

## PHDs NOT PHCs

Suchetha Pai Javali

### India's Health Scenario

Dr. K, who was working in a village in Bellary district of Karnataka, felt helpless when irate villagers came to attack him. A patient with snakebite laid writhing in pain. But he had to advise the villagers to take him to the nearest town, for the PHC (Primary Health Centre) did not have anti-venom. The villagers had to make do with an old tractor to shift the patient about 100 km away on bad roads. What would happen to the patient is anybody's guess.

Dr. K also shared his agony when he said that hundreds often queue up before the PHC to collect their medicines, but have to be turned away because there is no stock. They become so fed up that they stop coming. (It is thus easy to understand one of the causes for the failure to control TB!) He lamented that even commonly prescribed medicines are out of stock or past their expiry date. The basic needs of water and electricity are not met, and it is difficult to carry out a minor operation or conduct investigations in a PHC. He wryly smiled as he said that the PHC do not have even a toilet...

*This is not the picture in a single PHC. This is only one of the thousands in the country which has one of the worst health care in the world. Understaffed, ill-equipped, the whole system is in a state of collapse and many lives are lost for want of basic treatment, or people have to pawn all their valuables to afford treatment in the nearest private hospital. Dr. K is only one of the thousands of doctors in our PHCs which are expected to form a vital part of the health care delivery system in India. He correctly states that PHCs are PHDs (Primary Health Defaulters), not Primary Health Centres!*

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Any democratic country needs to consider its population as its greatest asset. It is people's health and well-being that can be its strongest defence. *However, the rulers of our country (no matter which political party they belonged to) have neglected this crucial need.* Their efforts to ensure the health of their capitalist masters took precedence over their public concern. India's freedom fighter B. Tilak once said that the parameters to judge a government are its budgetary allocations for education and health. According to this, our governments would never be able to earn a pro-people tag!

Human Development Reports indicate that India's ranking in the world stands at 127. Its health and education are badly affected by the policies of neoliberal development. The 2003 Human Development Report stated that there was widespread malnutrition, poor infrastructure in the health sector and high mortality rates among the poorest sections and rural SCs. Diseases like HIV/AIDS, tuberculosis and malaria continue to plague the population. More than 90% of the world's polio cases are in India, which has also the world's highest number of hungry people – 233 million.

According to the same 2003 Report, India's infant mortality rate is still 67/1,000 live births, and under-5 mortality 93/1,000 live births. Around 60-80% of children and non-pregnant women suffer from anaemia. Half the world's TB patients (14 mn) and a third of the leprosy patients (0.61 mn) are in India. Over 420 mn live in areas of endemic filariasis, about 109 mn of these in urban areas. India's National Family Welfare Programme has not been much of a success either. The estimated population which may not live over 40 is quite high. It is an irony that millions of victims of arsenicosis and fluorosis are shown in government records to have access to potable water.

*The Report moreover throws light on the adverse effects of privatisation and the gradual decline of government spending on the social sector, including health, education and agriculture. What then have our rulers been doing to alleviate the sufferings of the people?*

### The 1983 National Health Policy

*India, which became independent in 1947, did not have a National Health Policy (NHP) till 1983. And even this Policy came*

about because our country became a signatory to Health For All (HFA) by 2000, launched in 1977 by the WHO. Initiated at the 1978 Alma Ata International Conference, the HFA movement led to increased health awareness. The Indian Medical Association was then compelled to formulate a NHP based on the reports of the ICSSR, ICMR and the Ministry of Health. **The purposes of this policy** were to reduce the disparities between rural and urban health, supply potable drinking water, promote research on indigenous systems of medicine, combat malnutrition, and reduce the Infant Mortality Rate and Maternal Mortality Rate. There was however a shortfall in health infrastructure facilities.

The 1983 NHP took up these issues and concluded that the British imperialist policy was responsible for the poor health status of our people. Yet, it also admitted that **after independence national health had been made available ‘only to the upper crust of society’**. What else could one claim in a country where the disparity between urban and rural health stands at a ratio of 80%: 20%? The NHP added: “Irrespective of the changes, no matter how fundamental, that may be brought about in the overall approach to health care and the restructuring of 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.”

