CHAPTER 1

INTRODUCTION

One of the most striking features of the contemporary world politics is that a large number and variety of organized professional groups and associations have been actively engaged in influencing public policy making. In some countries their impact on related field of policy legislation and execution seems to be deep, whereas they rather seem to have relatively mild impact in case of others. It has been pointed out that many a times this “politicisation” of professionals leads to severe ergotism as well as a steep disapprobation of the credibility of such professions. This is particularly relevant in the case of health profession in the Indian context.

Doctors as members of the interest group, the specificity or diffuseness of their demands, their conceptions of political arena, and of the “rules of the game”, the ethos and the mores which they bring with them to face or pursue the legislative authorities, etc. have considerable impact on the development perspective as well as on public policy.

While accepting the medical profession as an extremely important profession in achieving the overall community development, especially in the context of developing countries we think it worth our while to carefully consider the role of medical profession as an interest group. Going further, it may be proposed that the role of professional medicine as a pressure group or interest group is one of the key factors in shaping and changing public health policies both in the developed and developing countries.

Statement of the Problem

While accepting the importance of medical profession in achieving overall community development in developing countries it is also very important to see the role of its members as actors in policy making process in mainly three ways, firstly through the Director General of Health Services, i.e. from inside the government,
secondly, by being part of various committees and thirdly, from outside by making professional organisations.

The Union Ministry of Health and Family Welfare has three departments—Department of Health, Department of Family Welfare, and Department of Ayurveda, Yoga-Naturopathy, Unani, Siddha & Homoeopathy (AYUSH). The Health Department is headed by the Secretary and it has one attached office, the Director General of Health Services. The DGHS is the principal advisor to the Union Government in both medical and public health matters. The DGHS is dominated by doctors and thus through their advices doctors tend to have an influence on health policy.

Secondly, doctors are a very important part of all the committees that are formed to give advice on health related matters. Mudaliar committee had fifteen medical professionals and only one non-medical member; many other committees were also headed by doctors like Dr. Jungalwala and Dr. Shrivastava. All these committees had presented overwhelmingly the view of medical professionals, for example Shrivastava committee had concluded that we need doctors even for rural areas and had found no justification to make any changes in the policy of producing an adequately trained general practitioner.

Thirdly, doctors form professional associations to exert pressure on government from outside. The activity of the Indian Medical Association shows the power and influence enjoyed by them. The IMA members attend a wide range of committees, around 18; the IMA President is usually invited to attend the meeting of Central Councils of Health and Family Welfare though not as a full member.

The professional associations usually do not adopt the methods of protest and demonstration but if need be then they take part in these also. On the question of the National Health Scheme of 1972 doctors took to streets, they felt that their professional status was at stake.
Theoretical Considerations

Several attempts have been made to clarify how decisions are made in the political system. The most widely used general explanations are "society centred" or "state centred".¹ Within the first category fall the class approach (decision making is dominated by particular social classes and outcomes always favour those classes); pluralist approaches (no one elite dominates decisions, different groups compete, and policy outcomes are in the public interest); and public choice approaches (the state is not a neutral arbiter among competing groups, but a self-interest actor itself, making alliances with other major interests, resulting in policies which are not necessarily in the public interest).

None of these approaches is entirely satisfactory in its own right, and they are the subject of much debate in the political science and policy analysis literature. Society centred approaches grant little initiative to the government policy makers while in contrast, the state centred approaches tend to reduce policy making to the government controlled interaction, in which external forces play little role. What is needed is a broader framework which takes into account the basic structural concerns of the society centred approaches, about where power lies, and overcomes the weaknesses of the state centred approaches which concentrate too closely on the government control of the policy process.

In another layer of analysis there are members of groups, of institutions, of political parties, of professions. Most of the analysis is focused at this level, and looks at the actual processes of policy and the actors involved at each stage. I have asked questions about how problems are recognized, and turned into issues that get on to the policy agenda. How are policies formulated, implemented and evaluated? I have asked how far the policy process is a rational search for the best possible solution to a particular problem, or whether in fact policy is made up of small, incremental

changes that are hardly even innovatory or evolutionary. And since processes do not have a life of their own, but are dependent on actors to give them expression, analysis of the policy process is interwoven with an exploration of which actors are involved, and how far each may be exerting influence on policy.

