

FROM PHILANTHROPY TO HUMAN RIGHT: A Perspective for Activism in the Field of Health Care

Dr. Amar Jesani

The paper begins with a historical evaluation of health care in India and the developed countries and then tries to analyse the existing health care services in our country. It highlights how health activism of the last three decades has raised people's consciousness and concerns for health issues. In the last few years activism has shifted from experimentation in provision to the demand for better provision and control over providers. The paper concludes with suggestions for encouraging the emergence of a health movement.

INTRODUCTION

In last three decades the campaigns on health issues have come to occupy a rightful place in the agenda of social activists and social workers. The efforts of health activists in this period have gradually brought health issues into the consciousness of a broader section of people. Some educational and training institutions have separate departments studying and teaching health and health care. New institutions exclusively devoted to research, education, training, etc. in health and health care have been established. The popular media for long highlighted only the spectacular achievements of medical sciences. However, they too have started giving better coverage to the health issues, which affect masses. There is increasing evidence to suggest that in coming time the health issues may figure more prominently in the national debates than ever.

Ironically, when health issues are emerging as issues of everybody's concern, the activist organisations working specifically on health and which were in the first place responsible for bringing health on to the agenda of so many other organisations and movements, are showing signs of profound crisis and decline. This paradox is perhaps inevitable and points to the need for fresh thinking. Its inevitability flows from the very fact that the health issues have spread beyond the confines of the health activist groups, making the work on health by these organisations less prominent than it was in the past. The health activist groups are thus required to cope with new reality, reintegrate their efforts with others and develop a perspective that could knit multiplicity of efforts into a larger movement for changes in the health situation. The responsibility of other social forces and organisations dealing with health issues is equally daunting, for they have developed concerns on some of the health issues in the same line taken up by the health activist groups for so long. There is also a danger that their work on the health issues might remain episodic, devoid of real strategic significance in their struggle for social change. Thus, the need to understand lessons of last three decades of health activism and evolving an integrative perspective on health has become more urgent than ever.

WHAT ARE HEALTH ISSUES?

It has always been difficult to clearly define health. I take the easiest way by using the most quoted definition. The World Health Organisation (WHO) defines *health* as "a state of complete physical, mental and social well being and not merely absence of disease or infirmity". This definition is widely accepted as it not only puts the health care intervention into proper perspective but also emphasises need to integrate all developmental efforts which could make healthy living possible. Thus, health is one of the essential goal of all developmental efforts. Taken from this angle, even when "health issues" did not separately appear in the development and in people's struggles, those developments and movements were also for improving health. Struggle for better wages, for land, etc. and strategies for rural development, poverty alleviation, community development etc. were therefore also geared to the task of achieving

better health status for people. Second point emerging from the WHO definition is that if the health is “a state of well being”, such a state cannot be static. So it is not possible to say that if one has achieved certain health status indicators, one has achieved health once and for all. Whenever certain health indicators are used as goal for achieving health, they only mean presently desirable or socially acceptable level of well being. The state of well being is thus very much a product of people’s perception and understanding of health and objectively, of the stage of development or the kind of socio-economic system that the development promotes.

Thus, improvement in health status or its deterioration is an invariable part of any development. Each achievement of a level of health status creates new state of well-being which, in turn, lays the foundation for further development of better health. That makes the whole debate on how and for whom the development should take place, essentially a debate on health. There are four terms that provide key to the genuine development. They are equity, participation, empowerment and sustainability. *Equity* addresses to correction of the maldistribution of control over and access to resources. *Participation* ensures equal opportunity and creation of conditions for utilisation of opportunities, and it is not only in terms of benefiting from the developmental programmes but in terms of participation in formulating and implementing development plans at the local and national levels through the democratic institutions. In a way, it also demands the extension of democracy from the political sphere to social and economic spheres. Equity and Participation should be *empowering* in nature, that is, they should provide education, technique and skills for exercising and sustaining control over the development process by the people. Such genuine development should not be episodic, excessively dependent (thus perpetually at the mercy of outside forces), and have internal dynamism for *sustaining* it in the medium and long term. Going one step farther, one can even say that sustainability does not mean static sustenance at one point, but also the sustainability of the dynamic of development. Many societies and social systems initially showed great promise by reorganising their systems and by achieving good equity, but they collapsed simply because they could not develop a dynamic of growth at a level expected or demanded by people.

All these aspects of development apply to health, for the *health* is a part of the development. It is both an outcome of the development as well as a condition for achieving development. The Alma Ata Conference (WHO, 1978) recognised that “health is dependent on social and economic development, and also contributes to it”. For example, the iniquitous social and economic development creates iniquitous health status of the people and iniquitous access to all necessary health care; and they in turn affect the quality of life of various strata of people. The proponents of market economy often see health primarily as productivity and contributor in creation of better productivity in the market economy. For instance, the World Development Report (World Bank, 1993), identifies four ways in which the improved health contributes to economic growth:

“It reduces production losses caused by worker illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases enrolment of children in school and makes them better able to learn; and it frees for alternative uses resources that would otherwise have to be spent on treating illness”.

While contribution of health in development is a truism not needing more emphasis, to emphasis usefulness of health primarily for a particular system of economic organisation, the capitalism, is close to the kind of objectification of everything that market economy creates. For example, often women’s education is advocated for the purpose of reducing population, as if had the population come down by keeping women uneducated, they wouldn’t have considered it useful to educate them. In the market economy of health care, the system advocated by this report; there is no evidence that better health has reduced society’s proportionate expenditure

on health. On the contrary, for example, as the developed countries became “healthier”, their health care expenditure have increased, particularly the market health care of the USA. Besides, such an approach to the health usually runs counter to the developmental and health care needs of the aged, the disabled, the unemployed, the dispossessed, the children - the strata of people considered non-productive. Since household work done by women is not considered a part of the productive economy of capitalism, a big proportion of women would also get less emphasis.

If the health is the state of well being of people, all efforts that go into caring and achieving better well being would automatically constitute health care. As explained above, such effort encompasses entire range of the pro-people developmental activity and change.

Narrowly defined, the health care would constitute those efforts that cure, prevent and promote people to have life without illnesses. This definition flows from the much-maligned medical model of health care, and includes curative, preventive and promotive aspects of medical care. Since medical model is often more narrowly understood as curative care, the term health care is used to emphasise that all three components are given importance. Further, when we talk of increasing importance of health issues, we normally mean health care issues as narrowly defined here and at the most, those specific socio-economic issues which have some *direct* implication on health and health care.

