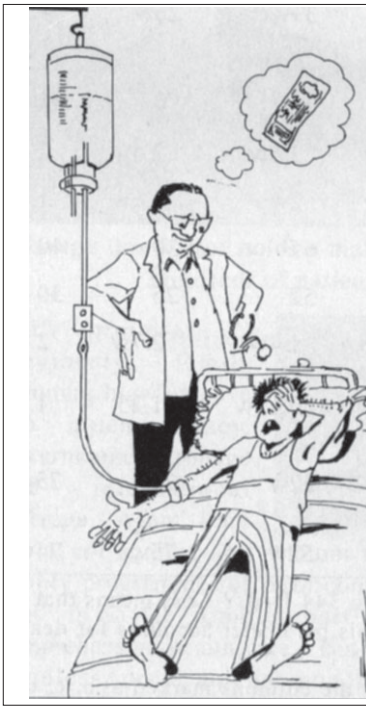
Health Care in Bharat

A National Blind Spot

Dr Sham Ashtekar

WHEN I left a postgraduate assignment as a medical officer in 1978 and joined a Primary Health Center (PHC) in a village near Pune, I was in a typical romantic mood fired by examples of reformists taking to villages. But the setting I chose was quite unromantic, a government health center run by a *zilla parishad*. Nevertheless, I justified the decision to myself since at the time, and for years to come, I truly felt that government had the only machinery that could ultimately deliver health care to all of our people. Ratna, my wife, (we married two years later) shrank at the prospect of joining government service. However, both of us hated private practice and felt it was unethical to make a living out of asking for money to heal someone's suffering. I also abhorred '*Sansthas*' (NGOs). My impression was that most of them made money by peddling human suffering. In the ensuing 18 years, I have gone through virtually all the available options in health care — public, private, and voluntary — and have learnt to qualify each of my convictions arrived at in a time of romantic idealism. But final answers continue to elude me as the situation becomes more complex and hopeless by the day.

Being a doctor in a PHC was considered the stupidest thing to do by most graduating doctors in those days. Young doctors would accept the obscurest postgraduate assignments such as radiology or dermatology rather than suffer the ignominy of being a PHC doctor. In the 90s doctors have, in effect, abandoned PHCs. For instance, even in the otherwise flourishing district of Nasik where I currently live and work, more than half of the 80 odd rural positions for doctors in PHCs have remained unfilled for the last three years, notwithstanding the fact that Nasik has had a cabinet health minister in the last two state governments.



For those who need hard statistics for getting a feel of things, I am enclosing some in Table I. A quick glance will convince us that India's health status is miserable compared to most countries, except for some in Sub-Saharan Africa. We are even worse off than Sub-Saharan Africa on some parameters like percentage of stunted growth in children and public sector spending on health care in terms of the gross domestic product. Furthermore, the overall picture of India hides the bimodality of the India-Bharat divide. Actual figures for Bharat are bound to be much worse; there are few countries that are as split as India is along these lines.

Poor living conditions, high morbidity, and a failure to build a

Primary Health Centres

PHCs are a product of the high profile Bhore Committee, whose report came about the time we became independent. The report had extensive recommendations on making health care available to all, without any consideration of capacity to pay. It included all levels of health care and was intended to provide well-equipped hospitals even at the *taluka* level. A PHC was to be a Phase I institute covering the entire countryside. To begin with, each would serve a community of one lakh It would give all initial care — curative, preventive and promotive — through its various peripheral health workers. It must be noted that the Bhore Committee never thought of a private sector in health care; the state was to take charge of all health care. The Committee recommended that we should spend at least five percent of our gross national product on health care. It is now nearly five decades after independence. Apart from the caricatures that are our existing PHCs, the proposed centres are now not even a fiction, thanks to the command economy bosses. Committee after committee later tried to make small reforms here and there to compensate for missing the bus, but without substantial benefit. Health care in India is in shambles, especially in our villages.

