association and the West Bengal Drug Action Forum, Kishore Bharati,** women's groups and others, were putting in a tremendous effort to generate a public debate on critical problems in these areas. By tacit consent we decided to put our energies into these for a rather than in brin out substantial material in the ***RJH.***

What now? Do we still feel that the journal can fulfill a need? Have we contributed to the development of a marxist debate on health care? Certainly things have changed much since we began. For one thing the last four years have seen an upswing in the interest in and awareness of health issues. Interestingly the three issues we mentioned above have been both a cause and consequence of the changing situation. During this period we have also seen a large number of health periodicals, some occasional, some regular, emerge. Also, publications encompassing a broader canvass of social analyses have begun to devote more space to health issues.

We do not attempt here to answer these questions. Because we really have no means of evaluating the ***RJH*** qualitatively. We invite you, our readers new and old, to give us your feedback. Because after all the whole point in starting this journal was so that it could provide a forum for participating in the evolution of a radical, marxist critique of health. In the meanwhile we will continue to do our bit as best as we can.

So here comes a fifth year of ***RJH!***

Padma Prakash

Health Care, Health Policy and Underdevelopment in India

ravi duggal

SINCE independence health policy making and the design of health programmes (like all other development programmes) have been guided by programmes of imperialism. As a result the Indian peripheral population has been denied state-sponsored health care services (that exist theoretically) and have instead had to depend on the vagaries of the market forces in which operates the overwhelming private health sector that has virtual monopoly of curative health services, being supported to the hilt by the multinational pharmaceutical industry. Privatisation, high technology, population control, low-cost models, aid and the consequent dependency are the means imperialism uses to shape our health policy and programmes.

THE underdevelopment of health is not an original state, but an active process generated by imperialist exploitation. Thus the nature of the third world health problems and the obstacles to their solution are to be found primarily in the structure of the economic relations historically created between the capitalist powers and their satellites. This is reinforced by the economic and social relationships created by imperialism within particular underdeveloped countries. [L Doyal and I Pennel. *EPW* August 1977]

The links of underdevelopment with imperialism are today well established. The world systems approach [Baran, 1975; Frank, 1967, Amin, 1974; Wallerstein, 1976] that critiques the developmentalist paradigm of liberal political economy has also looked at the health sector, then it moves on to discuss the underdevelopment of the health sector in India establishing the linkages with imperialism based on an analysis of health and population control policy.

Modern medicine got established in the developed world only in the last quarter of the nineteenth century. And now for over a century it has prospered under capitalism and has spread globally under imperialism expropriating the health of the people. In developed countries sanitary reforms and other public health measures had provided the foundation on which modern clinical medicine could grow and flourish. This did not happen in what are today's underdeveloped countries because the latter were colonies of imperial powers. In underdeveloped (colonial) countries modern medicine developed as an enclave sector and therfore, though early in introduction, modern medicine catered to a very small proportion of the population.

The phenomenal growth of modern medicine under capitalism in the last one hundred years and its expansion under imperialism had no doubt revolutionised medicine. But in its rushed growth to find a pill for every ill the medical-industrial complex, under the auspices of monopoly capital and imperialism has not only become an expropriator of health but also global expropriator of surplus through a network of large multinational corporations. Good health is not only a question of availability and accessibility of modern medical care but is also related to the basic question of the right and access to a comfortable, human standard of life.

Today the difference we see between the developed countries of the west and the undeveloped countries of Asia, Africa and Latin America is the gap that imperialism has created. The question is not one of lack of resources in the peripheral (underdeveloped) countries but that of expropriation of their resources by the centre (developed) countries. The world product today (far below level as which human beings can produce with the present level of productive forces) works out to over US $ 3500 per capita per annum. If equitably distributed this is sufficient to support a comfortable life-style for the entire global population. However in the present world the underdeveloped countries, which have over 3/4ths of the world's population, get only 1/5th of the share of the world's product [World Bank, 1984]. The situation in 1800, for instance was a little different. The same population of underdeveloped countries had 44 percent of the share of world output. Since 1800 the gap has widened because of the expropriation of surplus of the underdeveloped countries by developed ones, earlier through colonisation and now through imperialism. And this gap today is widening further because of the stepped up process of privatisation all over the world. Thus under capitalism and imperialism development alone is not possible-development is necessarily constructed on the foundation of underdevelopment. The growing of such a development (increasingly for fewer people) also means a growth of underdevelopment (increasingly for more people). [see Navarro, 1976] health sector.

A futher point to be noted with regard to the health sector is that it has historically belonged to the category referred to in western economics as the welfare or social sector. The argument is that a healthy population is essential for higher productivity. But under capitalism the production sector is unwilling to bear the burden of maintaining the health of the population, therefore this function is transferred to the state. The state collects taxes and makes provision for health care services either through its own delivery system or through subsidies or support of the private health sector. But with the strengthening of monopoly capital, contradictions of capitalism become completely bare and it seeks the support of the

state, the latter tripping into a fiscal crisis. The direct consequence is a demand by capitalism for a cut in social expenditures (health, education, welfare etc). However, at the same time monopoly capital is well prepared to take on social expenditures because new techonological developments have rendered this sector profitable. It is not that there were no profits in the health sector earlier-the pharmaceutical industry, private pracitioners, medical equipment manufacturers etc were grossing large surpluses. Only now, because of the new medical technology, large scale corporatisation of health services has become possible.

This development in the health sector is not restricted to the developed world. It has diffused very rapidly in the underdeveloped world further advancing (sic) the underdevelopment of health in these countries. The developed and the peripheral mass has less and less of basic health care. On the contrary, imperialism pushes 'new' low-cost, self-care models for the periphery. "In the health sector, we find substantial cuts in government health expenditures with privatisation and commodification of medical services, accompanied by the ever-present ideology of self-sufficiency and self-care brought to those peripheral countries by transmission belts of dominant core ideologies, such as the international agencies of aid". [Navarro, 1984].

Underdevelopment of Health in India

In India the growth of the health sector has followed the enclave pattern of development. Public health in India was completely ignored. Unlike Europe, India and most of the third world missed the opportunity of implementing sanitary reforms because they were colonised [for details see Ramasubban, 1985]. Even until today, because of the nature of capitalist medicine and imperialism, this simple and basic change has not been possible in underdeveloped countries—the entire focus of modern medicine is centred around the clinic and the only beneficiaries of this are the providers and monopoly capital. The recent cholera and gastro deaths in Delhi and other parts of India shows how underdeveloped public health in India is and it also proves the enclave sector pattern of development.

The genesis of an institutionalised health care delivery system in India began with the consolidation of British colonial rule. The motive of the imperial government for providing such modern and sophisticated medical care was not to improve health care of the general Indian community but as a concern for the health of its own armed forces and civilian administration. This very enclave sector introduction of modern medicine in India became the basis of its growth in the country. This pattern continues even today. Upto the end of the war modern medicine in India was not introduced to the periphery at all. It was only available to the rich Indians and civil servants, besides the Britishers and the Indian Army. With the advent of provincial government after the Government of India Act 1919, some semblance of a medical care network evolved. By 1941 India had 7441 hospitals and dispensaries (2150 hospitals). For rural areas there was one unit (hospital and/or dispensary) per 45,966 population and for the urban areas one unit per 16,913 population. (only 7.6 per cent of all these units were in the private sector) [Government of India, 1946]. Anyway, these facilities were too meagre to be of any significance, especially considering the fact that they largely catered to a select population.