A focus of many debates in the past has actually been on to what extent the narrowly defined health care contributed to improving health status of people. The origin of these debates was in a reaction to the highly dominant medical model of health, the unprecedented increase in the power of medical profession and medical institutions, and they becoming the sole decision-maker on everything about health. Interestingly, the ascendance of medical model started in the 19th century when the scientific medicine achieved hegemony in the Western Europe. Germs were discovered, the germ theory of disease became popular, and so were many other advances. And above all, the professionalisation of medicine took place. So it was natural that in that century only the first rigorous effort to show limits of medicine occurred. The pioneer of social medicine, Rudolf Virchow (1985), carried out intensive studies in communicable diseases and brought out the socio-economic determinant of health and illness. He indeed coined the slogan that “Medicine is a social science and politics nothing but medicine on a grand scale”. But Virchow worked at a time when scientific medicine was getting strengthened but had not yet produced tools to control diseases. So the best way that society could employ to combat ill health was public health campaigns. Mid-19th century England thus witnessed great exposure of abysmal conditions of people and at the same time movements for legislations and regulations for controlling factory conditions, looking after indigent, providing education, public health, etc. Thus, some of Virchow’s revolutionary ideas were implemented by the state in non-revolutionary ways.

But as medicine progressed in developing tools, particularly the discovery of antibiotics during the Second World War, and the post-war boom in the economy with technological revolution producing effective remedies, it strengthened its position, and that of medical profession. This position of medicine was challenged only in 1960s and 1970s when strong critique of medical model reappeared. This was aided by the works of persons like Thomas Mckeown (1979), who by doing historical analysis concluded that though the clinical medicine has its own, but modest, place in health care, other factors like nutrition, environment, behaviour and so on had long term impact on improving health status of people. After all, the developed countries had brought the communicable diseases under control long before the medicine to treat them were discovered.

THE HEALTH ISSUES DISCUSSED IN THIS PAPER

From what I have narrated so far it is clear that health and health care are not something that could be restricted to medicine and doctors. It would appear natural that our perspective should focus on the socio-economic determinants of health and not on the health care or medical care services. However, there are other important reasons for discussing health care issues in relation to formal health care services, including medicine.

1. This is a somewhat neglected area of discussion, particularly by the non-health groups. The non-health activists often feel intimidated by medicine. They feel that since they do not understand its science in so well a way as health activists do, it would not be correct on their part to take it up on a big way. But it need not be so. It must be kept in mind that the activist health groups, which have significantly contributed in making health issues everybody's business were or are not constituted by the committed and socially oriented doctors alone.
2. It would have been easy to underemphasise health care had it been merely a collection of technologies and technocrats. They are there, but they are only a part of the social, economic and political organisation of health care. They derive their power, prestige and privileges from this system, and therefore, it is the society to ultimately decide on what kind of system it needs. The specific aim of health activism is to bring about changes in the organisation of health care services so that services are made accessible, they are brought under the control of people and finally, people are participants in the delivery and not just recipient.
3. The developmental issues such as equity, participation, empowerment and sustainability are as valid for these services as for attaining better health status and the level of development.
4. The correct emphasis on the socio-economic determinants has sometimes wrongly ignored the rightful place of medicine and health care services. While there are limits of medicine, there is also indispensable need for medicine and health care services for people and the society. While emphasising the prevention and promotion in health care, we must keep in mind that curative care is not ignored.
5. The health care services in India are likely to witness great upheavals in the next few years. As I will show later, the deliberate government policies have encouraged the mindless high cost growth of private sector. In the new economic drive for the market and privatisation, this private sector, operating both in provision of services and financing is becoming more and more impatient to encroach and take over the public health care services. A balanced pro-people perspective for health activism in this area is therefore becoming an urgent need.

HEALTH CARE SERVICES: A BRIEF HISTORY

The concern and work for health is as old as the human civilisation. Survival and good living have always been the prime concerns of human beings all the time. Thus, the development of civilisation also had an element of the development of health care. Health care was indeed conditioned and determined by the level of development, and the knowledge, skill and technological base of the society at that point of time. Two other crucial elements played their part in the development of health care. One was the dominant ideology of the time and another was social and economic structure. They either helped in the development or retarded it. For instance, the Indian medicine made a transition to rational and scientific therapeutics very early in the history and showed great promise of scientific development. However, as

Chattopadhyay (1977) has argued, the changes in social conditions of that time stifled the growth of its rational kernel. The entrenched priestly class and its “counter-ideology” showed prolonged contempt for medicine and its practitioners, and that seriously interfered with the development of Indian medicine. Only in the short spell of revolutionary Buddha period the medical science flourished again, but this spark was extinguished when Buddhism lost its revolutionary fervour and was eventually defeated. The Indian medicine, thereafter, could never come out of these fetters, The upheavals of medieval times and deliberate neglect as well as undermining of Indian medicine under the British rule crippled it further.

In terms of development of public health and services, there are some scanty evidences available. For instance, as per the archaeological evidence, in the earliest known Indian civilisation, the Indus Valley Culture (3000 to 2000 BC), the cities had well planned drainage system, almost all houses had bathrooms, many houses had latrines and most houses had wells for water supply (Sigerist, 1987, pp. 143). This indeed provides evidence of state’s involvement in public health. On the other hand, the evidence of state’s regulatory function on health care is available from Kautilya’s *Arthashastra* (written sometime between 4th Century BC and 150 AD). It provides evidence that the state exercised authority on doctors at the time of epidemics, it mandated reporting of treatment of severely wounded persons, and most importantly, it prescribed an elaborate system of granting monetary compensation for injuries due to treatment, particularly when the doctor had failed to provide information about the treatment involving danger to life (Kangle, 1972). On the other hand, our ancient text books of medicine, particularly *Charakasmhita* is very elaborate on the internal ethical regulation of physicians. Similar involvement of the state in regulating health care is recorded elsewhere, the well-known of them being the Babylonian Code of Hammurabi (300 BC) wherein, the rights and duties of physician were provided and harsh punishment for negligence and causing injuries were prescribed. There were also other state sanctioned codes at that time such as the Assyrian laws, the Mosaic Code, the Code of Hitties etc. The best-known code for internal regulation of doctor’s conduct was the Hippocratic Oath of Greek medicine.

HEALTH CARE SERVICE SYSTEM

While the points made above indicate concomitant development of medical science, codes of internal regulation and the state’s interest in regulating health care in early times, even all of them put together do not amount to the evidence of well organised system health care services. As the kingdoms were organised as a coalition of various powers under the rule of a kind, they were unstable and their boundaries were shifting. The medicine practised for people by the healers was very much a part of the social organisation at the local level, while that practised for the elite was better organised but its fame or discredit were based more on the outcome of healing rather than on the science behind it, for the science itself had not developed to that critical degree. Health care was practised as an occupation and trade, the state regulations, if any, only tried to provide few safeguards against the harm likely to be caused by the less qualified.