Comparison of Health Status Parameters of Select Countries and World Regions

(Adapted From the World Bank's *World Development Report: 1993)*

	India	China	Other Asian Countries & Island	Sub Saharan Africa	Latin American Countries & Caribbean	Middle Eastern Crescent	Former Socialist Economies	Established Market Economies (USA, UK etc)	World
DALY* loss per 1000 pop	344	178	260	575	233	286	168	117	**259**
Yearly new TB cases in 1 lakh pop	220	166	201w	220w	92w	99w	52w	20w	**142w**
% of stunted growth in children in 2-5 year age group (a)	65	41	53w	39w	26w	—	—	—	**42w**
Expected % deaths in 0-4 year age group	12.4	4.3	9.7	17.7	6	11.1	2.2	1.1	**9.6**
%GDP spent on health — Public Sector	1.3	2.1	1.8w	2.5w	2.4w	2.4w	2.5w	5.6w	**4.9w**
%GDP spent on health — Private Sector	4.7	1.4	2.7w	2w	1.6w	1.7w	1w	3.5w	**3.2w**
%population without — Sanitation	85	15	60	65	30	40	15	15	**40**
%population without — Safe Water	30	30	40	52	25	30	10	5	**30**
Health Services (per 1000 pop) — Hospital Beds (b)	0.7	2.6	1.8w	1.4w	2.7w	2.9w	11.4w	8.3w	**3.6w**
Health Services (per 1000 pop) — Doctors (c)	0.41	1.37	0.31w	0.12w	1.25	1.04w	4.07w	2.52w	**1.34w**
% of children under 1 year immunised — 3rd dose DPT (d)	83	95	81w	52w	71w	75w	77w	80w	**80w**
% of children under 1 year immunised — Measles	77	96	78w	52w	75w	74w	86w	77w	**79w**

*DALY is disability Adjusted Loss of Years: 344 DALY Loss means that Indian people spend 344 years in sickness-disability in 1000 person years. This parameter accounts for deaths and diseases in the community.
w= weighted average.
All statistics relate to 1990 data, except for the columns marked a, b, c, or d.

Each value refers to one particular, but not specified, year within the time period denoted:
a. 1980-90; b: 1985-90; c: 1988-92; d: 1990-91

dependable state health service has made it possible for private operators to take over the provision of health care in the rural areas. The vacuum in rural health care left by the failure of state health care was filled by all kind of people who pose as healers to helpless communities living on the wrong side of the India-Bharat divide. As the years have passed, private care has become such a dirty business that few would rate it as 'care' at all. The thought of being treated by such rural private practitioners would make most of us shudder. Both the state and the private sector have failed to provide essential health care. However, there could have been a third possibility — a community-run effort to provide its own health care. Unfortunately such attempts have been infrequent and have become distorted because most of their support comes from outside their community, not from within.

A basic structural failure in providing proper health care in villages has resulted in a multitude of problems. Let us get to know some of them in detail.

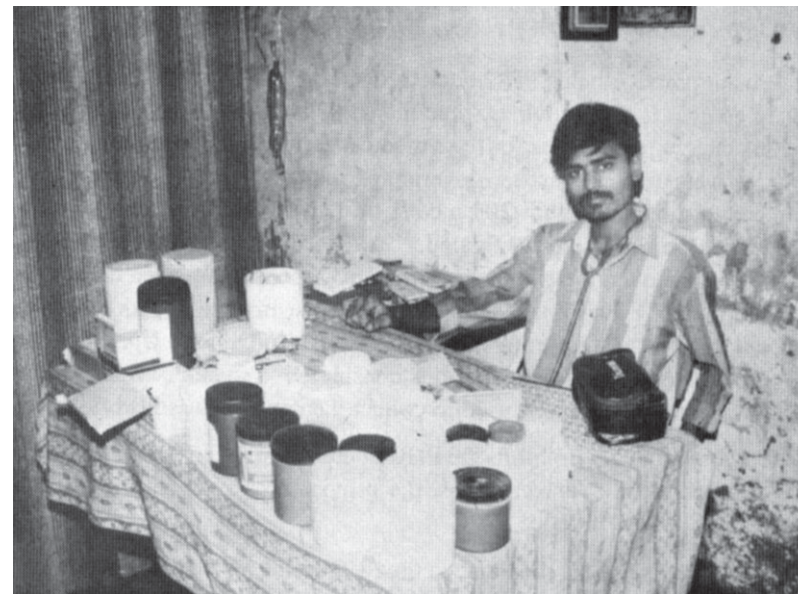
Rural Neglect

Most people bypass rural state health care institutions. Studies indicate that only about a tenth of the rural population ever attend a PHC, its sub-centers or the rural hospital.

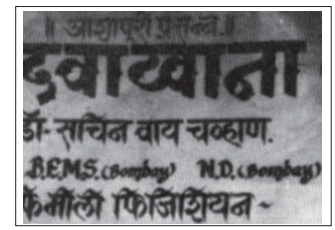
The rest line up before private clinics. The government machinery has attempted to evade the plain meaning of this fact by saying that curative care is hardly their domain, because they are mainly in the lofty business of 'preventing' illness.