**The goals set by the 1983 NHP** include the following: reduce the infant mortality level of 125 in 1978 to below 60 per thousand, raise the life expectancy at birth from 52 to 64 years, reduce the crude birth and death rates from 33 and 14 per thousand to 21 and 9 respectively, and provide potable water to the entire rural population. For this, it was planned to establish one health sub-centre per 5000 people in general and 3000 in tribal and hilly areas, and one PHC per 30,000 in general and 20,000 in tribal and hilly areas. A Community Health Centre would be established per 100,000 population. There would be one health guide from the community for every 1000 rural population and one midwife or birth attendant for every village. Multipurpose health workers would also be trained. **But little happened. The government could not even achieve half its goals. No wonder then that the objective of HFA by 2000 was not met!**

### The 2002 National Health Policy

The 2002 NHP raised the same issues. The people were blamed because *the “efforts made over the years for improving health standards have been partially neutralised by the rapid growth of population”* (#2.28.1) The government was thus absolved of many responsibilities. *Instead of nationalising the health facilities, it encouraged voluntary organisations and private houses to cater to the health services!* **The 2002 NHP moreover opened the path to privatisation. HFA now means Health for ALL WHO CAN PAY.**

### The Causes of India’s Deplorable Health Conditions

Those with a good knowledge of history and political economy are aware that T.R. Malthus himself admitted that his population theories had been disproved. To put the blame on increased population for the failure to deliver health is therefore not acceptable. Socialist countries like Russia, Cuba and China (till it turned to the market economy) have clearly shown that **it is the system of production and distribution that plays a decisive role in any economy**. In India, most policies have been in favour of monopoly houses. Our country has some of the greatest human and natural resources in the world. *But its human resources go waste, while its natural resources are tapped for filling the coffers of private profiteers*. How else can one indeed explain the poor health status of our people along with an army of often unemployed health workers and doctors?!

In the late 1990s, our country with over a billion population had only 134,108 health subcentres, 22,349 PHCs, 5,587 Community Health Centres, 410,904 health guides, 410,800 doctors, 660,996 trained dayees (midwives doubling as nurses), 13,692 hospitals, 449,351 nurses, 188,551 multiple health workers, and 596,203 hospital beds. *In comparison to the set targets and the needs of the people, there was a shortfall of 136,339 subcentres, 22,010 PHCs, 2,622 Community Health Centres, and 539,096 health guides.*

India lacks the political will to consider health as an issue of national importance. **Wishes for the good health of our people cannot come true without sufficient public expenditure on health.** Countries like the Philippines, Pakistan, and even Bangladesh spend

more of their budget on health than India. In the first Five-Year Plan, the health outlay was 4.98%; this came down to 1.7% in the 7<sup>th</sup> Plan (1985-90). According to the Central Bureau of Health Intelligence, the combined expenditure of the Centre and States on health in 1995-96 was only Rs 924 cr. *This was only 1.69% of the total development expenditure.* In the 10<sup>th</sup> Plan, this touched a miserable figure of 1.004%. But such facts are hidden from the masses.

These figures stand in stark contrast to the Rs 77,000 cr spent officially on the military budget. *The health budget corresponds to what is spent on the military for nine days.* In fact, the expenditure of the military on liquor is much more than that for health and education combined! And what to say of the crores spent on the lavish lifestyles, foreign tours and security of our so-called VIPs, the revenue lost in black money (some estimates speak of 40% of our GDP!), and the enormous concessions given to industrialists? In the name of development our government borrows huge amounts from the World Bank and other funding agencies under closely guarded terms and conditions, *and it is the people who are paying for this! No wonder that the government does not have 'enough' money for health and blames the situation on the rise in population!* **Ultimately, our country's poor health status and the poverty of the bulk of our population spring from the inequitable distribution of our national wealth.**

### Drug Policies and Patent Laws

*Every health care delivery system needs the support of sufficient and affordable drugs. A proper Drug Policy is therefore a must.* Yet, the 1978 National Drug Policy and the subsequent policies in 1986 and 1994, and the Drug Price Control Orders (DPCO) since 1979 (if they can be termed *Control* orders at all) mainly supported profit-earning by the drug houses. **All these policies indeed paid scant regard to the mandatory production of essential drugs,** as well as to their quality and affordability.

*The Hathi Committee (1975) Report had however recommended that multinational drug companies be organised under the public sector, and that 117 essential drugs be enlisted and their availability ensured.* It had also suggested generic rather than brand names, so that the marginalised could afford health care.