MODERN HEALTH CARE SYSTEM

Thus, the real development of the formally organised health care service system took place only in the modern time, and particularly in the Western Europe. In the sixteenth and seventeenth centuries, the European society underwent a change due to decline of feudalism and the rise of merchant capitalism (or early capitalism). The merchant capitalism resented feudalistic trade restrictions. Therefore, it created pressure for developing national economy and centralised nation-states. This enabled them to mount expeditions, conquer ‘colonies’ and bring back wealth from these colonies for developing their societies. All these created ideal social condition for the first industrial revolution in the late eighteenth century. The repercussion of these

social changes started being felt on medical science and health care services from the early days of nineteenth century. Rapid developments took place in both the fields. Doctors began their agitation for a uniformly recognised basic degree and state registration, leading to the passing of Medical Act in 1857 in the United Kingdom and thus, the medical profession emerged as an organised social force. Buoyed by scientific discoveries and the social power, the doctors gradually eliminated all competitors and became the sole authority in the field of health. They also brought under their authority the new cadre of health care, the nurses.

THE STATE AND PUBLIC HEALTH

Increasing wealth of the European society made the problems of poverty more visible, and the working class entered as a major social force on the scene. In response, there arose the Benthamite collectivism whose utilitarian ideology was consistent with the social system of the time and made charity for indigent and labour for the poor able-bodied people a state policy. The poor laws, factory regulations, public health laws and massive public health campaigns were witnessed in this period in England both in response to people's demand as well as due to the realisation of the elite that their own health and wealth were determined by the better public health in the society. By all accounts, it is clear that in this historical prime time of the classical *laissez-faire*, state regulations and direct involvement in the health were rapidly increasing.

THE STATE AND MEDICAL CARE

Curative care or the system of medical care came under the purview of the state on a later date simply because, as stated earlier, it had not as yet developed good tools for treatment. The major institutionalised technology for curative care, the hospitals, were in abysmal shape in the early-nineteenth century. What existed were inadequately staffed with poorly trained health personnel and badly provisioned public work houses (run by the government under the poor laws) for the pauper and the voluntary hospitals for the 'deserving poor' financed by philanthropy. The hospitals flourished only when importance of asepsis was understood and adopted, and the trained nursing staff made entry. That also increased the cost of hospital care. As philanthropy failed in adequately financing such care, the patient fees were gradually introduced. At the same time, as the effectiveness of hospital care became evident, for the first time in the history, the elite started demanding hospital care, and the private hospitals emerged on the scene. It should also be kept in mind that in the developed countries, the common infectious diseases were brought under control much before the real effective remedies were discovered. The general improvement in living standards and the public health campaigns were responsible for such achievements. The reduced mortality and increased longevity meant that people needed medical care for longer duration of life than they needed earlier. Added to this was the fact that increasing industrialisation was demanding more productivity which in turn needed healthy work force. High morbidity amongst workers and their families, causing loss of working time, loss of assets and above all increased indebtedness for buying medical care therefore became prime concerns for the state regulations and direct health care provision. (Jesani & Anantharam, 1989, Iyer & Jesani, 1995).

There was a model available for European nations at that time. That was the late nineteenth century Bismarkian model of welfare through insurance, in Germany. Thus, in the early part of the 20th century, the limited National Insurance spread in developed countries. The social scientists describe this transition of the state as a transition from the 'night watchman' state to the 'social service' state. For the purpose of our discussion the importance of this change is that it made health care an inseparable concern and function of the state. The present day popular perception that the state cannot leave health care of people to the mercy of market forces and the good will of providers, flows from these changes observed in the developed

countries in the nineteenth and early twentieth centuries. In the later part of the twentieth century, there was a consolidation of this trend in what is known as the welfare state.

WELFARE STATISM AND UNIVERSAL ENTITLEMENT TO HEALTH CARE

The consensus on state welfarism changed the society's understanding of health care. Health care came to occupy a prime place in the functions of the state. Just as the abject poverty had become an ethical and political issue under the social service states in the developed countries, the non-provision of universal access to health care became a political as well as ethical issue for welfarism was supposed to guarantee three things simultaneously:

- ▶ a minimum income to individuals and families, irrespective of the market value of their work or property
- ▶ a system for narrowing down their insecurities and meet certain contingencies, such as sickness, old age, unemployment and so on; and
- ▶ all citizens, without distinction of status or class are offered the best standards available in relation to certain agreed range of social services.

Thus, the goal of social development was set as accomplishing a floor of social living for all citizens, irrespective of their capacity to pay, social status and class (Briggs, 1966).

Naturally, in the field of health care, these ideas led to massive struggles by people for having universal access to medicare and hospital care. These struggles affected all developed countries and all of them, without exception, carried out massive reorganisation of their health services. In each country where such reorganisation was carried out, there was a great opposition from the medical associations, private health insurance companies and other entrenched interests. For instance, in Canada, the doctors went on national level strike at least twice before such a system was put in place in the late 1960s (Taylor, 1978). The kind of specific system that emerged from such skirmishes was somewhat different in each country depending on the relative strength of the social strata joining the combat. But nevertheless, each aimed at providing universal access. In all countries of the Western Europe and in Canada in North America, thus, some form of universal access systems were established. Only in the USA, where the demand for universal access to health care had weak social support base, the radical reorganisation was not carried out and the health care allowed to remain dominantly in the hands of private sector. However, the USA too could not avoid going half way. In the 1960s, it also introduced Medicare and Medicaid programmes and other state health care financing methods, thus starting massive health care financing by the state.

HEALTH CARE FINANCING IN THE DEVELOPED COUNTRIES

Reaganism and Thatcherism in the developed countries made the most significant efforts to dismantle welfare states and in claiming a victory over all ideas and theories which advanced health care as a fundamental human right of people. However, the rhetoric apart, despite the long spell of such ideologies ruling those countries and the concerted efforts to dismantle universal access health care, the states in those countries pay for most of the health care expenditure of people. Perhaps no underdeveloped country in the free market set-up matches the scale of state health care financing provided in the developed countries.

In the USA, the state finances over 40 per cent of total health care expenditure, which is the highest in terms of the proportion of GNP of any country in the world. If we take the Western European countries as examples, in the UK, Denmark, Finland and Sweden, the states finance 79 per cent to 91 per cent of the total health care expenditure of their people (Weiner, 1987). A similar figure obtains from Canada. The point to keep in mind is that, in all these developed

market economy countries, the good access to health care for people, particularly for the underprivileged masses, has been achieved through the high involvement of the state in health care and not by withdrawal of the state from health care.