Compared to any significant health care delivery system in the developed world the facilities and investment in India were miniscule and of little consequence for the health of its population. For instance, before the start of the second world war India had a bed/population ratio of 0.24 beds for 1000 population with a state expenditure of about 16 annas per capital only (5 per cent of Government expenditure), compared to Britain and USA which had bed/population ratios of 7.14 and 10.48 beds per 1000 population and a state health expenditure of Rs.54-8 annas 12 pies and Rs.51 -6-0 per capita (20.4 per cent and 13.8 of government expenditure), respectively [Government of India, 1946]. The fact is that Britain's and USA's state health expenditure was equivalent to India's national income and their health care even worse today. In 1984 health expenditure in the USA was $ 15.80 per capita out of which state expenditure accounted for 41 per cent (Levit et al,1985). By comparison in the same year health expenditure in India was only Rs.50 per capita. State private expenditure in 1984 is estimated at Rs.47 per capita by the CSO [GOI, 1988] but is more likely around Rs. 190 per capita [Duggal, 1986]. Even taking the latter estimate of private health expenditure in India, the USA spends 66 times more on health than India. Futher, the US health expenditure alone in 1984 was eight times that of India's national income (state health expenditure alone of the USA was 3 $^1/_2$ times India's GNP).

In India the Bhore Committee Report had provided the first insight into dimensions needed for a comprehensive health care system in India. It was a plan that was almost equivalent to Britains own national health service but having features closer to the Russian model because of Dr. Sigerist's and Prof.Ogenov's influence [GOI, 1946]. The committee stressed that suitable housing, sanitation and safe drinking water were primary conditions for good health was not to be equated with health services or illness care. The beneficiary was identified clearly as the tiller of the soil and the committee drew pointed attention to his plight. Specific groups such as women and children and industrial workers, were also paid special attention." [Giridhar et.al.,1985].

However, after independence the Bhore Committee Report remained unimplemented. The main reason for this, as also for the poor performance of other social

sectors, was the role of the Bombay plan (also known as Tata-Birla Plan) in shaping India's economic policy. Briefly, the Bombay Plan directed the nation's economic policy to serve the needs of private capital by making the state invest in heavy economic infrastructure, under the cover that such participation by the state in economic production would evolve a socialist society. That was as far as Nehru's socialism went and the private sector got state subsidised capital goods and services sector (steel, minerals, transportation, communmication, finance capital etc.) from which to reap benefits. It is clear that state investment has historically dominated in areas which helps the growth of private capital.

In the health sector the government let private practice of medicine flourish. For instance the government subsidised significantly the growth of private medical practice by training medical personnel from tax-payer funds and by providing bulk drugs at very low prices to private formulation units. However, the government took the entire responsibility of public health largely preventive and promotive programmes with curative services (the primary need of the population in terms of demand) taking a back-seat.

Investment in Health Sector

As mentioned earlier, at independence the investment in the health sector was marginal. Hospitals, dispensaries, health centres, health personnel and pharmaceutical production were abysmally low to have any impact on the health of the population, especially the poor masses. Between independence and today the growth of the state health sector has not kept pace with the needs of its population and quality.

Between the beginning of the first plan and 1986 the number of hospitals have increased from 1,694 (1,17,000 beds) to 7,474 (5,35,735 beds) but in terms of availability to the population the situation has not very siginificantly improved. Thus in 1951 one hospital served 1,34,001 population (3,085 population per bed) and in 1986, 1;003,48 population (1,400 population per bed). The situation gets worse when we look at the rural - urban differentials. For the earlier years this figure is not available but even in 1986 only 21 per cent of the hospitals (and 12 per cent of the beds) were located in rural areas, one rural hospital serving 3,49,394 rural population, and one rural bed serving 8,135 rural population. In comparison to this in the same year one urban hospital served 34,281 urban population and one urban bed served 432 persons in the urban areas. In 1956, 24 per cent of all beds were in rural areas but in 1986 this figure had declined to 12 per cent (GOI-CBHI, respective years). Further when we consider access factors like morbidity rates, sanitary conditions, malnourisment etc, the rural health sector investment appears to be only a marginalised investment. (See Table 1).

It also appears that compared to the growth of the private health sector the growth of the state health sector is very slow. For instance in 1974, 16 per cent of all hospitals were in the private sector (16.2 per cent beds) but within a decade in 1984 private hospitals had grown to 42.3 per cent of all hospitals (26.7 per cent) (Ibid). This means that availability of health care for the poor classes, who constitute more than 3/4th of the population, is becoming more and more expensive as they have to increasingly rely on market forces.

The urban population, besides having the cream of the state and private health services also have access to relatively good and well organised local-body sponsored health services, and the organised sector working class in addition has the benefit of having either health insurance [ESIS, CGHS] or reimburesement of costs (by employer) or even special health care facilities by railway, mines, defence, public sector undertakings, corporate health facilities).

To check this imbalance a network of primary health centres have been established to cater to the needs of the rural population. Between 1956 and 1986 the ratio of population served by one PHC has changed from 5,51,724 to 88276 but no siginificant impact on the health of the population is perceptible. The problem with this is that PHCs are different from hospitals and dispensaries. People's need and demand is for curative services (i.e. hospitals and dispensaries), rather than public health and family welfare. On an average only 1/5th of PHC funds and time of the staff are spent on curative services when over 90 per cent of those who visit the PHC seek curative care. When curative care supply in such institutions increases, such as in case of upgraded PHCs, its utilisation by the population also increases. Similarly a good PHC doctor (in terms of providing curative care) increases the patient-load of the PHC substantially.

Drug production is one area (the other being the production of doctors) in which considerable success has been achieved and the targets surpassed. The reason is simple that profitability is high and an effecient (even though largely irrational) pharmaceutical industry is the lifeline of private practice of medicine and vice versa. Pharmaceutical formulation production (including net of import/export) has increased from Rs.51 crore in 1956 to Rs.1993 crore in 1983 [FRCH, 1987]. In terms of population served, this means drug availability of Rs. 1.30 per capita in 1956 and Rs.27.68 per capita in 1983.

But the most important segment of the health sector in India is the private medical practitioner. Today there are over 700,000 medical practitioners (including institutionally and non-institutionally qualified and non-qualified from all systems of medicines); out of these 36 percent (250,000) are allopaths. Besides this there are about 800,000 paramedics, pharamacists, nurses, various medical teachnicians etc. Of all qualified allopathic

practitioners only 28 per cent are located in rural areas and out of these 40 per cent work in the government's rural health institutions. Of all non-allopathic (qualified as well as others) practitioners. 56 per cent work in rural areas; and from among these only 2 per cent work in the state health sector 6 per cent of qualified non-allopaths) and of course, most of them practise allopathy. So here again we see that rural-urban differentials are very marked. And finally what is the proportion of medical professionals working as private practitioners? Of the qualified allopaths about 172,000 (or 69 per cent) are in private practice. And of all the non-allopathic (qualified and not qualified) practitioners 90 per cent of 400,000 work as private practitioners. This means that about 5,72,000 practitioners (one per 1300 population) of all sorts constitute the largest chunk of the health sector, [extrapolated from Census -1984; GOI, 1986].

This overview of health infrastructure development and investment in India clearly shows that the pattern of growth of the health sector in India has only contributed to its underdevelopment. The three high growth areas of medical education, pharmaceuticals and private practice have only helped imperialism and monopoly capital. Development of health care service has been concentrated in the enclave sector benefitting largely the urban-enterpreneurial economy. Health care services, like all other sectors of the economy, in the periphery are backward and what little exists is both poor quality and of difficult access.

There are various issues health and non-health, involved in this debate.In this article the discussion is limited to the nexus between imperialism and the health and population control policy in India and how they perpetuate underdevelopment.

Health Policy and Imperialism

In the colonial period health policy was unabashedly in favour of the enclave sector. The periphery existed only for expropriation, not deserving even lip sympathy. However, a few years prior to Independence both the Government of India and the Indian National Congress decided that the health of the periphery needed attention. The now famous Bhore Committee and the National Planning Committee's reports on the health situation in India and what could be done about it appeared on the eve of independence. Both these reports clearly favoured the establishment of a broad based integrated national health system that would be equally accessible to the entire population, irrespective of their ability to pay.

