CHAPTER 5

INFLUENCE OF INDIAN MEDICAL ASSOCIATION ON THE FRAMING OF HEALTH POLICY

As the largest association of doctors Indian Medical Association has shown its willingness and desire to intervene in the health policy framing. Association officials, however, generally complain that they are not taken into official confidence in medical decision making. Dr. R. Jayachandra Reddy in his Presidential Address said, “At present, the Government feels that Indian Medical Association (IMA) is not strong enough to be taken into confidence and therefore it does not take the IMA into confidence in policy making, regarding the health of the people and matters concerning medical profession. In contrast, the British Medical Association and the American Medical Association are so strong that those Governments can’t turn a blind eye and a deaf ear and take any policy making decision without the consent of these organisations." Dr. T.N. Mehrotra also in his Presidential Address said, “I strongly feel that Government must take IMA into confidence while formulating any policy regarding health and nutrition and its view should be given due importance and weightage. I can assure the Government that if IMA’s co-operation is sought in these matters, their scheme shall be more realistic and popular with the public as we know the pulse of the nation.”

In our survey of IMA doctors, when the question was asked, “Should IMA have a say in the framing of health policy in India”? The response was:

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1 Dr. R. Jayachandra Reddy, Presidential Address, 73rd All India Medical Conference, Daman, 1997.

2 Dr. T.N. Mehrotra, Presidential Address, 75th All India Medical Conference, Pune, 1999.
Should IMA have a say in health policy framing in India

A = 64, yes, because after all doctors have to implement it
B = 11, yes, because knowledge of doctor’s will be useful in policy process
C = 6, no, it is government’s and bureaucracy’s job to make policy
D = 0, no, because doctor’s own concerns will become more important than broader public good
AB = 24

Thus, the overwhelming majority of doctors felt that they should be part of policy making process.

But when the question was put “Are you aware of Government’s new health policy”?
The reply was:

Are you aware of government's new health policy

A = 58.1% = Yes
B = 41.9% = No
Thus, out of 105 doctors 44 doctors were not aware of the new health policy.

When further question was asked, “Which part of the policy do you strongly agree with”? The response was:

![Diagram showing the distribution of responses to the question: Which part of the policy do you strongly agree with?]

- A = 32, Increasing the outlay on health
- B = 0, Establishment of Medical Grants Commission
- C = 0, Increasing the outlay on medical research
- D = 0, Providing health services on commercial basis to seekers from overseas
- AB = 3
- AC = 2
- AD = 6
- ABC = 5
- ACD = 2
- ABCD = 17
- E = 38, Did not answer the question

Then the question was asked “Which parts of policy do you strongly disagree with”? The response was:
A = 2, Establishment of statutory professional councils to monitor doctors
B = 14, Levying of user charges
C = 6, Increasing role of NGO's for providing health services to the community
D = 13, A code of ethics to be notified and rigorously implemented by Medical Council of India
E = 43, Did not answer the question
AB = 7
AD = 8
BD = 4
CD = 3
ACD = 3
ABCD = 2

Thus, the major concerns of doctors becomes very clear from the last two questions but the real problematic feature in the responses was the large number of IMA members who did not respond to the question. Thus they were either completely unaware of the issues involved or did not wish to state their opinions openly.

Its headquarters moved from Calcutta to Delhi in 1948 to be nearer to the centre of power and the IMA has worked constantly to be “taken into confidence” by politicians and medical civil servants.³

During the 1960's 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 the laymen. The IMA was to study proposed legislation and publicise its view in the media and “through personal approach to the legislators or health department officials, administrators and others directly concerned.” The Committee’s main objectives 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.” In the late 1960’s and early 1970s the Government was planning to regularise the practice of medicine by unqualified personnel, and the IMA tried to generate public support to oppose its action, using protest days, marches, and more concerted approaches to the press. However, this strategy was largely abandoned by 1975 (when the emergency made public protest illegal) and the IMA reverted to its former methods. Its 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 Member of Parliament) to improve relationship with Government. Perhaps it is surprising that the IMA has not followed a clear cut policy of promoting private medicine; for a period during the 1970s it favoured a complete nationalization of medical services as a way of dealing with the problems of overcrowding in medicine. Even now when privatisation has become the buzzword in the government, IMA has not been in favour of complete privatisation. It does talk about importance of private practitioners but it still continues to maintain the important role of State in welfare services. Nevertheless, IMA officeholders still believe that their access and relationships do not resulted in any policy influence.