This myth of prevention must be laid bare. Policy pundits and health care sharks are in the habit of going 'preventive' when it comes to rural health care. They conveniently and rather shamelessly assume that it is wasteful and stupid to try to cure the illnesses of rural people. As planning gods, they must think preventive health care instead of curative treatment serves the long term interest of the ignorant *ryot* better. Therefore, treating illnesses such as headaches, backaches, *kala azars*, and worms are not their responsibility; only vaccinations and preventing births are their vital and measurable tasks. Let me hasten to say that I am not against preventive programmes. They must be expanded enormously and made more meaningful. However, one must not pretend that preventive health care is a substitute for comprehensive health care.

More misfortune befell rural health care during the sixties and seventies, when population control was pushed down our throats as '*the* health programme'. Foreign agencies who felt threatened by the population 'explosions' of the third world pumped a lot of money into birth control programmes that distorted the entire world view of the health care community. (Incidently, on my table there is a letter from a networking NGO shark which reads something like this: "...there is a possibility of (getting) funds for family planning from an international agency and about 25-30 voluntary agencies should be 'participating' in this..." and further "...we are ready with the draft proposal....") Obviously, family planning bigwigs have too much money, government patronage and international leverage. Again, I am not at all against an optimum and quality programme for birth control that is a legitimate part of comprehensive health care. But the mindless, cruel and incompetent treatment of a serious subject that is so linked with human development and women's lives puts off many people including me.



Though this doctor holds a make-believe degree (BEMS) it doesn't stop hundreds of patients from flocking to him daily



The two major distortions that continue to haunt our rural primary health care services are given below. Hidden in the story are numerous tales of how we have botched up a basic service that is essential to national development.

Private care has become such a dirty business that few would rate it as 'care' at all.

First of all, both the central and the state governments are unwilling (not unable) to put serious money into health care. A lot of our health programmes are funded by international charities. It has become a part of our government's regular manner of functioning to implement health programmes only if they get central (i.e., international) funds. In this way, AIDS becomes important, yet we have neither ideas nor programmes to make effective use of these allocations. Community health worker programmes for villages, for example, should have been an important programme that could have provided a backbone for the country's efforts to improve rural health care. But just Rs 2 crore are spent for these purposes annually in the relatively progressive state of Maharashtra when about Rs 25 crore would be required for a well-designed and implemented programme of health care. The centre wants to withdraw even this piddling

Private Practice in Government Health Centers

Private practice helps PHC doctors overcome their helplessness and shame at having fallen so low as to have joined a PHC. It also provides some monetary compensation for the years they are going to lose. Almost all PHC doctors charge private fees for their medical services. Some of the doctors at PHC posts are officially permitted to have a private practice since the government wanted to attract doctors to the PHCs. But such permission is conditional; they cannot practice within 200 meters of the official dispensary or during routine office hours. In reality, these restrictions are almost always flouted. The PHC doctors conduct their private practice either at their official residence or, more commonly, right in the government dispensary — even during office hours. The health department calls it 'table practice'. PHCs at which table practice is encouraged attract enterprising candidates. Postings to and cancellation of transfers from such PHCs are at a premium. If a successor is not able to keep the previous doctor's illicit private practice flourishing, it is considered 'a shame'. Money collects in the drawers of the table. I know of a district health officer who used to collect the day's fees as his bribe during his monthly visit to the PHC.

If a post officially prohibits the PHC doctor from practising he gets a non-practicing allowance which is about Rs 400-500 per month. Nevertheless, the provision of such an allowance does not restrain most doctors from also conducting private practice.

PHC doctors use the medicine in the PHC stores for their private practice. Some of the doctors sell off the stocks to private medical stores right away and prepare fake case papers to account for the expenses. The subsequent lack of medicines provide another benefit to these doctors – they can get out of seeing non-paying patients by complaining about the absence of medicines, thus catering only to those patients with money.

Surgeons posted at rural hospitals rarely operate unless a patient (needy or not) agrees to pay a suitable bribe. These payments are simply treated as mandatory fees for patients. Yet the PHC surgeon has full access to the government-funded facilities; overhead does not cost him a *paisa* — it is all pure profit.

In Maharashtra all PHCs and rural hospitals are supposed to post a clearly visible notice that states that all care is offered free. But medical officers have found ingenious ways to make such notices less visible. A lot of political management goes into making 'free medical care' a laughing stock. Bribes and caste politics are very handy instruments for this. The lowest rate these doctors charge is five rupees for injections. A saline drip costs the same as it would in private practice — around Rs 60. Anything from Rs 50 to Rs 300 is charged to attend a childbirth. Surgery costs Rs 1,000-Rs 2,000 depending upon the category. These illicit fees are pocketed in broad daylight. They remind me of the pride our traffic police show as they proudly collect bribes on our highways.