It should also be noted that, within this common phenomenon of state's direct involvement or financing, those countries which radically restructured their services have achieved better access to health care for people and control over cost of health care than those which did not. For instance, in the USA the massive state financing of the health care by the state was not accompanied by radical restructuring of the health care. The state increasingly used private sector for implementing its welfare schemes. All available evidence suggest that this strategy led to massive expansion of private health care business and industry without actually achieving the universal access to health care for all the US citizens, and without bringing any control over the cost of health care. If one reads any health care literature on the USA, one would not fail to notice the plight millions of uninsured US people and debates on how to control the rising cost of health care (of course, without disturbing the sacred cow of private sector and the market). Interestingly, in the free-market USA, we find the highest number of regulations for controlling physical structures and financing of health care in the world. However, despite being the richest, the most advanced in health care technology and so on, the health status indicators of the USA are less impressive than other advanced countries who comparatively spend less and use advanced technology less often.

The new medical technologies and increasing demand from a section of people to make them available in health care have brought the health care systems of other advanced countries under pressure. However, the introduction of competition in their National Health Services, limited user-fees etc. have still not completely overturned the universal access system for any attempt to complete jettisoning of universal access system has met with strong resistance. However, in many areas the collaborations have also taken place. Many political groups and medical association have collaborated in making the system more efficient by introducing competition and decentralised planning. Since the governments have no option but to explain to their people that the changes are for their good, for making system work better for them, they are finding it difficult to take the free market agenda to its logical conclusion.

HEALTH CARE IN INDIA

Two hundred years of colonial rule in India basically did two things for health care services:

First, the colonial rulers did not do what they had done for their own people. None of the public health measures they took for their own people in UK, to improve their health conditions were seriously consistently pursued in the colony. However, they did create their own islands (for example, cantonments) where their officials and troops stayed and where the public health was maintained at the highest level. Since they were more interested in taking away the wealth of the country rather than reinvesting for the welfare of the people of this country, establishing such high level of public health throughout the country was found to be very costly and they used all excuses for not making such investment. However, one can clean such islands of all filth, but one can't all the time stop the diseases of the filth originating from the area around from entering the islands. So what one finds is that instead of spending money on high achievement of public health, they devoted them to studying public health and tropical diseases so that selective and specific measures, both curative and preventive, are discovered to stop the spread of diseases. It should be noted that such public health research is necessary, should be pursued and attract many committed and sensitive human being in the endeavour. However, all such efforts are less than effective if the places and environment which breed illnesses are left untouched or are only selectively improved.

Second, its policies of the British resulted into gross underdevelopment of health care or medical services. On one hand the colonial state neglected the Indian medicine. As a result, it did not receive impetus and support from the state to develop a scientific basis of its own, or integrate the science of Western medicine in its understanding. On the other hand, the colonial power gave more attention to the grafting of the Western medicine in India. Since the primary purpose of developing the Western medicine was to cater to their officials, troops and the Indian elite, the investment was kept at the lowest level possible. Thus, at the time of independence we inherited a health care service system which was grossly undeveloped and maldistributed.

At the time when it became clear that the transfer of power was inevitable, the colonial government appointed a committee to survey and plan comprehensive health care services for the country. Its report, submitted in 1946 is well known as the Bhore Committee report (BCR) (India, 1946). The report was prepared at a time when, in the UK the welfare statism was being established and the proposals for establishing the National Health Services were being debated. The BCR remains relevant for all of us for the following three among many more reasons:

1. When one reads the BCR along with all subsequent reports, one is impressed by the fact that this is the only report, which surveys the health care services in their entirety, and gives recommendations which are for the whole system. It bluntly recognises the underdeveloped nature of health care services and strongly recommends the investment that the state ought to make in order to provide health care to all. It is the only report, to date, which gives a comprehensive plan for such investments.
2. It gives great emphasis to establishment of institutional structures for the delivery of health care services. The specific programmes for specific health problems are to be delivered from the platform of such structures and not without it.
3. Keeping in mind the underdeveloped economy of India, poverty and the lessons learnt from the European history and the history of Soviet Union, it asserts that the only way to make the health care universally accessible is by making it available irrespective of one's capacity to pay. These lessons also made it to suggest that for universal access it was essential to give leading role to the free public provision of basic health care.

While accepting the BCR in principle, its plan was considerably diluted, and this began from the First Five Year Plan document. The reason given for doing so was very simple; the lack of resources. The Bore Committee plan for building health care institutional structures had two important elements: First, it did not separate the curative and public health functions. This was something different from the National Health Service (NHS) which was excluded from the main responsibility of the public health. The Bhore Committee believed that in order to produce the maximum results from the health care interventions, the preventive and curative works must be dovetailed. So the infrastructure recommended by it was to perform this dual function. Second, it also believed that this infrastructure must provide good curative services. That is, the curative service must be adequate, of optimum quality, physically accessible and without financial barrier. Thus, its first level referral centre, the Primary Health Centre (PHC) was to cover only 10,000 population, to have six doctors (including specialists), 75 beds, and the public health staff for the preventive functions. This basic building block of the institutionalised health care delivery was kept incomplete.

At present, as a policy, the PHCs have only two doctors (sometimes one only), both of them are just graduates, and none of them are post-graduates or specialist, but often one of them is a non-allopathic graduate. The public health functions of the PHCs are carried out by the

auxiliary staff called multi-purpose workers or health workers, no public health nurse is appointed at the PHC. Not only that, the Nurse Midwives who were considered to be essential at the PHCs have been phased out and replaced by auxiliary nurses, thus the PHC does not have fully qualified graduate nurse at all. And lastly, but very important, the referral function of the PHC was completely undermined by not providing most of them with indoor curative beds. Thus, we have PHCs without the capacity to provide real referral support for the village level primary health care. The referral support is available only at the Community Health Centre, a 30 bedded rural hospital for over 100,000 population. The dilution of the capacity of the PHCs was accompanied by the expansion of coverage, which in simple terms mean creating difficulty in accessing the PHC services. Between 1952 and 1983, only 5,954 PHCs were established that is, in the first three decades after independence, on an average only about 200 PHCs with the highly reduced capacity than the ones recommended by the Bhore Committee, were set up every year. Thus, in 1983, we had one such for an average of 88,000 rural population. In 1984 it was decided that one PHC would be established for 30,000 population and in no time the number of PHCs were quadrupled. Thus, on paper, in 1991 there were 20,450 PHCs, defining a ratio of one PHC for about 31,000 rural population. Although officially each PHC is supposed to have two doctors, in 1991 only 23,490 doctors were appointed at the PHC, defining a ratio of 1.2 doctors per PHC. In other words, in the government sector, there is only one doctor for about 26,000 rural population.