On the issue of privatisation as Ketan Desai in his Presidential Address noted “the National Health Policy has promised to encourage “increased investment by non-

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5 Ibid., p.64.
governmental agencies in establishing curative centres." This policy, if implemented, will allow the illiterate impoverished simple people of our country being exploited by the big finance. A government committed to socialism cannot be allowed to commercialise health welfare.\(^6\) Again the concern of IMA became clear during the Ninth Five Year Plan when Planning Commission set up a Steering Committee on Health Education and Biomedical Research to formulate policy guidelines, strategies and programme objectives for health care delivery, health education and biomedical research and nominated National President IMA as one of its members. The National President Dr. N.K. Grover, attended the first meeting on March 20, 1996. Dr. Grover highlighted the wide gap between the planning and implementation of health sector programmes in BIMARU states, low allocation of plan funds for health care, low political priority being given to health sector, the resurgence of various diseases as well as new diseases like cardiac diseases, cancer, AIDS, increasing incidence of road accidents and trauma cases, disaster management and quackery. In reference to the health care delivery in the rural backward and difficult areas, the National President emphasised the importance of voluntary and private sector in providing health care delivery (primary, secondary and tertiary) in these areas, for which the Government must provide appropriate incentives to doctor.\(^7\)

Thus, the concerns of IMA have generally been for a mix type which has favoured a socialist model with a big role for State to provide welfare services as well as to provide support to the private sector. And in this framework IMA gives itself an important role and even asked for Rajya Sabha seat for Medical profession so that it can have a say in Government's policy making. Dr. P.V. George in his Presidential Address said "at present, members of Rajya Sabha are nominated from different walks of life, except from the modern medical profession. A modern medical graduate will be of much use in the Rajya Sabha to help the Government in many ways. Hence, I request your Excellency the President of India, who is a technocrat and, who has better understanding, to nominate few members of Rajya Sabha from

\(^6\) Dr. Ketan Desai, Presidential Address, 76th All India Medical Conference, Calcutta, 2000.

modern medical profession...Our Association is also having the technical expertise to advise the government on various aspects concerning the health, drugs, pollution control, water and sanitation, etc. I request the Government both Central and State, to take IMA into confidence and have fruitful consultations and discussions with IMA for the betterment of our people.8

In the survey when the question was asked "which sector in India do you think needs maximum attention"? The response was:

\[\text{which sector in india do you think needs maximum attention}\]

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<tbody>
<tr>
<td>a = Health = 25</td>
<td>60</td>
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<tr>
<td>b = Education = 6</td>
<td>40</td>
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<tr>
<td>c = Slums = 0</td>
<td>20</td>
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<td>d = Transportation = 0</td>
<td>0</td>
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<td>e = Power = 0</td>
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<td>ab = 39</td>
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<td>abcd = 3</td>
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<td>abede = 7</td>
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Thus most of the respondents answered health and education as their choice. They were concerned about the declining standards of health and education in the country.

8 Dr. P.V. George, Presidential Address, 78th All India Medical Conference, Guntur, 2003.
Indian Medical Association even prepared a draft National Health Policy in 1979, where it was stressed that:

1. The State should recognise the right to health as a fundamental right of the people.
2. Health should not be purchasable commodity and maintenance of health is not merely an individual responsibility but responsibility of the State as well.
3. The State must accept that success of the health care systems is very much dependent on the socio-economic uplift of the people.⁹

Talking about the National Health Policy and comparing it with the draft National Health Policy of IMA Dr. Ketan Desai, in his Presidential Address said, "The National Health Policy enunciated by the Government unfortunately has failed to lay proper emphasis on the fundamental requirements as put in the draft National Health Policy of IMA for achieving 'Health for All' and I urge the medical professionals to provide leadership to the people for organising movements on these demands. Of course, these movements are in the interest of common man and unless he comes forward, the medical profession can do very little in wresting these fundamental commitments from the Government." ¹⁰

**Drug Policy Patent Law and Indian Medical Association**

Quite often charges have been made against the Indian Medical Association that it is controlled by pharmaceutical industries. The IMA also wishes to influence the drug policy and patent laws. Speaking on the issues, Dr. K.S. Sachdeva said "we are all aware that the prices of medicine are already beyond the reach of a common man and this will further be increased after the implementation of Patent Law. Attempts of the developed countries headed by United States to impose the Dunkel proposal presumably as a condition of IMF and World Bank loan will seriously affect the trade Exports and even manufacture of commodities in the country particularly the


¹⁰ Dr. Ketan Desai, *Presidential Address*, op.cit.
agricultural and pharmaceutical products and infringes on the Indian Patent Act, 1970 as well as the fundamental rights of people of the developing countries including ours. Acceptance of Dunkel proposals regarding intellectual property rights will mean accepting process patent apart from product patents. It will be ludicrous situation and travesty of purpose because prices of drugs in developed countries will come down while in developing countries this will go up if Dunkel proposal is accepted."