Making Rs 100 a day is the most modest target. That was good enough in the 70s, but now, by the end of two or three years, these PHC doctors can generally save a few lakhs, enabling them to set up a private hospital without even requiring a bank loan. Complaints are of no avail, since it is not possible to fill a post once someone is fired from that post. The block office has to take care that they do not make a fuss about private practice. Otherwise, they run the risk of that post remaining vacant for years. Doctors must be respected at all costs. Tribal areas have special difficulties filling vacancies; such posts are openly known as 'punishment centres'. Once, however, a doctor is assigned to a tribal PHC there can be no further punishment; it is a safe haven for whatever types of practice he wants to engage in.

Private practice in PHCs and rural hospitals has done immense harm to the fabric of rural health services in India. The moment a doctor at a PHC gets his first rupee outside of his salary, his mindset is bound to change. Everything he does thereafter is coloured with the desire to get more extra money. At my original PHC posting I was officially allowed to conduct private practice, but I could never get myself to do it either 'on the table' or at my residence. Unfortunately, I was not given my monthly salary for one whole year due to accounting problems and had to do something rather than take loans from friends. I started going to another village on weekly holidays and tried to force myself to accept this idea of private practice so as to survive. Memories of those days still fill me with shame. I gave up the attempt after a few weeks. If we want our health centres to give humane and quality care, all private practice in government centres must be weeded out.

sum. And the state government mourns at the expenditure of such a measly amount of money, while it happily spends crores of rupees on subsidising money guzzling private hospitals posing as 'charitable trusts', not to speak of several crores on mere 'medical reimbursements' for its army of politically appointed *karamcharis*.

Naturally, villagers have not waited for state facilities; they have learnt that they will have to buy health care rather than go begging to the health centres and the great **'***Swasthya Ikais***'**. Of the total spending on health care, communities spend three fourths and the rest comes from the 'commanding heights'. Unfortunately, despite shelling out their hard earned money, people do not get back even a tenth of what they pay to the government as taxes for health care.

Thanks to low budgets, most health centres run out of medicines in two or three months. Often the annual supply of drugs is not even equal to the monthly wage bill of the PHC staff. The commission they obtain illegally on private sale of PHC medicines is perhaps the only job attraction for most health officials — apart from 'transfer money'. Therefore, one can hardly imagine the quality and content of most PHC's drug supplies. The rest is taken care of by the health centre doctors who look upon even this supply as their private property, which they fiercely guard for their private practice.

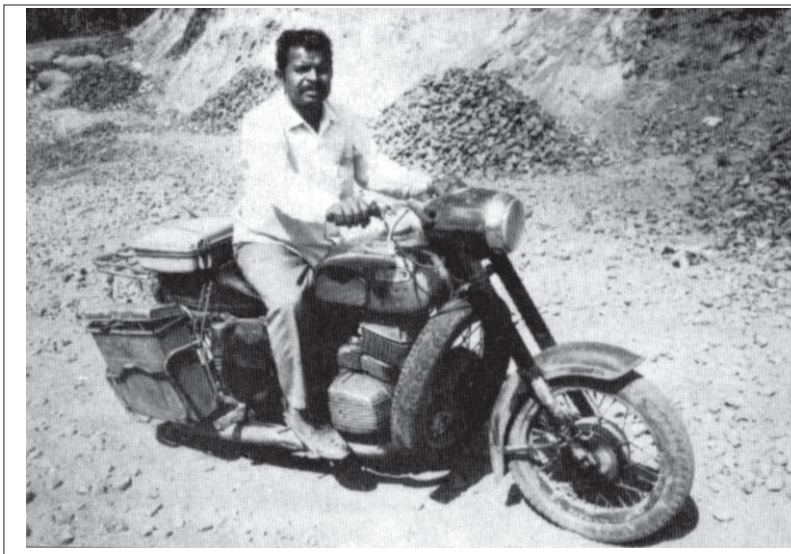
Rural service is treated as virtual *kalapani* by doctors. It is considered a 'disgrace'. I know of two doctors who hail from nearby tribal villages. They were raised in the poor ashram schools. But they never even thought of joining a PHC or starting a clinic in their own areas. Like all other doctors, they have now vanished into the urban crowds. It does not surprise me any longer.

Useless injections are for those who pay — those who can't pay are punished with useless prescriptions.