The Bhore Committee report used the Flexner Report of the USA as its basis in chalking out the plan for health care services for India but the influence of both the British National Health Services that was then emerging and the Russian model are clearly perceptible. However, it is evident that the Bhore Committee Report was clearly designed within the framework of welfare economics. It is a different matter that most of the recommendations of the report were rejected by the Indian state because the shrewd Indian bourgeoisie preferred a system of health care services where health care and medicine would be commodities (for instance the then prevailing Indian Medical Service that could have become the foundation of a national health service, was truncated and finally dissolved). The state was given the responsibility of public health and health care services for the periphery. The state was also made to provide the infrastructure medical education and research, bulk drugs, tax rebates and subsidies. Private medical practice developed as the core of the health sector in India initially strengthening the enclave sector, then gradually spreading into the periphery as opportunities for expropriation of surplus by providing health care increased due to the expansion of the socio-economic infrastructure. It must be noted that this pattern of development of the health sector was in keeping with the general economic policy of capitalism. And Indian capitalism had clear links with imperialism. Thus the health policy of India cannot be seen as divorced from the economic and industrial policy of the country. In India until recently there was no formal health policy statement. The policy part and parcel of the planning process (and various committees appointed from time to time) which provided most of the inputs for the formulation of health programme designs. However what programmes were to receive priority was decided by imperialism.

In the early years after independence the Indian state was engrossed in helping and supporting the process of accumulation of capital in the private sector through large scale investments in capital goods industry, infrastructure and financial services. Social sectors like health and education were low priority areas. Industrial growth was the keyword. But by the end of the fifties imperialism had convinced the Indian state and the bourgeoisie that if the periphery was left out of the development process then not only surplus expropriation but the existence of capitalism itself would be threatened. Imperialism did not want another Cuba or China. Earlier the US patented CDP had failed. Thus the Green Revolution and subsequently other rural development programmes came to India through assistance from the US Technical Mission and Ford and Rockefeller Foundations. Along with this came support for health programmes also. The aid that came to India was not only financial and technical but also political and ideological. The entire policy framework, programme designs and foci, financial commitments etc. were decided by the imperialist agencies. For instance, during the fifties malaria, which constituted, an international threat, was the main focus of our health care delivery system an overwhelming majority of the health budget going into spraying out the mosquito menace. This priority was dictated largely by US imperialism - 78 per

cent of the US (health) technical assistance and 68 per cent of PL 480 grants went to malaria control and eradication [USIAD, 1976]. Similarly in later years small-pox eradication assumed importance. This time 57 per cent of all WHO assistance to India between 1973-76 went to small-pox eradication [WHO, respective years].

In the fifties and sixties the entire focus of the health sector in India was to manage epidemics. The health infrastructure remained grossly inadequate, catering largely to the enclave sector (see Appendix 1).

Another area of imperialist influence has been medical education and research. The entire curriculum of medical schools in India is oriented to serve western capitalism. Trained medical graduates, who have studied in public financed medical schools have migrated to western capitalist countries en masse, the latter gaining cheaply (for them) trained medical manpower. Imperialism directly perpetuates this form of medical education and migration centres of medical excellence in India (AIIMS, PGIMR etc.) have been funded by imperialist agencies. For instance between 1950 and 1974, 98.7 per cent of all health sector assistance by the Rockefeller Foundation to India went to medical education and research [Rockefeller Foundation, respective years].

In the early sixties, alongwith the great push given to the Green Revolution imperialism was preparing the ground for a fundamental change in India's health policy. The epidemics that were being controlled were bringing down the death rate rapidly. The consequence was a sudden spurt in population growth. India already had an official population programme but in the Mahalanobis scheme of things population growth was not a priority factor in planning. For imperialism the high growth of population (compared to their own declining growth) in India and rest of the underdeveloped world was a major threat. The initial beginnings in guiding this policy change in underdeveloped countries was routed through private foundations of American capitalism [for details see Mass, 1976]. In India, for instance 84 per cent of all Ford Foundation health sector aid between 1955 and 1979 went to population programmes and reproductive biology [Ford Foundation, respective years].

In the first two plan periods the family planning programme was mostly run through voluntary organisations under the aegis of FPAI which received funds mainly from IPPF, Population Council and the FPA of Britain. It was only during the third plan that government agencies began to actively participate in pushing population control. It was at the end of the third plan that Family Planning became an independent department in the Ministry of Health (meaning its status for financial commitments etc. would be increased substantially) and the camp approach was tried out for the first time under the advice of the Ford Foundation. The budget Sky-rocketed from a mere Rs. 2.2 crore to Rs. 25.0 crore (an increase of 1036 percent as compared to only a 128 percent increase for the entire health sector) [Government of India 1982].

During the same time US imperialism had made inroads into the United Nations policy with regard to population control [Mass, 1976]. Following this in 1966 a UN advisory mission visiting India strongly recommended that population growth must be curtailed immediately and for this the resources of the health sector were to be used. "The directorate (Health and Family Welfare) should be relieved from other responsibilities such as maternal and child health and nutrition. It is undoubtedly important for Family Planning to be integrated (it had been integrated with MCH in 1963) with MCH in the field, particularly in view of the 'loop' programme, but until the family planning campaign has picked up momentum and made real progress in the states, the Director General concerned should be responsible for family planning only. This recommendation is reinforced by the fear that the programme may be otherwise used in some states to expand the much needed and neglected maternal and Child Welfare Services" [UN Advisory Mission, 1966].

Taking the cue the Indian government for the first time evolved a traget-oriented approach for sterlisation and the IUD programme. Resources were considerably enhanced and in the first year of its implementation the 'loop' programme netted a phenomenal 8.13 lakh acceptors (much more than sterillisations which had started 10 years before it). And with regard to sterillisations the number of female acceptors also increased substantially.

The above was made possible by redirecting the efforts and inputs of the Third Five Year Plan's ANM-subcentre health scheme, which was mainly designed to reach out health care to women and children, the most vulnerable section of the population. Before this massive investment of the third plan could reach its target, population with the various health programmes — child immunisation, ANC, PNC, domicilary curative services, preventive and promotive health programmes — the imperialist agencies had reoriented the policy to attacking the 'population menance'. Thus the entire basic health care services which were designed for the periphery were reduced to a population control programme at the behest of imperialism. This distortion of an already underdeveloped health sector continues even today.

The population control strategy was based on the imperialist hypothesis that imporved health care necessarily accelerates population growth. [World Bank, 1980; Mass, 1976]. Therefore to check population growth health intervention was to be kept at a minimal level, a level that would generate adequate surplus labour to perpetuate exploitative relations. This was to be realised through heavy financial assistance and export of the ideology of the 'population bomb' by the imperialist powers. The pattern of financial assistance and population growth in

underdeveloped countries is given in Table 2. It shows that the initial lead was taken by private organisations (mostly foundations of the corporate sector) and gradually transferred to bilateral and multilateral agencies through their influence.

(It is also evident that two decades of vast financial commitments did not dampen population growth in underdeveloped countries. Their hypothesis was proved incorrect but this did not decrease their interest in population control. Their own studies in the seventies showed that in underdeveloped countries there were strong economic reasons for high fertility. The nature of the subsistence economy makes it expedient for a household to have a large family so that exploitation of fluctuating opportunities of source of income can be maximised, especially so when most of these opportunities coincide in a particular season — monsoon in India [Chaudhary, 1982]. Also under such conditions children are highly cost-effective. The cost of their raising far outweighs the benifits that arise due to their plenitude children contribute substantially to households through their labour (not necessarily wage-labour) in the fields, outdoor activities (fetching water, firewood etc) and household maintenance (babysitting, cleaning etc.) [Caldwell, 1977; Epstein et. al., 1975; Hull, 1977; Nag, 1978]. Further, these studies also indicated that an important determining reason for high fertility was high infant mortality. The World Bank selectively picked up this latter point [World Bank 1980] and advocated the "child survival hypothesis" to replace the older one mentioned earlier. That is, significant effort needs to be invested in assuring the survival of children so that parents can visibly perceive lower infant and child mortality rates. Thus, instead of direct support to population control activities support to universal immunisation of infants, children and pregnant women becomes the key for achieving lower levels of fertility. Related to the child survival hypothesis is the corollary of 'safe-motherhood'. This corollary is essential because of high maternal mortality and neonatal mortality rates. It is unfortunate that these important issues of survival are being-dealt from the perspective of lowering fertility. In India the current mission approach (Sam Pitroda variety) to immunisation is a case in point. It may be further noted that the issues related to the subsistence economy of underdeveloped countries referred to above have been completely ignored because the underdeveloped countries can overcome their subsistence nature only with the destruction of imperialism.