In our own survey of IMA member doctors when the question was asked "what will be the impact of Patents Act"? Then the response was

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<td>A</td>
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<td>B</td>
<td>5</td>
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<tr>
<td>C</td>
<td>34</td>
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<td>D</td>
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<td>E</td>
<td>3</td>
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<td>AC</td>
<td>12</td>
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<td>AD</td>
<td>11</td>
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<td>ACD</td>
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A = 64, Prices of medicines will increase
B = 5, Prices of medicines will not increase
C = 34, Country will gain technologically
D = 4, The impact will be clear at a later date
E = 3, Did not answer the question
AC = 12
AD = 11
ACD = 2

Thus maximum number of IMA member doctors were concerned that price of pharmaceuticals is going to increase; although few doctors also felt that the country will make technological gains.

Interview with Dr. K.S. Sachdeva, Vice-President, Delhi Medical Association.
The IMA has also been trying to have a say in the making of drugs policy. Dr. Ketan Desai had dealt with the issue in great detail in his Presidential Address. He said "IMA is clamouring for a rational National Drug Policy for years. The Government of India has proposed to bring out such a policy many times and at last only recently it has seen the light of the day.

Over the years no scientific approach has been made to the problem of manufacture and supply of drugs. As a result the public sector drug industry has failed to play its role; one may feel that this might have done purposefully to ensure better market for the multi-national and big national drug industries."

Accordingly the first objective of a National Drug Policy should be to assess real need of the types and quantum of drugs and ensure their availability to the lowest strata of people. The policy should assure accessibility of the whole population to the most effective and safe drugs of essential quality at economic prices with priority for free supply to those who are indigent. This policy should also envisage setting up of a Drug Authority of India having chains of drug control laboratories spread all over the country.

Such a policy must ensure that public sector can play the pivotal role in the Drug Industry and multinationals cannot dictate terms to the Government and thrive at the expense of private, national or public sector drug industry. The policy should ensure a time bound programme by which country can become self sufficient in drugs through public sector and national drug industries and stranglehold of the multinationals could be got rid of. Various recommendations have been submitted to the Government on behalf of the IMA on this issue from time to time.

Dr. Ketan Desai in his Presidential address had said "it is imperative that the IMA must formulate its views on the drugs policy pronounced by the Government and take

\[12\] Dr. Ketan Desai, *Presidential Address*, op.cit.
up the matter with all assertion at its command so that the drug policy is made to serve the people and not the vested interests."\(^{13}\)

Even a Drug Policy Document was sent in the year 1995 by IMA to the Ministers of Health and Family Welfare and Chemicals and Petrochemicals for consideration and revision of Drug Policy of the Government of India. There is even a Standing Committee for Drugs and Medical Equipments of Indian Medical Association.

In our survey of IMA member doctors when the question was asked “should there be close cooperation of pharmaceutical companies with IMA”? The response was

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<tr>
<td>A = 52, Yes it will make IMA stronger</td>
<td>60</td>
</tr>
<tr>
<td>B = 4, Yes it will be for broader public good</td>
<td>40</td>
</tr>
<tr>
<td>C = 20, No it will be against medical ethics</td>
<td>20</td>
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<tr>
<td>D = 18, Why not such association already exists</td>
<td>0</td>
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<tr>
<td>AB = 6</td>
<td></td>
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<tr>
<td>AD = 5</td>
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Thus a large number of respondents wanted close cooperation with pharmaceutical industries because it will make IMA stronger. A sizeable number of doctors also accepted that such cooperation already exists. Hence although IMA wanted a

\(^{13}\) Ibid.
pharmaceutical industry of public sector dominance but covertly has been maintaining close cooperation with drug industry and thus also wants to have a say in the drug policy of the country. In the interview with Dr. I.P. Dhalla when the question was asked about cooperation between pharmaceutical companies and IMA his response was that “our intention is only to see that drug companies should not be selling medicines which have harmful side effects and that is our only concern.” Thus it is very difficult to prove that the relationship of IMA with pharmaceutical companies has any malafide intentions.

The Delhi Medical Association even announced the formation of a Task Force Committee to establish quality control over life saving stents. The task force will be under the stewardship of Dr. K.K. Aggarwal and will include member of the Cardiological Society of India, Dr. S.K. Parashar, and representatives of the All India Institute of Medical Sciences (AIIMS) and G.B. Pant Hospital.

Stents which are essential in dealing with a range of cardiovascular ailments-are a 600 crore industry in India. “It is unfortunately an unregulated industry,” said Dr. Aggarwal. More than 40 companies-both national and international-are involved in the production and distribution of stents. With foreign stents selling for as low as Rs. 18,000 many more are imported into the country. The Task Force has a broad ranging ambit to classify stents available in India, suggest a pricing plan, create a transparent policy to inform both patients and doctors about this life saving medical tool and also weed out stents that are regarded as unfit for use.

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14 Interview with Dr. I.P. Dhalla, IMA Past President and Member State Executive Committee, Delhi Medical Association.