Government is trying to fill the several hundred PHC vacancies in Maharashtra with Ayurvedic graduates who are untrained for this kind of work (since they have learnt nothing but pure Ayurveda!) There are many reasons why MBBS doctors have turned their backs on PHCs, but the foremost is that they do not want to live in villages — even for a day. The villages are considered worse than hell by most of our educated people. The economy, society, and politics of village life is simply incapable of providing their minimal needs as they see them. Schooling of their children is a major factor that puts them off. Most medical doctors do not plan to stop at their MBBS; they would prefer to obtain a postgraduate degree, which is becoming necessary for practising in cities. Giving these doctors more pay and allowances is no solution since PHC doctors earn much more through private practice than they get in their wage packets (though they start off at a better wage than the IAS). Leaving aside a few rare exceptions, all PHC doctors indulge in open 'table private practice' in the PHC. Using PHC facilities, they do not bother to consider that it is an official space where they are only supposed to provide free services. I have seen many PHC doctors rob the patients of all but their return bus fare — and for this dacoity they employ nothing but government medicines and staff services. No free meals, indeed.

Facade of Medicine

Science, quality, and humane care take a backseat in such situations. Case records rarely mention the diagnosis for which the patient was treated. Physical examination is reserved only for those who can pay. Everyone else gets examined using a 'hands off' method. The patients are expected to rapidly rattle off their complaints even before they are able to sit down or relax. The few examinations are mainly meant to maintain a facade of medicine rather



Motorbiker who goes from village to village disbursing medicines

In the Name of Maternal Health

Women matter in public health systems primarily if and when they are current or prospective mothers. Family planning is the overt and covert primary objective of reaching out to women in most health programs. Yet even the quality of contraception services has been extremely poor and unfriendly to women. Even by self-promoting official statistics, not more than 10 percent of 'eligible' village women use spacing options. Government is touting hormonal methods, even the injectable ones, but their haphazard method of distributing *mala* birth control pills to women leaves a lot to be desired.

Safe childbirth services must be a central and practical concern in centres providing women's health services. Yet the ground reality reveals that such services are simply not available. Nearly 80 percent of all childbirths take place in villagers' homes. Incidently, most births take place at night, many during the rainy months. All this adds up to a '*Janamashtami*' situation — rain, dark nights and a mother Devaki in chains. Much is said about the services of traditional birth attendants, but many *dai*s indulge in practices that are grossly injurious to the mother. They are reluctant to give up such practices even after training. But the fact remains that they are the only experienced hands around at childbirths. The village auxilliary nurse midwifes (ANMs) and the PHCs are of little help. Sadly, they even fail to ensure proper antenatal care. India has very high maternal and infant mortality rates. About half of these fatalities can be prevented by providing proper antenatal health care. These services exist only on paper today, except for tetanus immunisation. The government is unwilling to provide maternal and infant care. It is simply a blind spot in rural health care.

Deaths apart, poor childbirth services are causing serious threats to womens' health. Injuries, infections and uterus prolapse are long-term threats. Abortion services are equally underdeveloped. Under the Medical Termination of Pregnancy (MTP) Act, only registered doctors can do abortions in registered centers. As this is the case, is it not the lawmakers' duty to see that these rural centres are actually set up with doctors to provide these services? Of the many PHCs I have visited, not one is equipped to perform MTPs. If there are no qualms about doing tubectomies in dilapidated buildings, why do they develop cold feet when it comes to doing MTPs in clean PHC theatres? The fact is that most PHC doctors do abortions clandestinely and at a premium. They will lose their illegal fees the moment safe abortions are provided at the PHCs. I have reasons to guess that there is on an average not even one recognised functioning MTP center per development block in Maharashtra.

than making a proper diagnosis. The treatment rarely reflects the diagnosis. Useless injections are for those who pay — those who can't pay are punished with wasteful prescriptions. I know a PHC doctor who takes Rs 100 for forcing a saline (salt water) drip on every TB patient reporting for his/her monthly medicines — and this is not an exceptional case. Another doctor refused to attend a girl's bullhorn injury since her parents were unable to pay Rs 50 for suturing the wound.

If the living are thus taxed, the dead are not spared. As soon as I joined a PHC, I was offered a hefty Rs 500 in a sealed envelope after doing a routine post mortem. Horrified, I learnt on enquiry that it was a routine *khushi* (pleasure) after post mortems.

One of my friends, Dr Anant Phadke, reports in a recent study that half of PHC doctors write irrational and useless prescriptions, which is only a little less frequently than their private sector counterparts.