The Indian state and bourgeoisie have found this imperialist ideology beneficial for their own survival. All problems (especially economic and health) are linked by them to overpopulation. For capitalism and imperialism it is important to regulate fertility because surplus labour beyond a certain level can pose a threat. (The World Bank calls it the spectre of communism). Further, modern capital intensive technology makes generation of surplus labour under capitalism even easier, thus making the need for population control even more urgent.

Population control policy is one area of imperialist intervention in the health sector of underdeveloped countries which has kept health care services underdeveloped in these countries. The other area is promotion of low-cost primary health care for the periphery of these countries.

In India the Narangwal experiment in Punjab in the sixties set the framework for the 'low-cost' 'self-care' approach [Johns Hopkins 1976]. Following this similar experiments and projects were undertaken in Maharashtra and other states by various non-government organisations (Jesani, et.al. 1986). The consequence of this was the questioning of the medical model (especially the Bhore Committee) and promotion of a "community" health care approach. This proliferation of NGO experiments and models became the basis for an important change in the health policy framework of the state. The population control obsession of the health policy of the decade between 1966 and 1976 suffered as set back, albeit temporary, after it had reached its peak during the emergency.

It is interesting to note that the liberal western economies offered full support to the coercive population control activities during the emergency by stepping up their financial assistance for the family planning programme. When in 1976-77 the state's expenditure in family planning increased by 114.6 per cent over 1975-76 (and sterilisation by 204 per cent, assistance by imperialist agencies (bilateral and multilateral) increased by 50.8 per cent in the subsequent year. But when the Janata government came to power in 1977 and government expenditure declined by 46 percent (and sterilisation declined by 88 per cent) the cut in international aid for the subsequent year was 43.4 per cent. And to prove that this was not a mere coincidence the coming back to power of Congress (I) in 1980 increased population control aid by 111.7 per cent [Government of India, 1982].

In the mid-seventies a global change in the health strategy in underdeveloped countries was being worked out by the international agencies. It emerged in the form of Alma Ata declaration of 1978. India had anticipated this earlier with the influence of NGO models which were mostly funded by international agencies [Jesani et.al.1986].

India had officially started with the Community Health Worker Scheme (now called Community Health Guides) in 1977 with the idea of decentralising further the PHC and subcentre model which had failed to work, except in meeting Family Planning targets. There was no guarantee that the CHW scheme would not end up pushing family and planning traget precisely the same thing happened.

Before the introduction of the CHW efforts had been made to integrate the paramedical workers of the vertical health-programmes (malaria workers, vaccinators, ANMs etc.) through the multipurpose worker scheme as suggested by the Kartar Singh Committee. This integra-

tion idea had again emerged from the Narangwal experiment. "The committee unanimously agreed that the concept of multi-purpose workers at the periphery was both the operational research experience of Narangwal, Gandhigram, conclusion" [Giridhar et.al.,1985]. But the integration did not help in anyway in even starting the process of deceleration of the underdevelopment of health in the periphery. On the contrary all the health workers (alongwith many non-health workers, supposedly to justify the promise of interdepartmental cooperation and integration) were laden with carrying the burden of population control targets.

The consequence of this, over the years has been that the state's health care services in the periphery are today viewed by the people as family planning clinics. People in general have developed a distrust for the state's health care delivery system. Thus, thanks (sic) to imperialism primary health care, health services integration and Universal Immunisation Programme 'child survival') have become 'new' flag-carriers of the population bogey.

In the midst of all this for the first time in 1983 an official National Health policy (NHP) was announced. It was largely based on the ICMR-ICSSR Committee Report [ICMR/ICSSR, 1981]. The policy states: India is committed to attaining the goal Health for All by the year 2000 A.D. through the universal provision of comprehensive primary health care services. The attainment of this goal requires a thorough overhaul of the existing approaches to the education and training of medical and health personnel and the reorganisation of the health services infrastructure. Furthermore, considering the large variety of inputs into health, it is necessary to secure the complete integration of all plans for health and human development with the overall national socio-economic development process, specially in the more closely health related sectors, e.g. drugs and pharamaceuticals, agriculture and food production, rural development, education and social welfare, housing, water supply and sanitation, prevention of food adulteration, maintenance of the prescribed standards in the manufacture and sale of drugs and the conservation of the environment. In sum, the contours of the National Health Policy have to be evolved within a fully integrated planning framework which seeks to provide universal, comprehensive primary health care services, relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of the various health programmes is through the organised involvement and participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the health sector [Government of India, 1983: point 5, pgs. 3-4;]

Very progressive and comprehensive indeed! but all this gets pushed into the background with the paragraph that follows the above: Irrespective of the changes, no matter how fundamental, that may be brought about in the overall approach to health care and the restructuring of the health services, not much headway is likely to be achieved in improving the health status of the people unless success is achieved in securing the small family norm, through voluntary efforts, and moving towards the goal of population stabilisation. In view of the vital importance of securing the balanced growth of the population, it is necessary to enunciate separately, a National Population Policy [Ibid: Point 6, pg.4]

There is ample evidence in implementation of this policy to prove that the population control programmes emphasised in the NHP has been accorded an overriding focus in the "comprehensive primary health care programme" and rest all (specified in the first quote from NHP) is just for the record!

The consequence of this health policy making in India and the resultant programmes with the assistance, guidance and ideological inputs of imperialism has kept the health sector underdeveloped. Even today in India 80 per cent of all health resources and medical manpower are located among the 25 per cent urban population, when 75 per cent of the country's population resides in rural areas: even in urban areas 80 per cent of the health resources are accessible only to the top 20 per cent of the socio-economic strata. This shows that the enclave sector structure of health care services continues even today.

Inspite of this apalling situation the government is talking of privatisation of health services : The policy (NHP of 1983) envisages a very constructive and supportive relationship between the public and the private sectors in the area of health, by providing a corrective to re-establish the position of the private health sector.... with a view to reducing governmental expenditure and fully utilising untapped resources, planned programmes may be devised related to local requirements and potentials, to encourage the establishment of practice by private medical professionals, increased investment by non-government agencies in establishing curvative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the health field [Government of India, 1983].

This process of privatisation is not confined to India or to underdeveloped countries but has also been going on in western developed countries which have state supported health programmes. Further privatisation is not limited to the health sector but extends to all sectors of the economy. Privatisation is a response of imperialism both to firm its control of the international economy so that any process of socialisation of production and services is truncated and reversed, and a response to tiding over the fiscal crisis of the state.

This process has begun in India too in a big way. But this is in contradiction to the policy of promotion of low-cost self-care health models. However, this contradiction does not appear sharp because of the enclave structure of our

economy. The high technology and corporate health services are for the few who already have more than adequate health services accessible to them, and the low-cost models are for the periphery.

The low-cost model strategy is a deliberate attempt to keep health care out of the reach of the periphery because without the latter's underdevelopment the over-development of the centre cannot exist. This takes us back to the Bhore Committee model which talked of a level of development of the health sector for India which was on par with developed countries during that time. That level of development is the minimum required if health care services must be adequately available to all. The Bhore Committee also re-commended that health services should be available free of cost to everyone. The rejection of the Bhore Committee report as a policy statement and instead shaping our health services over the years on the whims and fancies of imperialism is one of the important causes in underdevelopment of the health sector in India. Of course the Bhore Committee could only have been implemented if our economic policy had also been radically different.