The high population coverage by the PHCs have some negative effects. Firstly, its utilisation for the regular curative care remains confined to only few nearby villages. Thus, a big majority of the people supposedly catered to by the PHC actually have no physical access to the facility. Second, the staff providing in the outreach and public health services is spread too thin and lack supervision and support from the PHC. Third, public health gets reduced to selective preventive and promotive targets. Given the over-riding emphasis on the family welfare, the non-curative work at the PHCs is overwhelmingly for the family welfare. Fourth, all these problems get compounded by the very low level of essential supplies, namely medicines, equipment's, transport facilities, and so on.

ARE OUR HEALTH CARE SERVICES REALLY UNDERDEVELOPED?

When this question is asked for our rural and the government health care services, the answer is yes, but when it is asked in relation to the health care available in the country as a whole, the answer is no. This paradox is created by the existence a very large volume of health care services in the private sector.

We have on one hand government health care services having too many bureaucratic fetters, too many targets, too many objectives and too many rules, all of them so many that their efficiency is often compromised. On the other hand, we have private health sector wherein there do not exist even minimum standards for establishing a hospital and nursing home, the doctors do not need continuing medical education for renewing their license to practice, there is no price control over the fees charged, and so on. The following information would show that in India, we have reasonably well developed health care services but they do not serve the deserving poor people simply because they are maldistributed and are largely controlled by the private sector which does not care for the social goal of the services.

HEALTH CARE HUMAN POWER

Doctors

India has one of the largest health care human powers in the world. Of them the doctors occupy a dominant position, numerically as well as otherwise. In the year 1990-91, the country had 9,28,072 doctor of all systems of medicine trained in the properly recognised

training institutions. Of them, 3,94, 068 (43 per cent) were allopathic or modern system, 3,37,966 (36 per cent) ayurvedic, 1,48, 707 (16 per cent) homeopathic, 35, 350 (4 per cent) unani, 11,801 siddha (1 per cent) and only 180 naturopathy doctors. In the 1991 Census (India 1991) the doctor population ratio defines at one doctor for 912 persons! If the ratio is calculated only for the allopathic doctors it comes to 1 allopathic doctor for the 2148 persons. The country also had 10,751 dentists in 1991. It should be noted here that another quarter to half a million non-qualified and non-registered doctors also practice medicine in our country, making the number of actually available doctors very high.

However, there is a gross maldistribution of doctors between rural and urban areas and between the government health care sector and the private sectors. The rural urban distribution of doctors is available only from the census documents. From 1961 to 1981 (three censuses), the proportion of doctors located in the rural areas has declined from 49.6 per cent to 41.2 per cent. Indeed there appears to be a progressive “deruralisation” of doctors. The allopaths and ayurveds who together account for 79 per cent of all doctors have shown greater affinity for locating their practice in the urban areas. Applying the 1981 Census (India, 1981) figures of rural urban distribution to the stock of doctors in 1990-91, we get the doctor population ratio for the rural areas as one doctor for 1644 persons and one doctor for 399 persons in urban areas. Obviously, this maldistribution has made the ratio in the urban areas comparable to the developed countries while our people in the rural areas are grossly deprived of the doctors’ services. Further, there has been no regulatory attempts by the government to correct this maldistribution. The distribution of doctors between the government and private sectors is even worse than the rural urban disparity. In 1991, only 22,013 doctors were employed at the PHCs in the country. Another 39,466 were employed in other government institutions. According to our estimates, at the most only 15 per cent of doctors of all systems of medicine are in the government sector, the rest directly provide service to the people in the completely non regulated market environment.

Nurses

As against the high production of doctors and contrary to the health care norms, the number of nursing human power is very less. In 1991, there were only 4,79,558 nurses of all categories in the country. Thus we have doctors almost twice in number than nurses. This is a far-cry from the norm of having two or three nurses for one doctor. Of the nurses, 3,11,235 (65 per cent) were general nurse and midwives, 1,50,431 (31.4 per cent) auxilliary nurses and the rest health visitors.

HEALTH CARE INFRASTRUCTURE

We have already discussed the underdevelopment of public sector services, the PHCs, Subcentres and CHCs in the rural areas. There is a gross maldistribution between rural and urban areas and public and private sectors of hospitals, dispensaries and beds. In absolute numbers we had 11,174 hospitals and 6,42,103 hospital beds, defining a ratio of one hospital for 75,739 persons and one hospital bed for 1,318 persons. However, their rural location was only 32 per cent for hospitals (a ratio of one hospital for 1,76,163 rural persons) and only 20 per cent for hospital beds (a ratio of one bed for 4,970 rural persons). It should be kept in mind that the government is also responsible for locating much of the hospital care infrastructure in the urban areas and for neglecting rural areas. The 30 bedded CHC are few compared to needs and many of those established are not optimally functional due to lack of specialist doctors and other problems.

In 1992, 57 per cent of hospitals, 32 per cent of beds and 60 per cent of dispensaries were in the private sector. These data supplied by the government agency, (Central Bureau of Health Intelligence) (CBHI), are apparently deficient because there is no proper registration system for

the private hospitals and dispensaries in the country. As a consequence we suspect that there is a gross under-reporting of private medical care infrastructure. For instance, in a survey done by the Director of Health Services (Andhra Pradesh) and the Andhra Vaidya Vidhan Parishad, it was found that in 1993 there were 2,802 hospitals and 42,192 hospital beds in the private sector in Andhra Pradesh as against only 266 hospitals and 11,103 beds reported by the CBHI (whose data we have also used) in the Health Information of India, 1992. This survey showed that the CBHI data were underreporting the private hospitals by 10.5 times and beds by 3.8 times. This could be further buttressed by using the CBHI data that in the periods 1974-79, 1979-84 and 1984-88, the rate of growth of government hospitals was 6.37 per cent, 1.02 per cent and 2.61 per cent respectively and that of beds was 11.35 per cent, 1.92 per cent and 3.29 per cent respectively. On the other hand the private hospitals increased in the same periods by 43.07 per cent, 12.06 per cent and 17.21 per cent respectively while the private beds increased by 20.09 per cent 3.86 per cent and 6.81 per cent respectively. Thus, if one were to correct the existing data for the underreporting, it would be found that in the hospital care sector too we have reasonably well developed infrastructure but its main drawback is gross maldistribution. This maldistribution makes it physically less accessible to a large number of people while the small number who have greater access are subjected to irrational and unnecessary medication (Phadke, Fernandes, Sharda, Mane and Jesani, 1995) in order to keep high level of profit in the unregulated market.