But the Report has been gathering dust while millions die of avoidable diseases like TB and malaria. Children below five become blind for want of a single Vitamin A injection. About half the children are not fully immunised. The basic drugs are produced by large private companies and sold at high prices; 23 of the 80 top selling drugs are considered irrational or hazardous for lack of quality control. The idea of generic drugs has been put aside and brand names are in circulation, some of them banned in Western countries. Moreover, government hospitals do not have 'enough stocks' and this opens the door for private business. *As shown by the resurgence of malaria, all this has an adverse impact on people's health. What else can one expect when people cannot afford proper treatment due to the Drug Policy?*

After the GATT accord, the 1994 Drug Policy was changed to amend the patent laws and bring them in consonance with the 1991 Industrial Policy and the Exim Policy. The licensing for bulk drugs (FERA and MRTP) was thus scrapped *and the number of drugs exclusively reserved for the public sector was brought down to 5.* This sector could now produce only Tetracycline, Oxy Tetracycline, Vitamin B1 and B12, and Folic Acid. Even this was to be reviewed after five years. 51% foreign equity participation and treatment at par with domestic firms were allowed, and all foreign technologies (except those related to the DNA) were given unrestricted entry. *The revised DPCO moreover cut down the number of drugs under price control from 143 to 76.*

The Indian Patent Act 1970 (IPA 1970) had been created to protect the Indian pharmaceutical houses and enable them to flourish and gain strength. *But the pharmaceutical public sector was purposefully ill-managed and allowed to degenerate, while the private sector saturated the national market and even the country's exports by the 80s.* In the 3<sup>rd</sup> and latest amendment to the IPA 1970 in operation since 1st January, 2005, the Indian pharmaceutical corporate, preying for markets in other countries by using the WTO, has agreed to the process patent of TRIPS. *As a consequence, the price of drugs has shot beyond the reach of even the middle class of our country and other developing countries.* But this does not seem to be a matter of concern for the successive governments at the Centre and in the States.

### Today's Unholy Alliance

India's 5 Central undertakings – IDPL, HAL, BCPL, BIL, and SSPL – have already been declared sick by the Board for Industrial and Finance Reconstruction (BIFR). *The operations in the main units of IDPL have come to a stop since Oct. 1996.* The employees are on the verge of a disaster: they will soon be jobless and fall into the abyss of poverty. **In fact, the entire drug sector is being thrown open to unrestricted privatisation without any control on production, price or profit.** The country is already flooded with drugs dumped by MNCs. *The right to life has become subjected to the right to super-profit and merciless exploitation. Drugs have become delinked from health concerns or care.*

The 1990s brought the most dangerous and destructive viruses into India, and they are being nurtured by every government in power, both at the Centre and in the States, notwithstanding their ideological differences. **The viruses of globalisation, privatisation and liberalisation have played havoc in the life of our people in every sphere.** The greatest anxiety of doctors was the affordability of drugs and their worst fears have come true. Why to speak of the poor when even the middle class cannot afford medicines today?

Big MNCs have swallowed smaller companies. Mergers were only an euphemism. Government hospitals have become trading centres by levying fees for every small service. Corruption is a feature in most government hospitals. *But the more dangerous nexus is between health authorities and drug cartels.* Companies can manipulate findings and force doctors to prescribe drugs when their adverse effects are known. Even the government supports such manufacturers. Doctors refer their patients to specialists and labs for investigation for common ailments. Nursing homes and diagnostic centres thus make money, while the poor are fleeced.

Government hospitals and PHCs are so severely understaffed that people are compelled to go to private clinics and hospitals. *In the era of globalisation, there is even a move to hand over government hospitals to private undertakings in the name of Private-Public Partnership (PPP) in the Health Sector.* 'Specialist' hospitals charge fees that ordinary people cannot dream of, and they attract company executives and foreigners. The 2002 NHP had

already mooted the idea of PPP to promote the 'infrastructure industry' of health care in the private sector. India is thus becoming a popular destination for 'health tourism'.

The PHC is only a microworld, a symptom, in the larger context of the entire nation being plagued by illness. The health system itself is ailing. It is not the PHC alone which fails patients. As Dr. K said, the PHCs are our **PHDs** (Primary Health **Defaulters**), but the **government is our greatest PHD.**

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