[Conclusions]

To sum up the discussion one can conclude that the underdevelopment of health care services in India (and similarly in the rest of the underdeveloped world) is part of the process of underdevelopement which is the consequence of monopoly — capital and imperialism. Imperialism controls, monitors and manipulates every aspect of the social structure to the extent that it also expropriates the culture and mind of the population in under-developed countries. Our policy makers, planners are brainwashed and bought over so that our underdevelopment is perpetuated for the development of imperialism. Thus for a small investment in brainwashing and a paltry financial assistance imperialism is able to sell underdevelopment to underdeveloped countries.

Since independence health policy making and the design of health programmes (like all other development programmes) have been guided by programmes of imperialism. The core of the entire health policy and programming of the Indian state has been population control. This has been largely due to imperialism's successful propagation of the 'population bomb' phenomena. As a result the Indian peripheral population has been denied state sponsored health care services (that exist theoretically) and have instead had to depend on the vagaries of the market forces in which operates the overwhelming private health sector that has virtual monopoly of curative health services, being supported to the hilt by the multinational pharmaceutical industry. Today the policy of privatisation is making the scenario for the periphery even worse.

Privatisation, high techonology, population control, low-cost models, aid and the consequent dependency are the means of imperialism to shape our health policy and programmes. Imperialism exploits, expropriates, creates dependency and generates underdevelopment, both within and outside the health sector. And to prevent underdevelopment from getting out of its control imperialism keeps throwing up new tricks (or old tricks in new garbs) each time the contradications of its existence threaten to knock it down. In India too these new tricks have surfaced time and again and have helped underdevelopment survive, even though breathless.

Table 1 : Growth of Health Infrastructure and Investment in Population ('000s) Served Per Rupees Per Capita

	POPULATION (000s) SERVED PER					RUPEES PER CAPITA		
YEAR	HOSPITAL	DISPENSARY	PHC (RURAL)	HOSPITAL BED PERCENT	MEDICAL COLLEGE	QUALIFIED ALLOPATH DOCTOR	DRUG PROD-UCTION	STATE HEALTH EXPEN-DITURE
1951	130(NA)	55.4	-	3.2 (NA)	12890	5.8	0.96	0.9
1956	120(NA)	56.3	550	2.5(25%)	8230	5.5	1.30	1.60
1961	140(NA)	46.7	140	1.9 (NA)	7310	5.4	2.27	2.67
1966	120(NA)	48.3	80	1.6 (NA)	5410	4.2	3.90	4.13
1971	140(NA)	50.3	80	1.7 (NA)	5770	3.6	6.11	6.86
1974	150(16%)	60.3	80	1.7(13.2%)	5530	2.9	7.55	11.71
1982	100(44%)	41.7	90	1.4(13.4%)	6600	2.5	27.87	36.26
1986	100(45%)	27.9	90	1.4(12.5%)	7070	2.5	NA	53.94

Compiled from : *Handbook of Health Statistics*, CBHI, respective years; *Combined Finance and Revenue Accounts*, CAG, respective years; Commerce (supplement) *Pharamaceutical Industry - A Growth Perspective November 12, 1977. Health Status of the Indian People*, Sonya Gill (ed,), FRCH, 1987.

International Assistance for Population Control 1960-1980.
Assistance by Selected Major Donors (000's US$)

Year	Western Government	Multi-Lateral Agencies	Private Organisations	Population Change in Underdeveloped Countries Over Last Decade (Percent)
1960 *	91	--	3107	22.4
1970 *	87187	18750	56012	25.6
1980 **	369800	287900	16000	31.6

Source : * Quoted in World Bank Staff Report : *Population Policies and Economic Development*, John Hopkins Press 1979.
** Compiled from *Population Reporters* January-February 1983, Population Information Programme, John Hopkins 1983.
*** World Bank, *World Development Report*, 1983.

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Health on Political Agenda in Pakistan

SAR

In April 1987 the Pakistan People's Party (PPP) released a well-researched and scholarly document entitled the People's Health Scheme, which together with Benazir Bhutto's speech at that time may be taken to comprise the party's health manifesto. Can the PPP hope to implement it successfully in the event it comes to power?

(Reprinted from Viewpoint, *July 16, 1987)*

THE People's Party has issued a 72-page document entitled the People's Health Scheme. The document was released on April 30, 1987, at a function attended by Benazir Bhutto, whose speech is also included in the document of the party. Given its inclusion, one assumes that it is also part of the document, as it does indeed raise a number of very relevant points.

Before I proceed to the contents of the documents, there are some things which need to be said about the presentation of the document. I have been most impressed by the document, for it is one written by a group of professionals who seem to know their stuff well. The document has numerous references to statistics and publications from the government and international sources, thus giving it great credibility and authenticity. The statistics have not been presented just for the sake of the exercise and a very intelligent and well-researched methodology has been used.

The People's Party is the only political party which has openly and courageously expressed its views on numerous issues, all in published form. Whether one agrees with the contents of the published stands of the party, or with the ideological approach of the party, is something different, but at least we have the opportunity to know its stands and then make a decision for ourselves. Further, despite the fact that some of their published documents have come in for a lot of stick (the Awami budget, the Labour policy), the party has continued the process of making its attitudes public, all backed up by hard facts. It goes to the credit of the People's Party to be able to organise teams of experts on various subjects and then to publish and make public their views.

In her speech which serves as a preface to the document, Bhutto has raised some relevant points about the health system in the country today. She has lamented the plight of doctors, their unemployment and poor renumeration; the role of the last PPP government has been discussed and Benazir has cited the opening of medical colleges, large hospitals, and expansion of facilities under Bhutto; she has clearly understood the causes of ill health when she says "Good health is less the work of doctors and hospitals than of advances in public health. We need improvement in clean water and sanitation; improvement in housing and nutrition"; she has also understood the need for a healthy and educated society in order to build for growth and progress. She has also recognised the fact that of the 10,000 medicines produced in Pakistan, only 250 are needed, as recommended by the World Health Organisation. She has promised to supply the minimum number of essential medicines at very low prices and intends to keep in line with the WHO recommendations.

The salient features of the main report are as follows:

(i) To decentralise the entire health set-up by creating elected District Health Officers — democratisation at the local body level.

(ii) The upgrading of public health services.

(iii) A broadening of the social security scheme.

(iv) The private health sector will be given incentives to improve and enlarge its scope and will be completely separated from the public health sector. General practitioners will be given soft loans for buildings, equipment and cars.

(v) All medical graduates will be given jobs as soon as they finish their house jobs and rural service.

(vi) A National Formulary for drugs based on the WHO list will be introduced and these will be made available even in the smallest villages of Pakistan.

(vii) The obsolete Mental Health Act shall be replaced and new laws according to the present needs will bemade.

(viii) Laws relating to quackery shall be strictly implemented.

(ix) Hikmat and Homoeopathy will be formally organised.

This seems to be a rather comprehensive programme which should be a positive step towards providing 'Health For All' by the year 2000. It is not the purpose of this article to either belittle the programme of the People's Health Scheme, or to find faults with it, or to point out all that could have been said and which was not mentioned in the document (the role of multinational corporations in the provision of drugs). The purpose is to analyse the programme, which on paper seems to be quite good, within the broader social, economic and political structure of Pakistan, for one cannot look at health, or education, or employment, out of a wholistic context.

It is my contention that the problems of health care in the country are linked directly to the prevailing social, economic and political system that determines the alloca-

tion of resources within or outside the health sector. It is this class system which is responsible for the lack of adequate infrastructural and health facilities in rural areas and urban slums and this class system is also responsible for the reluctance of doctors to practise in these areas. Very briefly and in a simplified manner, we can identify five basic issues in the health sector today which affect the distribution and availability of health care.

Urban and Class Bias

The first point regarding the health system which strikes us is that despite the fact that 70 per cent of the population lives in rural areas, most of the medical and health facilities are found in the cities. For example, 85 per cent of the practising doctors work in urban areas giving a doctor : population ratio of 18.01 for urban areas and 1:25.829 in rural areas. In Sind, the rural doctor : population ratio is 1:57.964. For nurses, this ratio in Sind is an astonishing 1:58. Similarly, 23 per cent of the hospitals in the country are located in rural areas and only 8,754 beds are available for a population of 60 million.