Rural hospitals should be the great hub of rural health services. A rural hospital is meant to be a 30-bed hospital with three to four specialist doctors working full-time. One or two such institutes are supposed to serve every block. The buildings and equipment are there in many places but half the specialists are missing. Some are yet to be appointed and some turn up on only on pay days. Private practice is an unwritten norm in these hospitals. Precious little essential hospital care is provided. These institutions are expected to at least provide high quality maternity care such as caesareans, abortions and all related post-natal care. In reality all the rural hospitals in Maharashtra put together do not perform as much surgery as Dr Appa Mhaskar, a great old surgeon and social worker, has been doing every year single-handed with his mobile van. The government is more interested in constructing buildings and buying piles of things than in running the hospital services.

Bazaar clinics are replete with dirty tricks to make fools out of hapless patients.

PHCs are supposed to run peripheral sub-centres staffed with

The health department is sitting on thousands of applications requesting recognition of private MTP clinics. In our own case, our application has been needlessly kept pending for three years. Consequently, despite the law, countless women have to subject themselves to unqualified hands and dangerous practices. I have seen many such cases myself. Puncturing the amniotic sac with a sharp stick or steel barb is a common practice with many quacks. Women suffer from guilt piled upon guilt — first for seeking an abortion and then for getting it done illegally. It is easy to see that fees for abortions are levied according to ability to pay, degree of guilt felt and extent of secrecy required.

The attitudes of government doctors who are supposed to be running MTP centres in district hospitals is condescending at best and punitive at worst. Abortion is an emotionally charged matter for most women. It is a necessary evil that many of them are undergoing for reasons that are not solely under their control. Perhaps some of them have faltered in contraceptive care or even thought lightly of this procedure, believing it to be simple and entirely safe. Couples need to correct some of their attitudes towards MTP but doctors need to do so even more, especially while dealing with unmarried persons who seek help.

The issue of gynecological care, eminently raised by Drs Abhay and Rani Bang, is entirely neglected by the public health services. Skills, facilities and awareness of the problem is entirely missing from general rural health care, even in Maharashtra. Pelvic infections cause untold suffering as well as infertility; sexually transmitted diseases and menstrual disorders make the lives of countless women miserable, yet these services are entirely missing from PHCs.

Health education for girls (and boys too), especially in regards to reproductive health, is a highly important area that we must urgently take up. It is vital, but can be done simply and effectively even without spending much in terms of money and time. Once learned, this knowledge will be valuable for generations and it is a liberating programme in a sexually oppressed society.

We ceremoniously drag our tender girls into nuptial beds, before they are even fully aware of the simple facts of life. Even in our rather well-to-do district of Nasik peasant girls (except tribals, thankfully!) are married as soon as they get their first menses. No one respects the legal age of marriage. I have known several farmers who have export connections for grapes, travel every year to European markets for business trips, and yet still marry off their daughters at 16 or 17. For banning and stopping *sati* we needed a Lord Bentinck. Do we need another for enforcing the Age of Marriage Act?

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auxiliary nurses and male health workers. Despite getting good pay, half the nurses do not stay at their rural stations. The minimum expected of them is vaccinations and childbirth services. The latter is rarely attended to by nurses. Eighty percent of childbirths in villages get no help from the PHC. Barring a poor old *dai* or a neighbour, most women get help only from their family members. Illegal private practice is becoming routine, with nurses practising medicine in many villages much like the untrained quacks who dot the village bazaars. Cash flows quickly and its shares soothe and silence the PHC officers, who are equally neck-deep in corrupt practices. Many male health workers — malaria 'doctors' and the like — have been playing doctor to villagers for decades. People need health care badly and anyone who can provide the slightest promise of help is good enough to run to when nothing better is available.

In 1977-78, the Indian government planned to do something

Family returning home from a PHC since there is no doctor there

for our villages that was long overdue. We started a community health scheme that was designed to be much like China's barefoot doctor programme, though it was far more modest. Unfortunately for us, the basic functional elements needed for such a programme — like a functional *panchayat* organisation — were entirely lacking. Its opponents (bureaucrats and doctors) found it easy to destroy once its supporters were out of power. The scheme officially continues to go on even now, but only on paper. The community health workers are paid a monthly sum of Rs 50 but given no medicines lest people become fond of them. In a country which produces more doctors than any other nation and even exports them to lucrative markets abroad, there is not even as much as a community health worker to care for its village people. Yet we talk of `Health For All' without even making the effort needed to correct these obvious and basic maladies. Many of us are convinced that a well-trained and properly supported community health worker programme is a precondition for any serious national rural health care programme. Unfortunately, those who decimated the present programme are mostly found on policy-making health committees, instead of being convicted of malpractice and punished.

The state has not only failed miserably as a provider of health care, it has also failed in its regulatory role. This has happened both in the urban and rural sectors, but the problem is more acute and serious in the latter. This has resulted in a chaotic situation in the rural private health care sector.