**Policy Making in India**

There are two major approaches to policy development in the government. One approach is represented by those who believe that policies are made through the process of political bargaining and represent adjustments and accommodation among competing demands and pressures. Therefore policies can neither be anticipated nor drastically changed, but only modified in limited ways. The second approach to policy development is presented by those who believe in the possibility of discerning patterns and trends in human affairs and advocate injection of greater rationality in the management of national affairs so as to be able to steer national system in desired directions. Such a course would require anticipation of events as well as policy planning to meet emerging eventualities. The Indian government with its ambitious goals, low resource base and slow historical rates of change has no option but to adopt the second approach and to accept the validity of policy analysis and development to strive for the maximum possible degree of optimality in policy formulation and implementation.²

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 the balance tilted in favour of the first approach, thereby putting the issue of optimality to a ridiculous low. As found out by Dayal Mathur and others³ from their studies of six cases, the basic policy choice is invariably given by a committee appointed for the purpose. After reviewing the policy formulation process

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in Government of India, Dayal and his colleagues sum it up as follows: “the style of policy formulation involves extensive advice and consultation. The outstanding feature of policy making is characterized by accommodation and settlement involving the political, administrative and specialist groups as far as possible.”

There is no single process of policy making in India and nowhere in the world. By its very nature the process is polyarchal and perhaps justifiably so as no two major policy issues either emerge in the same fashion or do they develop policy decisions in the same manner.5

The role of pressure group is also very important in policy framing. Myron Weiner has observed that “nothing can be more destructive of democratic culture than a conception of national interest which deprives special interests of the opportunity to bargain to be heard, to enter creditably into the flow of demand and policies of the political process.”6

The development of pressure groups in India’s political system is generally regarded as a vital element in the process of political modernisation, insofar as it represents to increasing functional differentiation and to the breakdown of traditional types of authority. Since independence, after the adoption of modern political system, the most dominant interest articulators in India have not been the social and economic interests but their still pervasive caste, community, regional, religious and language antecedents.7 Many observers however feel that the Indian political system is moving towards a period in which the aggregation of political demands of all sectors, modern and traditional, will come to play a much more significant role than in the past.

4 Ibid., p. 66.


For analytical purposes, the interest groups can broadly be divided into the following types: organized interest groups comparable to similar formulations which exist in western industrial societies, such as trade unions, professional associations of government employees, and the like “demand groups”, defined as broad categories of people who have been mobilized from time to time in movements of one sort or another, such as “students” or “peasants”, and influence groups, which operate in non public arenas such as parliament or the state legislature or come into being at critical moments such as succession.

The policy process in India emerges in a mixed form. In some cases where process is placed through a careful grill such as in some of the sectoral areas of the development plan, the policy output is relatively neat and rational. But in large number of cases, the process is indeed very haphazard and problematic. It is little consolation for us in India that the process is equally haphazard in many countries developing or developed.

**Health Policy Formulation**

India’s approach to organizing health care services was strongly influenced by the British system, which evolved in the 1940’s. A major component of this was making high quality health services, largely curative in nature, available at little or no cost to every citizen. This model is probably inappropriate for India, for two major reasons. One is that Britain and other countries with far greater resource bases then India’s have found this model expensive to sustain. More importantly, India’s epidemiological profile suggests that greater emphasis on prevention and control of communicable diseases would have had the maximum impact on improving health by reducing exposure to disease. Preventive services are currently largely provided out of an institutional setting of qualified doctors and their staff i.e., the institutional setting of curative services.

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The context of health policy making after 1947 is set by two major influences, the report of Health Survey and Development Committee known by the name of its chair Sir Joseph Bhore and the activities of the Central Council of Health.

Subsequent to the Bhore Committee India’s health policy has essentially been carried on with little effort to alter directions in response to experience. The policies have essentially been altered in two ad-hoc ways. One is that policies have been altered by default, when funds could not be found or certain programmes could not be sustained during a particular planning period. The other way has been by superimposing massive new programmes on the existing structures, such as the ICDS (Integrated Child Development Services) or the Universal Immunization Programme.