This 'urban bias' in health (and almost all other) facilities exists due to a few reasons. For one, the ruling class, whether, bureaucrats, military personnel, industrialists, and even absentee feudal landlords, live in cities and enjoy the fruits of 'development'. Secondly, organised, articulate and politically active groups, such as trade unions, students and professionals, who live in urban areas, have also acted as pressure groups and raised their voices to demand social infrastructure. The elite, the middle classes, and the politically 'noisy' sections of society live in the cities and, thus, it is largely this section which determines the allocation of resources. The 'natural' outcome will be an 'urban bias'.

It must be emphasised, however, that this 'urban bias' is an impressionistic bias and only reflects the geographical location of health services. There exists a deeper and more fundamental bias which is main determinent of access to health facilities. This is the class bias. The facts reveal that not all urban inhabitants have equal access to health facilities, nor are all ruralites equally discriminated against. It may be easier for a feudal landlord to have access to good health care than for a slum dweller in a large city, A 'basti' dweller may have 'apparent' access, in the sense that he may know of existing facilities, but it is not likely that he will be able to afford the high cost of quality private care. At the same time, the quality of care at a government hospital OPD which is available to him, where a doctor has less than 60 seconds for a patient, is indeed questionable. Similarly, for residents within cities, great differences in access exist. Those with money can afford the 'best and latest' technology and have immediate access to facilities, while the majority, like our slum dweller mentioned above, faces innumerable hurdles.

Thus, despite the apparent urban bias, we can conclude that irrespective of geographical location, it is class location which determines access to health facilities.

The purpose of medical education is to produce medical personnel who can work effectively in the existing model of health care in a country. Thus, the doctors produced after six or seven years of training in Pakistan are those who work best in the setting described above: one that is urban-care oriented, and work in the interests of the richer inhabitants of the country.

Medical students in Pakistan are taught from books written in and for the developed countries. The diseases our students learn about are more specific to developed capitalist nations than to underdeveloped ones. For example, they learn from their books that cardiovascular disease and cancer are the main killers, while the real situation in Pakistan is that parasitic and infectious diseases are responsible for 54 per cent of all deaths, while diseases of the rich and of western countries (heart disease and cancer) account for less than 2 per cent of deaths. The teaching methods and books leave such a profound influence on the students that they begin to believe that one of the main causes of death in Pakistan is indeed cardiovascular problems!

Not only does the diagnosis of the disease come from western sources, so does the appraoch to care and cure. The developed country curative care approach is copied in underdeveloped countries where the emphasis turns to urban-based hospitals. The teaching faculty plays a contributory role in accentuating this 'cultural imperialism'. Professors go to the west for training and urge their students to do the same to acquire skills in disciplines such as neuro-surgery and plastic surgery. When (if) these doctors return, they become even more aliented from the masses of their country, who live in urban slums and rural areas. Firstly, they lose touch with common ailments which afflict the poor, such as gastroenteritis and tuberculosis, and can deal best with the diseases of the rich. Secondly, and more importantly, the western-trained doctors are available to only a select few who can afford their high fees.

In underdeveloped countries like Pakistan, where most diseases are of a communicable and preventable nature, the emphasis should be on training doctors who are well-versed in primary health care techniques. Yet, the course in community medicine in medical schools is taken very lightly by students and teachers, who have no real community experience. Often one finds examples where qualified doctors are unable to cope with simple and common problems, such as snake-bite. The training and practical experiences of medical students are solely dependent on their interaction with patients who come to their

urban hospital, again, for a curative approach, when a preventive one may be preferable.

The explanation for this inappropriate medical education is quite straightforward. Since it is the ruling class which essentially determines the dynamics of the health sector, it is also responsible for the production of a specific kind of doctor. This ruling class requires a doctor who works best in a hospital-based curative-care setting and can deal effectively with the diseases of the rich of Pakistan, which are similar to those common in the developed countries. Consequently, the curriculum in medical colleges is designed to produce the desired product.

An important outcome of this type of education and training is the 'westernisation' of doctors. Since doctors in Pakistan are taught about 'western diseases', most doctors can, after some acclimatisation, work easily in hospitals in the developed countries. Our system of medical education has been a major reason for the medical 'brain drain' from Pakistan, with nearly 50 per cent of our doctors practising outside the country.

Had the curriculum been designed to suit the needs of the poor masses of Pakistan, with more emphasis on conditions in rural areas and urban slums, this problem would not exist. At present, given their medical education and doctor migration, the UDC's are subsidising the West!

One would think that, given the poor health status of the population and the poor distribution of facilities, a feature like doctor unemployment would be quite unheard of in Pakistan. But this is not the case. At present, government sources themselves claim that more than 11,000 doctors are unemployed in the country. On the one hand, the country is faced with this unemployment, while on the other, the infant mortality rate is 125 per thousand and the doctor-population ratio in rural Sind is 1:57964.

The crisis of the unemployed doctors has been brewing for a number of years and has only just exploded. Given the policy of successive governments towards health care, this crisis should have been anticipated. Governments have been obsessed with the urban-based curative-care approach and have accordingly built medical schools to provide for the main pillar of the system, the doctor. This one-sided approach to health care has backfired: by not building medical infrastructure to absorb the entire output from medical schools, the doctors have ended up without jobs. Had a more balanced approach been followed, and had facilities been built in accordance with the distribution of population, the doctors may have been able to find jobs, and some may have even considered moving out of the larger cities. Today the situation is indeed ironic and sad that despite the shortage of doctors in the country, the government has advised the unemployed doctors to seek employment in the Middle-East.

In Pakistan more than 7,500 medicines are produced de ite World Health Organisation recommendations that onl '50 are enough for underdeveloped countries. Significant 85 per cent of total pharmaceutical production in Paki. n is controlled by 15 MNCs!

There are two main reasons for this state of affairs, which is quite common in most underdeveloped countries. Firstly, in a country which supports a doctor-oriented curative-care model, the doling out of medicine becomes an essential requirement of the system. Doctors must have plenty of medicines to give to their patients. If, on the other hand, the approach to health care in Pakistan was prevention-oriented, with intervention taking place much earlier, the need for medicines would decrease and the cure would also be cheaper. The second reason for the continued prominence of pharmaceutical MNCs in UDCs is the link these MNCs maintain with the doctor community and with the state bureaucracy. Many MNCs sponsor international seminars with the ostensible aim of promoting medical science but which are essentially conducted to promote their own product. In many countries doctors are given numerous perks to promote certain medicines. Links with the bureaucracy are strengthened and influence is exerted to ensure favourable treatment in the case of pricing and production.

In the case of Pakistan, little research has been carried out on the pharmaceutical industry and it is time that some scholars took upon themselves the task to do so. It is important not only to know the profit that the MNCs made each year, but also to expose any unethical practices that they indulge in.

In 1978, a revolution took place in the field of health care. More than 130 countries signed a declaration in which they promised to give their people adequate health care by the turn of the century. Pakistan was one of the signatories to the Alma Ata Declaration.

Eight years have gone by since the signing, and only 14 years are left before this century comes to an end. Yet any impartial observer would be distressed by the status of health of the people of Pakistan. Not only have no significant changes been made in the last eight years, given the present trend none can be expected in the next 14. At best one can expect some small cosmetic changes within the warped health care structure in Pakistan, but no real indications exist for the overhauling of the structure itself.