Playing Doctor

Nearly 90 percent of rural doctors are non-allopathic (that is, other than MBBS). Half of them are devoid of any formal qualifications whatsoever. The other half are mainly homeopaths, with some Ayurvedics among them. (In the *taluka* where we practice we happen to be the only MBBS physicians in private practice). Yet a large majority of these people use allopathic medicines such as antibiotics, pain killers, steroids, injections and saline infusions, and some even undertake surgeries such as illegal abortions. Their prescriptions are honoured in medical stores. The government has simply closed its eyes to a very clear-cut Supreme Court order against all cross-practice. On the contrary, in response to a representation, the Maharashtra state government has issued a revolting statement saying that Ayurvedics can practice modern medicine "as much as they are taught in their colleges (sic)."

These 'doctors' have an aversion to diagnosis; unnecessary injections and saline infusions have become the

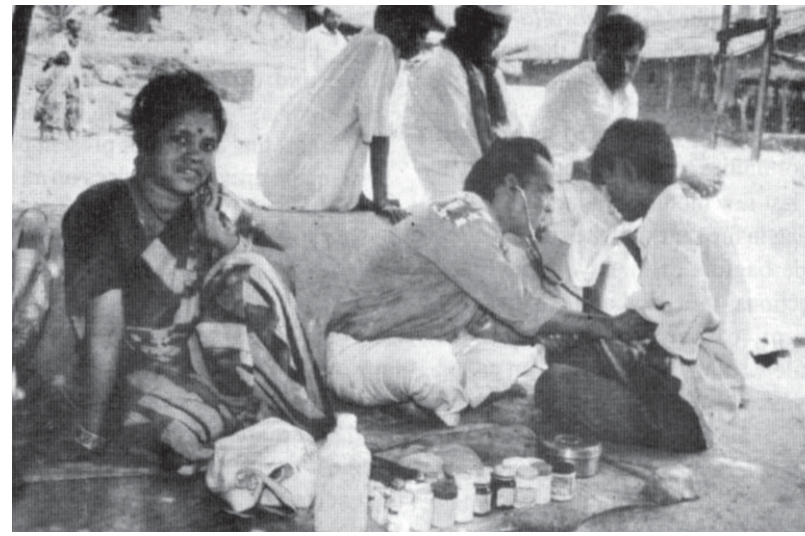
A Minimum Ten Point Reform Programme for Rural Health Care

- Reestablish a serious Village Health Care Workers programme with full political, administrative, financial and legal support. Hand it over to the *panchayats*.
- Establish proper specialist care in rural hospitals, free of cost and without any deceit.
- Develop a quality programme for birth spacing, using safe and women-friendly contraceptives available to all men and women.
- Make available a genuine women's health programme with gynecological care, childbirth services and referral facilities.
- Start a serious health education programme in schools and colleges including reproductive health education and hygiene.
- Regulate, standardise and modernise private health care; let no untrained person do something he/she does not know how to deliver correctly. Establish social and medical audits by specially designated expert panels of all who wish to be practitioners.
- Integrate the best of various healing systems at the level of first contact care so that the healer and the patient are able to choose a good option in mutual consultation.
- Institute more collective payment systems for all non-governmental health care, linking it to quality care.
- Enforce, via a bond, compulsory rural medical services for at least three years in state services or voluntary institutions for all medical graduates and postgraduates.
- Set up a health intelligence council for studying immediate and long term problems and solutions to various issues in rural health care, including occupational agricultural hazards.

very foundation of their practices. Even many MBBS doctors resort to such malpractice. I know of a quack who brandishes injections of coloured water priced differently to match the incomes of his customers. Injections usually contain either a vitamin such as B complex, pain killers like analgin/baralgan, terramycin (an antibiotic which can and should be given orally), or plain distilled water. All these are utterly unnecessary for most situations. One doctor killed many a patient with penicillin because he did not know what to do when a patient suffered a life-threatening allergic reaction. Some injections are given bang on target, on the head for headaches, the knees for knee pain, and in the abdomen for abdominal pain.

Saline is a real money maker. A bottle of saline, with its tubing set and needle, costs about Rs 15 to 20, but can make anything from Rs 60 to 100 for a quack. As a result, any clinic with a couple of wooden benches can make a clean Rs 1,000 at the end of the day provided they can get about ten patients to lie down for an infusion of a bottle or two of saline. This is not at all difficult to do. This kind of quick and dirty money has created unprecedented problems for those attempting to conduct an ethical practice. Ethical practitioners have to struggle, while deceit rakes in the cash.