HEALTH CARE FINANCING AND EXPENDITURE

As mentioned earlier, the presence of the private health sector is overwhelming. Therefore, it is natural that it also accounts for a larger part of health care expenditure. Unfortunately, at the macro level there is virtually no information on private health expenditures. In the recent years micro studies have provided a good deal of information on the private health sector, including expenditures. Various micro studies right from 1944 onwards to the most recent show that the share of the private sector in health care expenditures has always been around 80 per cent of total health expenditures. The 1944 study by R.B. Lal (cf. BCR, 1946) showed private health expenditure to be Rs. 2.50 per capita as against a State health expenditure of Rs. 0.36 per capita.. In studies done in sixties and seventies also an average share of the private health sector was above 80 per cent . Recent studies also show a similar pattern (Duggal & Amin, 1989). Thus, while the government was spending only Rs. 64 per capita per annum for health care in 1991 (including expenditure on water supply), people were spending from their pockets on health care Rs. 200 to 250 per capita. It is estimated that the total (public and private combined) health care expenditure in our country may be 5-7 per cent of the GNP, a proportion close to many developed countries, but unlike them 80 per cent of the same is accounted for by the private expenditure. The WHO has recommended that the government alone should be spending at least 5 per cent of its GDP on health, but our government has normally spent much less than 2 per cent.

The high level of private expenditure is taking toll of the poor households. The surveys show that on an average a household in India spends 5-6 per cent of its income to buy curative care in the market. However, this expenditure is unevenly spread. Thus, the rural household spend a larger proportion of their income than the urban households. Similarly, the rich spend a smaller proportion of their total income on health care than the poor. The situation seems to be so bad that private expenditure for health care has emerged as one of the main causes of indebtedness, asset alienation and poverty.

ISSUES TO BE TACKLED

From the above analysis the following issues become clear:

1. The health care services have grown in India, so much so that in some respect it has resources comparable to some of the developed countries. Non-availability of good data, lack of interest in collating survey findings, turning Nelson's eye to the burgeoning private sector and counting of only allopathic doctors have created a wrong impression that our health care sector is grossly underdeveloped.
2. The reasonably well-developed health care sector is unreasonably maldistributed. The lack of political will to correct maldistribution is responsible for pinning great hopes on the community health workers to serve 1000 people when we already have a trained doctor for 900 people but located more in the urban and private sectors.
3. While it is true that the government sector needs more investment, the attention must not be diverted from the fact that high investment is already taking place in the health areas we need the least and that such process is creating more inequity and maldistribution.
4. The exclusive attention to the public health services for health care reform is both unwarranted and would be self-defeating. It is grossly unjustified to keep on experimenting with the small proportion of public services in the name of reaching health care to people when the big proportion of health care in the private health care is not even touched to meet the social goals. Nowhere in the developed country such a large and virtually unregulated private sector is allowed to exist as in India.

Thus, unless the public and private sector are both brought under the purview of national health care planning, there is no way we can ever meet the social goal of making health care universally accessible.

HEALTH CARE ACTIVISM: PHILANTHROPY AND SERVICE

Philanthropy and Nationalism

Health issues have never been a priority for political activists and parties. The issues occupied only a secondary place in Indian political struggles. The first awakening on health issues came in the form of support to modern medical education and philanthropy. The leading figures of such awakening were the Indian business and educated elite. In the nineteenth century, they were motivated by their concern for establishing the basic facilities for modern medical care and education. For instance, the J. J. Hospital and the Grant Medical College in Mumbai were established by coming together of the Indian elite and philanthropist Jamshetjee Jejeebhoy and the colonial administrator Sir Robert Grant. The aim of education in this pioneering institute was to produce medical graduates who were as good as those produced in the UK. The teaching faculty was dominated by the British doctors and doctors in the government services. Thus, in this kind of medical philanthropy, there was direct collaboration with the colonial power to create services in the government sector.

Thereafter, as observed in Mumbai in the early twentieth century, in response to the increasing militancy of nationalist movement, the colonial government was decentralising administration in the hands of local bodies. The municipal bodies were entrusted with the work of medical relief. Since these bodies also provided opportunity to Indians in the administration, they created an environment conducive to philanthropy aimed at creating medical care institutions run in cooperation with the local bodies. The establishment of the K.E.M. Hospital and the Seth G.S. Medical college took place in this way in 1925-26. It also catered to the nationalist feelings by stipulating that the professors and teachers employed there would be properly educated Indian and not the English government employees. Another example of the close collaboration between the philanthropists and nationalist movement took place when the movement for non-cooperation was launched and the youths were exhorted to leave the

colleges. In medical field, this had an effect and the nationalist doctors-medical teachers began a separate college and hospital run primarily by the indigenous and non-governmental support. In Mumbai the Topiwala National Medical College was born in this way.

This wave of philanthropy linked to nationalism also helped in revival of the Indian medical systems. Although we do not have good documentation on this subject to narrate here, it has been explained by others that many colleges and hospitals for the Indian systems were established during this period by the nationalist leaders and their medical supporters.

There were two important aspects of the philanthropy connected to the nationalism. First, it was highly motivated by the plight of Indian masses. They believed that their efforts were must in order to provide some medical relief to them. Thus, they created institutions and brought finances for them so that the poor could avail of services either free of cost or at a very cheap cost. Secondly, because of its connection to nationalism, it was almost always thought that after independence it would be our own government to finance it, so there will not be a great need to raise money from philanthropy. Interestingly, after independence most of such experiments ultimately handed over services to the government or continued with the dominant component of the grant-in-aid from the government.

Philanthropy and constructive social work

The Gandhian current in the nationalist movement gave strong emphasis to reconstruction. This *Sarvodaya* movement gained momentum at the time of independence when Gandhi gave a call to serve masses in rural areas. Another set of voluntary action had developed as a part of Christian and non-Christian missionary activities. The former in particular gave more attention to the establishment of hospitals across the country, trained various categories of health workers and provided medical care to the needy masses. The non-Christian voluntary groups too gradually entered this area of work. For all of them, the health issues were primarily of medical relief and they were charity oriented. As the transfer of power seemed a reality, efforts were begun to do planning for the reconstruction of Indian society and the experiments carried out by voluntary agencies provided experiences for designing the work in the welfare sector for Independent India. The Community Development Programmes (CDP) inaugurated with the First Five Year Plan, were designed using the experiences of Albert Meyer in Etawah district of U.P. and the Y.M.C.A. in Martandam in Tamil Nadu. These experiences and the CDP that followed, integrated the development of health care services (Jesani, Duggal & Gupte, 1996)

Thus, in the first decade of independence, the health activism, both community development oriented and charity oriented, tried to provide inputs into the reconstruction and development programmes of the government. The basic understanding was that the nationalist government was breaking away from the past and trying to gear its efforts to uplift the poor masses, that all medical charity for the poor and voluntary health development efforts should support and supplement such efforts of the government. If we compare this phenomenon with the welfare statist development in the developed country at that time, it becomes clear that there was an ideological identity between these voluntary groups and the government that India should realise its promise given in the Directive Principles of State Policy in the Constitution and should usher into a classical welfare state. The break-down of this ideological identity between the state and the voluntary group took place only in 1960s when the large-scale revolt of rural masses brought out in open the failure of the planning to look after the poor of this country. That began the new era of voluntary action under the new name, NGOs.