Thus, it is quite clear that health care is a reflection of the social, economic and political structure prevalent in a country. If a small ruling clique controls the resources of a country and little or no participation by the people is

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tolerated, then the health sector will reflect this pattern, with health for a few and not for all. To bring about a revolution in health, it becomes necessary to bring about a revolution in society. The experience of socialist-oriented societies shows that once they have changed the pattern of the distribution of resources within the society, they have been able to change the pattern of health care, making access more equitable. Apart from socialist countries, some social democratic nations with a long history of participation by the masses have also provided adequate health facilities to their people and the resulting improvement in their health status is quite enviable. Thus, one cannot expect significant improvement in the health sector in Pakistan without substantial participation of the masses in the workings of society, and without substantial changes in the power structure as it exists today.

So, where does the well-meaning People's Health Scheme fit into all this? The People's Party is a populist party which means that it cannot and will not change the basic economic and political power structure as it exists in the country today. Thus, one cannot expect that it will drastically change either the health system or substantially increase the accessibility of health services. It is true that under the Bhutto regime, the expenditure on health care was much greater than it has been since 1977. But, caught up in a pseudo socialist-populist trap, the policies followed looked good only on paper. The eight medical colleges built in the country were created to appease the noisy middle classes. Had the government really been sincere it would have built rural health centres and basic health units instead of these great buildings called medical colleges. (For the cost of one medical college, 251 rural health centres or 556 basic health units could be built which would serve 5.56 million people - all of whom live in rural areas!).

Thus, the People's Health Scheme is a step in the right direction, and one can assume that some changes on the margin will indeed be made. However, meaningful radical change in the health sector, which would truly and honestly serve the people, will only come about once the existing social, political and, most importantly, economic relations are broken.

UPDATE

News and Notes

Continuing Disaster

The minority report of the Supreme Court Committee for Bhopal Gas Victims recently placed before the judges is a telling illustration of the impotency, inertia and inefficiency which charecterises our public funded research establishments. It also highlights a more fundamental issue : the growing signs of an erosion of authority of the judiciary and a disregard for legal processes. Tangentially, the report also draws attention to another aspect of the situation of Bhopal — that the disaster and all its ramifications have remained but a peripheral concern for opposition parties. As a consequence, little pressure has been put on the government, both central and state, to give the disaster the priority it requires.

The committee was constituted in response to a writ petition filed in July 1985 by Dr. Nishit Vora and others who were then in charge of a dispensary administering the only known antidote to the poisoning, sodium thiosulphate. The dispensary had been summarily closed down, its records seized and its doctors arrested. The petition pleaded for a court directive to the state government to allow the administration of NaTS. In August the court issued directions urging the state government to implement a time-bound scheme for detoxification as per the guidelines issued by the Indian Council of Medical Research in April that year. The state government on the pretext of seeking a clarification from the ICMR on the efficacy of the treatment even in August, did not reintroduce the programme.

On a reapplication by the petitioner, the court constituted the Committee for Bhopal Gas Victims comprising experts. Anil Sadgopal represented the petitioners and Dr Sujit K Das was nominated by the members. The committee was asked to specifically give recommendations regarding the detoxification with NaTS, the quality of medical relief being provided to the victims, the use and relevance of the various surveys being conducted at that time for determining compensation and to ascertain what further work needed to be done. In other words, here was an excellent opportunity for reassessing the emerging medical and scientific data and evolve, even at this late stage a programme for health services beginning with detoxification.

In keeping with everything that has happened in Bhopal, the committee muffed the opportunity. After 11 months of desultory functioning all it could come up with was a one-and-a-half page 'report' — the majority report. The committee asserted that NaTS therapy was 'efficacious' and it had been found to be useful in providing symptomatic relief. It concluded that "had the NaTS therpy been provided earlier a larger number of patients might have been benefitted." None of the other issues touched upon by court directive were even considered.

It was in these circumstances that the minority of two dissenting members, Dr Sadgopal and Dr. Das decided to undertake the stupendous task which the committee had opted out of. In doing so the report throws light on the disinterest of members about a matter of life and death concern to the people of Bhopal; it brings out the puzzling reluctance of the committee to call for information from the various institutions or even from the centres in which some of the members worked; and the marked lack of rigour in analysing the data placed before it. This committee it must be stressed was not of merely academic significance; it was constituted at a time when Bhopal's victims were gravely ill and many dying, to work out the best possible programme for detoxification. That it decided after 11 months to confine itself to one single recommendation, and even that on insufficient material is a shocking criticism of the, 'experts' who constituted the committee.

In contrast the minority report delves into a vast amount of data, obtainined with great difficulty. The report painstakingly documents the sequence of events in Bhopal — nothing short of an expose — which has led to the rapidly deteriorating health status

of the population. It once again raises questions which have been asked before but never been answered : Why was the ICMR so lackadaisical about implementing its early guidelines on detoxification ? Why was the state government health administration, especially certain sections of the Gandhi Medical College, so opposed to administering NaTS even when they could very well discern its subjective efficacy ? Even after the government apparently agreed to administer the antidote, why is it that only a miniscule proportion of the total population needing it has received it ? And most importantly, was the basis on which NaTS was prescribed and promoted by activists who took the experts — Dr Chandra's early study and ICMR's double-blind clinical trial — scientifically sound?

Even more significant however, is the report's reveletion that to this day there has been no effort to coordinate the various research projects being undertaken in Bhopal. For instance, although the ICMR listed 24 projects in Bhopal, it does not as yet seem to have made any attempt to collate the findings in order to evolve a broad toxicological perspective. This has meant that there is no cohorent understanding at present of the manner in which MIC has affected the population. The report points out that the possibility of systemic persistence of MIC or its metabolites in the victims and their role in the chronic phase have not upto now become a focus of attention. And yet there were enough data to indicate further investigations in this direction. What is even more puzzling is that three independent studies did in fact propose to focus attention on this matter : Prof Heeresh Chandra's early toxicological study; as early as May 1985 the ICMR postulated the possibility of chronic cyanide toxicity among the victims — the author of this was none other than Dr. S. Sriramachari; and in December 1986, the ICMR update stressed the need to study the "biological effects and metabolism of the toxic principals". And yet the minority members have not been able to obtain any information about these aspects.

In fact the ICMR appears to have been rather adept at compartmentalising its research — this despite having set up a Bhopal Gas Research Centre to ostensibly coordinate the work. For instance, the AIIMS team investigating thyroid activity in the affected population found evidence of persisting toxicity. Surprisingly however, although this too was an ICMR study, albeit not among the 24 listed as Bhopal studies. Not only were the findings disregarded, the project itself was terminated! Similarly, Dr NP Mishra, one of the loudest members of the anti-thiosulphate lobby in Bhopal, was forced to recognise in his October 1987 report for the ICMR the continuing morbidity of his gas-affected patients who had been treated symptomatically. Even this failed to make an impact on the Council's understanding of the situation.

Equally difficult to understand is the fact that investigations on animals exposed to MIC conducted in institutions other than ICMR such as the Defence Research and Development Establishment in Gwalior were probably not even known to the medical researchers. As such they failed to influence the direction of research being conducted over all. The minority members have also failed to discover any material which attempts to integrate the findings of the clinical, toxicological, epidemiological and autopsy findings and analyse them in the perspective of the results of studies on the chemistry of the decomposing products in MIC tank 610.

Part of the reason is of course the shroud of secrecy which surrounds every investigation in Bhopal. The minority members themselves had to contend with this constantly, despite the Supreme Court directive that all information was to be made available to the committee. This raises disturbing questions on the necessity of this secrecy. What was it meant to achieve : to keep information from Union Carbide or was it in fact to keep information from being disseminated to the people ?

— P. P

Dialogue 1

Problems in Documenting EP Drugs Campaign

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THE two articles on high-dose EP combination published in *RJH* Vol II. no. 3 do not aim at giving an account of the movement to ban this hazardous drug-combination. But there are certain inadequate or inccurate statements about the same. This response is to correct the unintentional misleading impression created by these statements.

