CHAPTER 6
CONCLUSION

Researchers have adopted various approaches in order to explain how decisions are made in the political system. Most prominent among these are "society-centred" (which includes class approach, pluralist approach and public choice approach) and "state-centred." However none of these approaches are entirely satisfactory in its own right and they are the subject of much debate within the discipline of political science and public policy. Society-centred approaches grant little initiative to government policy makers, while in contrast, state-centred approaches tend to reduce policy making to government controlled interaction, in which external forces play little role. What is needed is to provide a broader framework which should not only take into account the basic structural concerns of the society-centred approaches, about where power lies, but also to overcome the weaknesses of state-centred approaches which concentrate too closely on government control of the policy process. In this light, the present study has made an attempt to analyse the health policy making in India.

The Indian government with its ambitious goals, low resource base and slow historical rates of change has tried to adopt the view of injecting greater rationality in the management of national affairs so as to be able to take national system in the desired direction. But if we look at the policy formulation process of the Indian government, which involves extensive advice and consultation, revolving around the committee systems, we can clearly see that the policies are actually made through the process of political bargaining, making adjustments and accommodation among competing demands and pressures.

India's health policy has laid stress on curative high-technology medicine and urban hospitals, and pursued 'elitist' health manpower policies which had undermined the possibility of widely-available basic health care. Thus, it is difficult to deny the overarching role played by the doctors in the policy making process.
Doctors tend to influence health policy making in three broad ways; through Director General of Health Services where doctors hold important positions, through Committees which decide about policies where doctors are members and through professional associations like Indian Medical Association, which act as an external pressure group.

Professional associations are an important by-product of the modernizing process for the development of a political system. The Indian Medical Association was founded in 1928 as a coalition of local medical associations. Some of its founding members like Dr. B.C.Roy and Dr. M.A.Ansari were important leaders in the national movement. It was their influence which led to IMA gaining an important position after independence. Instead of maintaining the influence, the IMA started to loose its important position after 1960s. There are three major reasons for its weakness, first its dependence on the very government it wished to influence. The IMA is not wealthy, it does not employ any doctor’s full time and depends upon the commitment of working private practitioners to do the office work in Delhi headquarters or attend meetings and conferences during working hours. Many of its proposals (such as the involvement of IMA in school health and family planning activities) are only viable if they are underwritten by government funds. The IMA could expand its headquarters staff and employ doctors or other professionals in an executive capacity only with government support. Its major source of patronage-access to priority allocations of rare goods are provided by the government. The prestige activities-conferences, buildings, overseas tours, also depend on government funds and permission.

Its weakness also arises from internal disputes. Litigation connected with elections of the President and Vice President has in some years taken over five percent of IMA income. The infighting became so serious that IMA headquarters were virtually shut down in the year 2003. The faction fighting has also been accepted by member doctors as the major source of weakness of the association.
A third reason for weakness is the limited spread of doctors in rural areas. This may cause some doctors embarrassment at being unwilling to go where they are most needed. When political policy was largely the preserve of the urban intelligentsia, this may not have mattered much, but the changing structure of political life, with increased importance to rural areas, leaves doctors less well placed than unregistered practitioners to arouse rural public support or factional followings.

Indian Medical Association performs two major functions. One is to provide education to member doctors through various speciality wings and secondly, to act as trade union for protection of the interests of doctors. It has been shown in the present study that the courses that are offered by the speciality wings are not very popular and very few doctors opt for them. Hence, it is the second function which appears more important. Many of the members have accepted the fact that they became member of IMA, mainly because of the protection of their interests by this professional body.

IMA has not been very successful also because the member doctors do not take much interest in day to day activities of the association. The meetings of IMA are just another pretext for get-togethers. The member doctors are not very concerned about the policy issues. When asked whether doctors should have a say in health policy framing an overwhelming majority had said yes. But when asked which parts of the present health policy they agree or disagree with, a sizable number of doctors did not answer.