India’s new thrust towards greater market orientation makes this an especially important time for taking stock of its health policies, both in their fundamental conceptualisation as well as in their implementation. Increased discussion of the benefits of relying on market instead of on State interventionism for stimulating industrial development is likely to be reflected in discussion of applying the same principles to health services delivery. A great deal of careful thinking needs to go into how to combine public and private sector inputs to health service delivery. Simplistic views of the marketplace are not applicable to health, because it is not a commodity in which the consumer can judge the quality of the service being received. Besides some versions of ‘market place health’ would provide powerful incentives to health personnel to concentrate their energies on giving people certain types of services which are highly profitable but have little benefit for the consumer.

In the first twenty years after independence India’s health policy was in tune both with international ideas of how to deliver services in poor countries and with the developing structures of the Indian state. This situation has given way to one in which the three are out of kilter. The state is moving in one direction, international advice and funding is pushing in another, and the health care institution of the state are unable seriously to address the health policy issues which confront them.
These factors help to explain the success as well as many of the weaknesses of health planning. The first is the position of the Planning Commission, providing a base for the health planning perspective.\textsuperscript{10} The second is the presence in the Indian Medical elite of highly trained medical scientists open to the international development of ideas of appropriate health care. The third is the support of foreign aid, unusually willing to fund the technical aspects of several major policies, derive from the same sources. The Planning Commission had no mechanism to ensure that the policies were implemented in spirit as well as in form. Elite medical scientist never worked in primary health centre, District Hospitals, or in State Ministries of Health, and so they could ignore the realities of those situations. Foreign donors influence ended when their funding ran out, and much of their effort (willingly or not) has been amenable to transfer to use for family planning of an increasingly coercive kind. None of these groupings generated wider political support for their views, either within the conventional political sphere or among grass roots organizations.

Even about the new health policy Qadeer says “had the new health policy document proposed an overarching vision of how all the elements it enumerates would be put in place, it would have been a visionary document. As it stands the draft policy is riddled with contradictions and confusions. It spells a significant departure from the 1983 policy objectives of providing primary health care for all, specially the under privileged. Instead of creatively utilizing private sector to provide basic affordable health care, it all but hands over the task to the private sector, inevitably undermining the existing national health programmes. By encouraging the corporate involvement in tertiary and secondary level medical care without first ensuring their access to the under privileged, the draft denies the right of the poor to good care”\textsuperscript{11}


Professionals in Health Policy Framing

The professionals who provide health (medical) services have critical roles in the whole health system. As long as health care remains invasive of dyadic relationships, the medical professionals will continue to dominate the health sector. Some of the providers of health care are “less professional” in the sense that they have less training and greater interchangeability; but all providers:

(1) Aspire to, if they are not already recognized as holding, professional status; and
(2) Are the point of first contact for a patient in the health system.

That is to say, whether curing or helping or even just caring, the health providers occupy the centre of the system. Try as they will, the politicians and the bureaucrats can not replace the function of the health professionals; and the centrality of function is a source of power over all other actors.12

Doctors exploited progressive belief in science and rational thinking in modern India over the conventional and populist thought of self-help and self-reliance thus creating cultural authority for the medicine. Having increased the demand for medical care, they then succeeded in controlling supply. This they have done by restricting entry into the medical institution through limited admissions and licensing laws. They also succeeded in restricting the growth of indigenous systems of medicine by dubbing them as unscientific. Thus the modern allopathic medicine established authority over all aspects of medication in India.13

In the Indian context medical profession as an interest group have certain definite features. It is basically represented by the elites in the profession, placed in responsible position of authority in government organizations or running lucrative private practice. These members are linked by bond of concern and advantage related


to their professional practice. Such a group is organized to include continuing role performance by majority members. Its tactics and goals are mostly recognized as legitimate in our society. Control over vital information by the medical profession in a semi literate society strengthens its hands, and the decision maker’s perception of the consequence of the rejection of demands is essentially helpful to the interest of the profession. The Indian scenario, while different from the western situations in several respects has common threads of linkage in its general dimensions.

Because of the nature of medical and health services, society in effect gives organized medicine (as the representative of the collective will of the profession) almost total control over licensure, training, health structure in service centres, and the behaviour and responsibility of the physicians. The nature of understanding the organized medicine has, and the kind of bargain it engages in, with the power centre affects the professionals and the clients alike especially in the Indian context where the problems of supply and management of medical manpower and other resources are severely restricted.14

The main external pressure groups attempting to influence health policy are occupational groups-representative association of public sector doctors, integrated practitioners, and western doctors in private practice, indigenous practitioners, pharmaceuticals, medical representative and so on. The avenues for affecting policy are varied and favour some groups more than others.