Philanthropy for the Rich

One may find it difficult to understand how can there be philanthropic activities directed at the rich. For the philanthropy is always associated with charity for the poor. The rich are regarded as the philanthropists and the poor as the recipient of relief and welfare. However, such

understanding of philanthropy is very simplistic. In the market economy, the philanthropy does not remain an altruistic activity all the time. In the market set up, it is employed for various objectives. The philanthropy or a show of philanthropy has been used for the self-preservation, for providing scope for future business, to protect the business interests from getting split up, for saving taxes and so on. Often philanthropy is used for the dual purpose of providing relief or welfare for the poor and at the same time to create services for the rich. The hospital is the best place for obtaining such dual benefits. Here, one could create, by using philanthropic money, a good place for the free or cheap hospital care for the poor and at the same for the rich who are charged more for the services. This method is also described, by health economists, as a very practical way of financing health care. Since it takes more money from the rich to subsidise care for the poor, it is also called *Robinhood* method.

Thus, in our country, the philanthropy has acquired multiple functions. The Gandhian call for trusteeship was used both for altruistic purpose as well as for business purpose where the trustees do not earn profit, but their activities create a business climate for others to prosper. Sometime before and after independence, such activity in the medical care and hospital services created foundation for the development of private sector in India. A classical example of such development in health care is Mumbai where one finds majority of the expensive hi-tech hospitals catering largely to the rich and upper strata of middle classes, operating as charitable trusts for the provision of medical relief. Indeed, amongst the big private hospitals in Mumbai there is hardly any which is run as a private company or as a corporate sector enterprise. All of them are registered as trusts. These hospitals receive all benefits that go to any philanthropic institute run for the altruistic purpose. Yet nobody in this city would dare to regard them as philanthropic institute catering to the poor.

The tragedy of health research in India is that despite such great historic contribution made by philanthropy in establishing private health sector in India, there is hardly any study describing what were the initial motivations of those who donated money and how the institutes started with such genuine altruistic purposes have converted themselves into the profit making enterprises for the doctors working there, for the drugs and instrument supplying companies. Such historical research would contribute in our understanding of various strands of voluntary health activism a proper perspective.

NGO ACTIVISM AND ISSUE BASED CAMPAIGNS

As explained earlier, in the late 1960s when the failure of planning became evident and massive rebellion of the rural poor swept the country, a new and qualitatively different phase of health activism started. This period is characterised not only by the turmoil in India, but also in the international sphere. In the developed countries, the post-war boom of the economy had ended and radical students and working masses had come in the streets forcing numerous changes in the world.

Community health activism

These developments were met by the planners and the government by making appropriate changes in the development strategies. New experiments were mounted to provide thrust to the new strategies. A meeting point for the social activism and to cater to the immediate needs of people was found in the community health activism. The community health combined the service with activism. Thus, this health work was not just medical relief provided by the professionals to people, but it was health work of professionals with people. Some of the characteristics of the new health activism were as follows:

1. Unlike the earlier attempts, this activism was highly disillusioned by the developmental model adopted by the government and at least initially did not believe that government can, on its own, fulfill the task of development.
2. While many of the individuals in these groups or NGOs came from various political movements, they strive hard to establish non-party affiliated health care work. In fact, they often down-played politics and affiliation in order to survive their activities in the rural areas. In many ways this was useful, for that provided them a neutral space in the rural socio-political structure to negotiate contradiction and develop their health care work.
3. Many of these NGOs disliked the concepts of philanthropy and welfare. One of the premises they worked on was that the community has capacity to look after itself provided skills are generated and support provided. Philanthropy and welfare make them dependent.
4. Many of these NGOs embraced the community health approach. They saw the problems of health care delivery in the high level of bureaucratisation and professionalisation of services. Thus, their motto was to demystify medical care and deprofessionalise the work of health care providers. At higher philosophical plane some of them thought that such activity would integrate health care functions within the community and make it possible for people to look after themselves. Above all, it was believed that deprofessionalisation would create pressure on the professionals to reorient themselves.
5. In order to make health care available to rural masses, the above ideas were put into practice in an innovative way. The village level health workers were trained, newer and cheaper methods of tackling common problems were devised and innovations were introduced in the methods of delivering primary health care.
6. Some of these NGOs also experimented in devising newer methods of financing primary health care. Methods such as charging the rich to finance care for the poor (Robinhood method), user charges, social insurance by organising the community etc were tried out. However, barring a few exceptions, most of these NGOs always remained dependent on the external funding.

Successes

Began in the late 1960s, the community health activism struggled for awhile. However, the pioneers of this movement in no time showed to the world that their work could achieve a lot cheaply and in short time. By late 1970s, the community health activists have become well known nationally and internationally and the government was becoming more receptive to their ideas. Signing of Alma-Ata declaration provided the ultimate legitimacy, for it embodied many of the ideas developed in the community health projects.

While many of the experiences of community health projects were adopted in health policies but tardily implemented, the most important contribution made by them was the idea and practice of deprofessionalised and demystified health care. They produced one of the best critiques of profession centred medical care model. The control exercised by the professionals, the vulnerability of people due to the mystification of medical care perpetuated by them and above all, the overmedicalisation and iatrogenesis attending the commercialised medical care system were highlighted.

In the later years, specific campaigns on drug prices, the campaign for rational drug policy, the campaigns against the misuse of medical technologies and so on were highly influenced by the works and ideas popularised by the community health activists. Thus, it would not be an exaggeration to say that without the committed work undertaken by these activists, many of

the later day health campaigns would have either not taken off or would have remained incomplete.

Failures

The deprofessionalised health care model, the very strength of the community health activism, also turned out to be one of the key weaknesses for the period in which the community health activism was at its peak is also the period when the medical profession consolidated its position the most. This critique could not shake the power of the profession. The alternative agencies created for provision of primary health care were largely sabotaged or tamed under the control of the professionals. Interestingly, during this period the profession actually increased its numerical strength and control over the system. Ironically, sometimes the alternative efforts actually introduced "medicalisation" of health care where none existed, thus paving a way for the private medical professionals to reap the fruits of profit.