A few activists and journalists belonging to health and consumer groups had gathered in Pune in January, 1983 to discuss and chalk out an action-plan on mutually agreed issues. In this discussion it was decided to take up a campaign against high-dose EP combination. The technical, background material was then prepared by Mira Shiva and Satyamala of Voluntary Health Association of India. V.S. Mathur, Professor of Pharmacology at the post-Graduate Institute of Chandigarh, prepared a 'dear doctor' letter. This was circulated amongst different health, consumer, women's groups and signature-campaign was undertaken. We requested women's groups to include the demand for a ban on this combination, in the list of demands on the International Women's Day March 8 that year. We also managed to get articles published in news papers all over India on March 8 (which was incidentally a Sunday) arguing for a ban on this combination. This was followed up with representations to the concerned authorities.

The second source of determined opposition was in the form of petition in Supreme Court by Vincent Pannikulangara against the continued use of a number of hazardous drugs including high-dose EP combination. The Supreme Court ruling on this petition resulted in the public enquiry.

Thirdly, an article in the *Onlooker* published from Madras, claimed that Palaniappan from Madras has reported a very high incidence of congenital anomolies consequent to the administration of high-dose EP combination to pregnant women. There was a lot of uproar on this issue after this article. Questions were raised in the Parliament.

As a consequence of this determined opposition from different sectors, the Government requested the Indian Council of Medical Research to give its opinion about this issue once again. (Earlier, ICMR had said that there is no need to ban this product; only a warning be given along with the product that it should not be used in pregnancy.) We had argued that this warning, was not going to stop the misuse of this drug. Since there was no scientific indication whatsoever for the use of this combination, consumers would not be deprived of anything if this hazardous combination was banned. This second committee of ICMR also recommended its total ban. It is thus not correct to say that the use of high-dose EP combination "has created such havoc that the victims, i.e. some of the women, could not bear it any longer. Their protests led to the banning of the drug."

The relative success of the campaign on this issue in 1983 was one of the important factors responsible for the continuation of this networking that had taken shape around this issue. The All-India Drug Action Network, consisting of around a dozen health, and consumer groups, was born and continued to follow-up the demand for a ban on high-dose EP combination.

In the public hearings on high dose EP combination, member-organisations of All-India Drug Action Network have played a significant role. The method of publishing the notice about the public hearings in an inconspicuous manner and not informing the concerned action groups was severely criticised. So also the reported decision of the Drug Controller to stop the hearings after the Calcutta hearing. Fraternal organizations outside AIDAN, like FMRAI and Health Service Association of West Bengal also put up a lot of pressure on this issue. As a result of these efforts from different groups, the Drugs Controller had to decide to hold hearings in Calcutta and Bombay and had to send invitation-notices about these public hearings in Calcutta and Bombay to all the concerned groups. Mira Shiva (VHAI), Satyamala (MFC), Vishwas Rane (Arogya Dakshata Mandal), Amit Sen Gupta (Delhi Science Forum) gave a valiant fight at the Delhi hearing even though the pro-EP forte lobby was in the majority, had a few prestigious gynaecologists on their side. All these organisations are members of AIDAN. In the Bombay-hearing also ACASH, ADM, MFC, LOCOST—(all members of AIDAN) along with other similar groups presented a solid technical case against high dose E.P. combination, whereas various women's groups presented a social critique of the continued use of this combination against the interests of women. Amitav Guha's article, unintentionally glosses over the role of AIDAN in this movement.

The movement against high dose EP combination thus does not follow a classic pattern. It was not initiated by any women's group, nor did the women's group consistently follow up this issue, or took a lead in it. A lawyer (Pannikulangara), a journalist of *Onlooker*, a few committed health-activists from certain health-action groups (some of which are incidentally foreign-funded) played at least as important a role as women's groups or the trade union FMRAI, alongwith many others, did AIDAN remained the

'Cut System' Dilemmas

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forum which helped to pursue the matter and helped to co-ordinate the lobbying.

The above clarification is not at all meant to be a criticism of women's groups but to communicate as to how things took shape in reality. It indicates that sometimes initiatives are taken, events occur in such issues in health in a rather unexpected manner. What is the significance of this unorthodox picture? What are the lessons to be drawn? I hope, that there would be some discussion in *RJH* on this topic.

Today a friend of mine, a consultant earned Rs. 100/ -- out of which he gave Rs. 60 to the ever willing hands of the local GP. This patient had come to him with a diaganosis of 'chronic' appendicitis. The G P instructed my friend to get a host of investigations from a specific pathologist and a radiologist who in turn give their respective cuts to the GP. All his medical teaching was of no avail as he unnecessarily subjected the patient to a host of investigations and unnecessarily operated on a patient who actually had a mild attack of Amoebic typhlitis.

It is said that nearly 80 per cent of private health practice is part of this nexus of commission and cuts between the GP and the consultant. They go to any lengths to earn their bread and butter and probably, jam. They may be part of the so called 'Arab practice' or the 'Kidney transplant nexus'. They admit patients in their ICCU's with a (mis) diagnosis of an infarct. They manage seriously ill patients till they become critical before sending the patient to a general hospital. They even have nexus with the Medical representatives who give cuts for prescribing a particular drug albeit spurious or banned like EP forte for example.

The health services of our country like most others like pharmaceutics is an industry in itself. It is profit-oriented. All the state run health services are poorly equipped to deal with the illnesses of 700 million people, the government is not interested in providig better facilities, because of the poor cost-to-profit ratio. The drug industry is the second most profitable industry in the world after the arms industry. Hence there is flooding of spurious, banned and bannable drugs in the market.

Where does a doctor figure in the above maze of profit-oriented industries?

On one hand is what we have learnt and understood for the past 26 years, on the other is the pull exerted by the profit-oriented industry. Most of us do not have a capital to rely on, hence, tend to get pulled to the latter side. If we resist, then there is a theoretical possibility of falling into the abyss between the two philosophies.

We have to choose whether we are going to practice rational medicine or whether we are going to join the rat race. The latter choice is irreversible. If we choose the former, we can set an example for others to follow and hope that the profit oriented economy of drug and health services will surely meet its hour of crisis when the average patient says in unison "I cannot stand it any longer". Can we stand the test of time?

The irrational 'cut' practice was not so prevalent say 50 years back. At that time our elders insisted that honest, and ethical medical practice is important and unethical practice is to be shunned. Now, the same elders and colleagues say that if one wants to just about make both ends meet, he should practice irrationally. Why has it changed so drastically?

Even at that time there were two types of health services, namely 1) private practice and 2) the state run hospitals supposedly working selflessly. Over the last 50 years, a lot of money was poured in to set up large-scale drug industries or extensive diagnostic centres. The above works only to increase the invested money. The owners do not think about the average consumer but only in the amount of profits they get.

The health budget of the state of Maharashtra is one of the highest. It is believed that the effects of the increased budget would 'trickle' to the bottom increasing the health status of the millions of exploited in the city. Actually it appears as if that it has had no effect at all. Otherwise nearly 100 infants would not be dying of every 1000 live births or 50,000 people would not die of TB every year or thousands would not become blind every year due to lack of Vitamin A!

Let's now look at private practice in this respect. The private doctor is no longer an independent healer. He is part of the system whose owners are interested in the profitability of their drug enterprise or the diagnostic or therapeutic equipments. He is controlled by the very system that promotes the increase of capital at the hands of few industry owners. He no longer practices rational medicine. His idealism remained purely theoritical that is taught in the sheltered class -room of a medical college. He becomes a commodity that can be bought and sold by money.

Is it possible to fight this manace? If so will we get support from colleagues or others who are passing through the same process in other fields?

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tolerated, then the health sector will reflect this pattern, with health for a few and not for all. To bring about a revolution in health, it becomes necessary to bring about a revolution in society. The experience of socialist-oriented societies shows that once they have changed the pattern of the distribution of resources within the society, they have been able to change the pattern of health care, making access more equitable. Apart from socialist countries, some social democratic nations with a long history of participation by the masses have also provided adequate health facilities to their people and the resulting improvement in their health status is quite enviable. Thus, one cannot expect significant improvement in the health sector in Pakistan without substantial participation of the masses in the workings of society, and without substantial changes in the power structure as it exists today.

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