Even the new health policy15 says while in the country generally there is a shortage of medical manpower, this shortfall is disproportionately impacted on the less developed and rural areas. No incentive system attempted so far, has induced private medical manpower to go to such areas; and, even in the public health sector it has usually been a losing battle to deploy medical manpower in such underserved areas. In such a

14 Ibid., p. 116.

situation, the possibility needs to be examined for entrusting some limited public health functions to nurses, paramedics and other personnel from the extended health sector after imparting adequate training to them.

Another important way to look at the policy process and the role of professionals in it is by looking at some of the government programmes. In my study I have looked at three schemes first is the tuberculosis eradication scheme, second is the polio immunisation programme and the third is the village health workers scheme. Whereas the first two have found favour with the IMA, but the third has been severely criticized and opposed.

The schemes like polio immunisation programme or TB control programme are basically technocratic in approach. The declaration of self-reliance by the world at Alma-Ata brought swift and sharp responses from the major world powers that were opposed to the principles of sharing power and the distribution of resources and especially to moving away from a biomedical model of health. There was in view of Prof. D. Banerji a swift invention of the idea of “Selective Primary Health Care”, to nip the Alma-Ata declaration in the bud.\(^{16}\) This led to the utilisation of the very same WHO and United Nations Children’s Fund (UNICEF) for the implementation of a virtual barrage of specific and vertical programmes selected by them. These included universal programmes for immunisation, oral rehydration and other child survival strategies, and social marketing of contraceptives.

Not only were the vertical programmes techno centric, they were imposed on the people from above, their cost effectiveness was not demonstrated; and worst of all, they made developing countries dependent upon North for funds, supply of vaccines, and other logistic support.\(^{17}\)

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\(^{17}\) Ibid., p. 138.
Indian Medical Association

The IMA was founded in 1928 as a coalition of local medical associations. Its original membership of 200 doctors grew steadily to over 3000 ten years later.

The IMA was closely linked to the nationalist movement.\(^\text{18}\) Dr. M.A. Ansari, who was on the founding executive committee, had been President of the Congress session of 1927.

The IMA has attracted a membership of no more than 35 percent of western doctors in the country. Membership at independence was about 10,000 reaching 18,000 in mid 1950s, 26,000 in 1965 and 41,000 in 1975 and 1,30,000 by 2004.\(^\text{19}\) In the 1960s the IMA attempted to draw the associations of specialist into a closer relationship, preferably under its own speciality wing, but this was largely unsuccessful. Doctors in employees associations have occasionally sought the IMA’s assistance. Some campaigns (such as the agitation against “quackery” and for improvements in service conditions in 1969) have been jointly organized. But longer-term relationships have been resisted.

Second, the medical association is identified with the interests of private practitioners. Early government hostility left a residual bias against membership on the part of doctors in the public sector. Also, the benefits offered by the association tend to be directed towards private practitioners. Most local branch activities are organized at the convenience of private practitioners, taking place in the afternoons when most private clinics are closed but when employed doctors probably have to attend to their duties.\(^\text{20}\)


\(^{19}\) Indian Medical Association, Annual Reports, various years.

\(^{20}\) Roger Jeffery, The Politics of Health in India, op.cit., p.177.
Nonetheless, the IMA is the largest association of doctors and has attempted to present its views on medical policies as widely as possible. Its headquarters were moved from Calcutta to Delhi in 1948 to be nearer the centre of power, and the IMA has worked constantly to be “taken into confidence” by politicians and medical civil servants. Its representatives attend a wide range of committees. The most prestigious is the meeting of the Central Councils of Health and Family Welfare. The IMA President is usually invited to attend, though not as a full member.