Another major problem with IMA is that it is basically a private practitioners association and either the government doctors don’t become member of IMA or they do not take active interest in the politics of association. IMA also has adopted an attitude of neglect towards government doctors. Either the meetings timings are fixed in such a way that government doctors are not able to attend them or the major demands of the government doctors are never raised by IMA. On the other hand, many of the private practitioners who are members of IMA also feel that private doctors are neglected and government doctors are pampered by the government.
Inspite of many weaknesses IMA is not so insignificant. A major reason for its importance is that historically it had played an important role in the national movement and even after independence it continued to remain in limelight. Another advantage is that its membership is of over 1,30,000 doctors which is a sizable number. Therefore, the government also likes to take IMA into confidence before taking any major policy decision. The IMA President and Secretary General are called for the meetings of Central Council of Health. The case of closing down of Mantra Healing Centre at Maulana Azad Medical College because of protest of IMA shows the powerful lobby that association represents. It also shows that the association reacts not at the time of policy formulation but when it is being implemented. This becomes further clear on the issue of proposal to test doctors every five years when IMA was speaking in many voices.

Indian Medical Association has always taken a keen interest in Centrally Sponsored Schemes like Polio eradication scheme or Tuberculosis eradication scheme. Such schemes involve huge funds and are technocratic in approach. On the other hand IMA has vehemently protested against schemes which involve decentralisation of health services for example Village Health Workers scheme. The major rallying point for all the allopathic doctors has been abolition of quackery. However, the response of government has been less than favourable because of reluctance of doctors to go to rural areas. Quacks do represent some form of medical representatives in rural areas, and that is why government is always reluctant to take any tough decision against them.

It is surprising to note that inspite of being controlled by the private practitioners IMA has never demanded complete privatization of health services. The major reason for this is that the association itself is dependent on the government funding to run its day to day programmes. Also the fact stands, that growth of private sector in India has been possible because of governments support and subsidies.
Thus inspite of the weakness of Indian Medical Association one can wonder as to how come the health policy of the country has continued to remain techno-centric in approach. The main strength of the allopathic doctors comes from their representatives within the official hierarchy, where they have traded on their control over scarce, desirable resources, access to hospitals and medical colleges. Health policy in India has thus been made in the absence of sustained ideological debate; whether over the system of medicine to be supported or the role of private practitioners with regard to distribution of resources.

Key doctors involved in health policy seem to be medical administrators, especially those who control major national medical institutions or are at the apex of the medical hierarchy in the Ministry of Health in New Delhi. Indicators for this are few. Some Director-Generals of Health Services appear to have effected some policy changes. But perhaps the most significant policy changes followed the report of the Group on Medical Education and Support Manpower, established in 1974, chaired by Dr. J.B.Srivastava, then Director-General of Health Services. Its membership included Directors of the Indian Council for Medical Research, the Post-Graduate Institute in Chandigarh, the All India Institute of Medical Sciences in New Delhi, as well as the Member-Secretary of the Indian Council of Social Science Research, an administrator from the Central Ministry, and a Deputy Director-General of Health Services as Member-Secretary. Notably absent were members from State governments. The second important change came after the Ramalingaswami Committee report in 1981 which was again headed by the medical elite of DGHS.

These medical influentials operate on an international stage. For specific purposes they might include the heads of more specialised research institutes, such as those for nutrition, mental health, and population studies. Their careers are almost entirely within a research-cum-education framework (which excludes most academic doctors, who do very little research), and generally within the Central Health Service. Very few of them have worked in a State Health Services, or as District Medical Officers (the normal route to the Directorship of State Health Services). Within the Central
Health Service accelerated promotion is possible for clinical specialists, who may vault over competitors who worked for years as medical administrators in junior positions in New Delhi Directorate. After serving in top jobs in New Delhi, they may move into the international bureaucracies of the United Nations.

Thus, elite doctors tend to be open to ideas and proposals of foreign agencies. They may make apparently radical proposals often poorly related to everyday medical bureaucratic realities. Their networks usually do not include the leadership of IMA or employees association for which they have no need. They are probably members of the general intellectual elite by virtue of birth, marriage, school education, or overseas research careers.

As a professional organisation Indian Medical Association has not played a significant role in the policy process. IMA lacks a clear purpose, consistency and vision about the country's health policy. Hence, its attempts to intervene in the policy process in the health sector in India have been of limited success only. Its office-bearers and members are found to be excluded from both the formal and informal health policy making process pursued by the Ministry of Health.