In this period the greatest expansion of the private sector in health care took place. Community health activists instinctively believed that their model of health care could never be implemented in the for-profit private sector, so they had concentrated their advocacy efforts only on the government and more or less ignored the developments in the private sector. Their work in villages thus did not become a threat to the private providers, instead, it seems in some instances, actually helped the private sector in finding markets where none previously existed. They failed to understand that the precondition for the national level success of community health approach is reorganisation entire health care services so that both public and private resources are optimally utilised to provide simple but effective service to people. Indeed, an isolated emphasis on community approach only obscures the need for reform in the *entire* health care sector. If the community approach is applied and considered valid only for the public and voluntary sectors, it by default or design allows the professionals to flourish without self-regulation as well as external control in private sector.

Thus, in last three decades the community health care activism has patiently and through concrete devoted work in the under-served rural areas tried to persuade the policy makers, but it has not been possible for it to create a real threat to the established industrial and medical interests. This realisation prompted many of the community health activists to devote some of their time in building other campaigns such as, the rational drug campaign against misuse of medical technologies, regulations over the private sector, consumer activism and campaigns for medical ethics.

CONCLUDING REMARKS

The paper had begun with an attempt to understand the historical evaluation of health care in India and the developed countries and then tried to analyse the existing health care services in our country. The former tried to explain that it is not wise to get carried away by what the developed countries are doing today there, for they have come to that after several decades of health care reforms which made health care universally accessible to people. Besides, their current pro-market reforms in health care are only limited, they have not significantly reduced their health care expenditure and the objective of universal access has not been thrown overboard.

The issues raised on our health care service system were in order to understand the strength and weaknesses of the health care activism. First of all it is clear that the health care activism as developed as separate issue based campaigns or as direct response to the health care needs of the poor. Both in the community health activism and the issue based campaigns, there haven't appeared larger meeting grounds from which demand for thorough reorganisation of health services could be raised.

Second, doctors, as a professional body has not come under the sufficient pressure due to health activism. Community health activism attracted many doctors, but they preferred to stay clear of mainstream profession and hardly made any effort to create pressure for reforms from within. Only recent health campaigns on medical ethics, consumer activism etc have directed their attention to the mainstream profession.

Third, the health workers have shown less motivation to struggle for larger health care issues or take up struggles for the benefit of their patients. For instance, the doctors and nurses would make all compromise in the quality of care simply because of lack of resources, but they would not feel that to do so is unethical and it is their ethical duty to demand resources from the government or their employer. The struggles of health workers have unfortunately remained confined to their trade union issues. As a result we observe that in all major health campaigns, the health workers have not participated as a mass force.

Fourth, the health issues have failed to make prominent appearance in the struggles of various strata of people. The women groups are perhaps the only groups, which have raised the health issues of their concern consistently. While there is some activities on the occupational health problems, the organised working class movement has even failed to raise the demand for getting good quality care in services paid for by their members.

Thus, in the absence of any common programme for the reorganisation of health care of the country and that no significant organised strata of people have made reforms in health care a prominent demand, it is difficult to talk in terms of genuine health movement. Health activism of last three decades has raised people's consciousness and concerns for the health issues. In last few years the activism has gradually shifted from experimentation in provision to the demand for better provision and the control over providers. This is gradually opening up avenues for expanding the base for health activism.

In the last analysis, if the health activism is to succeed, it must strive to encourage the emergence of health movement. And for such a movement, three areas will have to be given special attention:

1. It needs to be stressed, and an alternative model for health care needs to be advanced, to persuade more and more people to the idea that universal access to basic health care is not only necessary to achieve, but is also feasible. A health movement must pursue a political programme, for without such a programme, it is difficult to create a political constituency of support.
2. Specific health campaigns need to be connected to the programme for the reorganisation of health care services.
3. Health campaigns should find place within the mass organisations to be successful. Thus, it is imperative that the health activists orient themselves to the organisations of people and strive to get health issues taken up by them. At the same time, similar efforts within the health workers is important. For they occupy a crucial position in the health care delivery and any success in drawing them to support issues relevant to people's health would greatly aid in enlarging the scope of campaigns.

After all, the people and programme for the universal access to health care would together make the health movement.

REFERENCES:

Briggs Asa (1966): *The Welfare State in Historical Perspective*, In S.P. Aiyar (Ed.), *Perspectives on welfare state*”, Bombay: Manaktalas.

Chattopadhyay Debiprasad (1977): *Science and Society in Ancient India*, Calcutta: Research India Publications.

Duggal Ravi, Amin Sucheta (1989): *Cost of Health Care*, Mumbai: Foundation for Research in Community Health.

India 1946: Report of the Health Survey and Development Committee, volume 1-4 (Bhore committee Report), New Delhi.

India: Registrar General of India 1981: census of India, New Delhi.

Iyer, A, Jesani A. (1995): *Women in health care: Auxiliary Nurse Midwife*”, Mumbai: Foundation for Research in Community Health.

Jesani A. 1996: laws and Health care providers, Mumbai: Centre for Enquiry into Health and Allied Themes.

Jesani Amar, Anantharam Saraswathy (1989): *Private sector and privatisation in the health care services*”, Mumbai: Foundation for Research in Community Health.

Jesani A, Duggal R & Gupte M (1996): *NGOs in rural health care*, Mumbai: Foundation for Research in Community Health.

Kangle R.P. (1972): *The Kautilya Arthashastra, Part II*, Mumbai: University of Mumbai.

McKeown Thomas (1979): *The role of medicine*, Oxford: Basil Blackwell Publishing Ltd.

Phadke A, Fernandes A, Sharda L., Mane P, Jesani A (1995) : *A Study of Supply and Use of Pharmaceuticals in Satatra District*, Mumbai: Foundation for Research in Community Health.

Sigerist Henry (1987): *A History of Medicine: Early Greek, Hindu and Persian Medicine (Volume 2)*, Oxford: Oxford University Press.

Taylor Malcolm G (1978): *Health insurance and Canadian public policy: Seven decisions that created the Canadian health insurance system*, Montreal: McGill Queen’s University Press.

Virchow Rudolf (1985): *Collected essays on Public Health and Epidemiology*, New Delhi: Amerind Publishing Company

Weiner Jonathan P. (1987): Primary Care Delivery in the United States and four Northwest European countries: Comparing the ‘Ciroirated’ with the ‘Socialised’”, *The Milbank Quarterly*, 65 (3) 426-61.

World Bank 1993: *World Development Report, 1993: Investing in Health*, New York: Oxford University Press,

World Health Organisation 1978: *The Alm Ata Declaration*, Geneva:

Indian Journal of Social Work, Vol. 59, Issue I (special Issue towards People-Centred Development – Part 2), January 1998, pp. 291-320.