This breed of rural doctors knows no fears. They have the right political connections and can get away with anything. They can perform abortions by any method they choose, charge hefty sums and get away unscathed if there are complications. When I published an article requesting rural doctors to use chloroquine in place of saline in the recent malaria epidemic, goons were unleashed on us by a king



Dr Verma "Abracadabra" and his wife (who also poses as a doctor). Here he listens to a patient's abdomen with his stethoscope, perhaps because the patient has complained of stomach pain

quack who happens to be the local Shiv Sena boss. The stakes are high and no method is mean enough.

All these 'bazaar clinics' are replete with dirty tricks to make fools out of hapless patients. Yet in permanent bazaars there is still a minimal amount of accountability to their customers, since their offices are stationed in respectable areas. But there are other quacks that only visit weekly bazaars. They put up tents there — not a bad idea in itself — and sell medicines and injections like any other market vendor. Medical treatment can take any *avatar* in this situation. Often they operate under

Dr Bambaiwalla's roadside dispensary and clinic in Chikadi weekly bazaar

fake names like '*Bambaiwalla*' so that no one can trace them if they choose to disappear after a mishap.

Epidemics are treated as godsent opportunities by all such operators. In the last few months, malaria has been raging in the state and the saline*wallas* made bagfuls of money. They used injections, infusions and what not — except, of course, chloroquine... While writing this article, I am called downstairs to see a woman wrapped in *chaddars*. She has been suffering from fever with chills for the last four months. She hails from Peth, a tribal area, and has undergone various treatments at bazaar clinics. She was probably pregnant when she came down with fever but there is hardly any sign of pregnancy. Malaria often ends a pregnancy. What she needs is just chloroquine and aspirin.

We see many such people turning up with malarious fever despite spending hundreds and even thousands of rupees. I know of a few who have sold their cattle or pawned a piece of land in the hope of buying a cure from such clinics. I also know some rural 'doctors' who send their patients to tantrics for cure if their own bag of tricks has failed them. Naturally, the tantrics also reciprocate by sending some patients to them after trying out their own kit.

If private services are worse than state facilities, why do they attract far more patients? Perhaps it is their accessibility, a crude sort of accountability to their customers, and in some cases, clan or caste ties that get people to decide in favour of even such an inferior option.

NGOs: A Catch 22

In a country where the state fails people and the private sector provides such inferior services, the community should organise its own health care. But there are some real obstacles. The foremost problem is that health care is an occasional need, not an everyday affair. Therefore, in most communities, there is no felt need to organise to support institutional arrangements for health care. Secondly, the cost of running a community dispensary with hired doctors is too expensive for the already exploited rural economy. The size of most villages make them unlikely candidates to support such units independently. Surprisingly, there was no regular tradition of health care in the village-artisan system; there is no traditional counterpart of community health worker or doctor. The activity was rather voluntary and nomadic and not organised in the socio-economic structure of village life.

So NGO efforts were a new area in health care. But there is a very large element of make believe involved, especially in community participation. There are few, if any, true community-based NGOs. The sine qua non of such efforts has to be community funding coming as a major share. Most NGOs are largely supported by international or government funds. In fact, some of them have made it a big business. In a society where real community support is not forthcoming, for various reasons, all support external to the community becomes a way of life for NGOs. The situation is a Catch 22. If one does not take external support, there can be little sustenance for many things that NGOs have been doing — and many of them are good. But external support has pre-empted the possibility of a biological relation — an umbilical cord between NGOs and the communities they are supposed to serve. Some NGOs have made a regular business of fund hunting from international and government agencies. Sadly, if not surprisingly, most of their work is self-serving and a hindrance to political solutions to the problem of rural deprivation. In recent times most NGOs have campaigned against GATT and a free market economy. That the central government might go bankrupt is not their worry. Their funding agencies can bloat them to larger than lifesize, with international seminars, foreign prizes, and media publicity — all of which keeps them in the public gaze.

Large health networks are being built in the name of rural health care. Often they are not attuned to community needs, since he who pays the piper calls most of the tunes. Some NGOs are getting mind-boggling funds to provide such programmes and all kinds of shoddy operations are consuming the funds while avoiding genuine work. NGOs, needed in all good democratic nations, are fast becoming a trojan horse for transnational priorities. ❐

Community Health Care

Good and efficient health care is a basic precondition for national development. The task is to institute a collective health care system without the defects that attend our present public programmes, in place of the current system that provides services on an individual basis, for a fee. The challenge is also to make such a system accessible to all, humane, efficient, technically sound, and up to date. Abore all, it must be relevant to our epidemiological realities. It is a national challenge indeed.