Association officials, however, generally complain that they are not taken into official confidence in medical decision-making. During the 1960s the IMA made a concerted attempt to enhance its influence. A public relations standing committee was established in 1963; its rationale was the progress of modern medicine and the enlightenment of layman. The IMA was to study proposed legislation and publicize its views in the press and “through personal approach to the legislators or health department officials, administrators and others directly concerned.”\(^{21}\) The committee’s main objective included communicating medical news and information and generating a positive image of the profession by preventing internal conflicts and “presenting a true, realistic picture of the medical men of today.”\(^{22}\) IMA’s office holders visit ministers with memoranda about policy proposals, they hold conferences on topics such as rural medical relief, and invite politicians to open or close the proceedings and medical civil servants to give papers or chair scientific sessions; and they use contacts (such as doctors who are members of parliament) to improve relationships with governments. Perhaps it is surprising that the IMA has not followed a clear-cut policy of promoting private medicine; for a period during the 1970’s it favoured a complete nationalization of medical services as a way of dealing with the problems of over crowding in medicine\(^{23}\).


\(^{22}\) Ibid., p.323.

It is interesting to note that the medical profession in India never seems to have attempted to do any soul searching. All the addresses of the Presidents of IMA during the last five decades, with one exception, repeat the same argument and reflect the same professional values. The one exception was the Presidential address delivered in 1967 by Dr. Bhola Nath, who for the first time recognized the problem of the wrong social orientation of the profession acquired through a western style education. He expressed his views with refreshing frankness and humility when he said that: “with a sense of shame I have to point out that even after 19 years of independence, we are still de facto guided by the General Medical Council of Great Britain for working out the curriculum, teaching programme, methods and standards of examinations. It is done so that our degrees are recognized by them and our students are allowed to appear in their examinations.”

In the face of growing pressure for the redistribution of health manpower, the Indian Medical Association faced a serious dilemma. Although it opposed the government’s populist policies, the Association could not reject the demand for extending health services to rural areas. But, at the same time, the Association could not persuade its own members to go and serve in those areas. Popular pressures for redistribution were also affecting the medical profession.

There are other ways also by which IMA tries to influence health policy for example during the 1998 elections IMA brought its election manifesto, which clearly brings out its main concerns.

Even with regards to new health policy Imrana Qadeer writes that, “will the government succumb to IMA pressure and allopathic medicine the prerogative of MBBS doctors or will the vast section of the less trained practitioners be educated and used as a part of primary level health care providers as was done with the health guide section? These real issues remain unaddressed as the draft policy deals only

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with the trained physicians of the private sector and that too secondary and tertiary level. In fact it leaves the issue of providers for the poor untouched. 25

Objective of the Study

- I have looked at the general attitude of IMA towards overall health situation in the country and the remedies suggested by it.
- The issues that have been raised by IMA and their general relevance.
- Various recommendations given by IMA President in various committees in which he has been a member and whether his recommendations carry any weight during the policy formulation.
- The importance of private practitioners in IMA and the attitude of IMA towards government doctors and their problems.
- The resource constraints faced by IMA and its other weaknesses and how they influence the capacity of the association in policy making process.
- The attitude of IMA towards privatisation of health care and its views on the new health policy.

Methodological Issues

This study has used the case study method. Case study has provided information through descriptions rich in details about the association. The source of information was obtained through observation, by interviews, by survey of IMA member doctors, and review of records and documents. In studying associations observation is very important because interviews with managers are less effective as many of know them what ought to be done but do things differently for a variety of reasons.

While case study does offer advantages its main disadvantage is the difficulty in making generalizations and in proving hypothesis. Nevertheless it is excellent device for initiating exploratory research and for evaluating real life problems in association.

Looking at poverty of secondary material related to the issues raised in this study the case study method was very helpful.

**Field Work and Survey**

I conducted a survey of 105 doctors in Delhi and Kolkata. I distributed around 200 questionnaires in Delhi out of which 89 doctors responded. I contacted about 50 doctors in Kolkata through mail out of which 16 doctors sent their replies. The questionnaire was about doctor’s opinion about Indian Medical Association, their general demands and their awareness and opinion about the health issues. Although the sample size is not very big but it generally substantiates the findings of our study.

Apart from the questionnaire I also interviewed many office holders of IMA, and Delhi Medical Association. Ministry officials at policy making positions were also tried to be contacted but the attempts were not fruitful.

In carrying out this study I faced the following problems:

(i) The office holders of the association often hesitate to reply to the questionnaire, as it may disclose the secrets of their working on a particular line.

(ii) They are even unwilling to give precise information about their tactics.

(iii) Bureaucrats, politicians and ministry officials are reluctant to admit that they are sometimes pressurised by lobbyists and interest articulators. In fact, here in India, pressure groups are still considered to be sinister forces and the people and politicians are afraid of them.