15 The Hindu, 1 August 2005.

16 Ibid.
Meetings of Central Council of Health and other Committees and Role of Indian Medical Association

A reading of the various committee reports clearly indicates that the policy followed by the Government vis-à-vis the private sector can best be described as a laissez-faire approach where state controls were practically nil. Over the years the private sector has grown and diversified and the present policy of liberalisation has further encouraged its growth. An important issue that needs to be kept in mind while studying the growth of the private sector in India is that it is not independent of the public sector. The state, through its investment in training of human power and creating institutional facilities, has provided a base for the growth of the private sector. Even within the public sector one finds that a large percentage of the doctors practice privately and private interests within the pharmaceutical and medical equipment industries play an important role in shaping public policy.\(^{17}\)

The benefits that private sector enjoys is because its interests are represented in various governmental committees. Indian Medical Association representatives attend a wide range of committees – the Annual Report for 1973-1974 lists 18, all with some governmental involvement. The most prestigious are the meetings of the Central Councils of Health and Family Welfare. The IMA President is usually invited to attend, though not as a full member.\(^{18}\)

The Annual Report of Indian Medical Association mentions that, “The National President, Dr. B.C. Chhaparwal and Hony. General Secretary, Dr. Jagdish C. Sobti participated in the 4th meeting of the Central Council of Health and Family Welfare held in New Delhi on October 11-13, 1995, under the Chairmanship of Shri A.R. Antulay, Minister for Health and Family Welfare, Government of India and IMA’s view points thereon were clarified.


The proposal for formation of an Education Commission on Health Services also came up for consideration and the stand and objections of IMA against setting up of such a commission were reiterated. As desired by the Minister, the stand of IMA was also sent to the Ministry in writing and he clarified that IMA would be represented on each Committee of the Ministry.\textsuperscript{19}

Various other committees and meetings that the representatives of IMA attended in that year were:

1) Meeting of the Rajya Sabha Select Committee on Trade Marks Bill 1995 in New Delhi in October 11, 1995.


3) Meeting between the Government of India and UNICEF for developing over all strategy for long term five year programme for Women and Children convened by the Ministry of Human Resource Development, Department of Women and Child Development in New Delhi on September 5, 1996.

4) Meeting of the Governing Council of National Board of Examinations held in New Delhi in September 11, 1996.

5) Meeting convened by the Ministry of Health and Family Welfare on September 30 and October 1, 1996 in New Delhi.

Thus Indian Medical Association takes part in large variety of committees and meetings and plays an important role in the policy making process through this channel.

\textbf{Quackery and Indian Medical Association}

The primary issue that has exercised the IMA since 1947 has been policy towards practitioners unqualified in allopathic medicine. Before independence the expressed attitudes of doctor-politicians were not very hostile. In the 1930s, indeed, several

Presidents’ of the IMA called for a re-approachment between allopathic and indigenous practitioners. Even so, the hand of friendship was only offered to “sincere, genuine” practitioners who maintained a “pure” practice of the ancient arts. But since 1947 the IMA has consistently drawn a clear line between allopathic graduates and licentiates on the one hand, and all other practitioners, usually called “quacks”, on the other. It has reluctantly admitted that trained vaids and hakims should be permitted to practice in their own line but has protested vehemently against integrated practice (training and treatment from more than one system) and the use of allopathic treatment by untrained personnel. In 1963 the public relations subcommittee commented that quackery is rampant in India and it would be the duty of the Association to acquaint the public and educate the illiterate masses about the same with a view to elicit their cooperation in rooting out this menace.

Unfortunately for the IMA, the public and many politicians and civil servants do not see the matter this way. Propaganda against travelling sellers of cures has been undertaken by the government, but neither the government nor most patients view established practitioners with dubious qualifications and the prescription of allopathic medicines by vaids and hakims as the same kind of issue. In many areas trained doctors are few and far between. The government has therefore argued that the unqualified practitioner is entitled to earn a living as long as he is not an actual threat to his patients, at least until there are enough trained doctors to replace him. This view is held despite legislation designed to:

1. Restrict unqualified practice by registering existing practitioners and then outlawing any further additions to the register (following a Bombay Act of 1938 as a model).
2. Prevent any medical practice by those unqualified in modern medicine (enshrined in a clause of the Act when amended the constitution of the Medical Council of India in 1956).
3. Present prescribing of drugs contained on a list of dangerous drugs (enshrined in the Drugs Act of 1940).
The IMA’s frequent assertions that this legislation be enforced have usually been ignored, may be because, at the local level, the relevant agencies (district medical officers, or the police) prefer to maintain illegal practices for considerations, or as part of the favours and obligations which are the everyday currency of political life. However, when government proposed to change that policy to overrule aspects of this legislation, the Medical Association has prevented most of these changes from being implemented.

The associations of indigenous practitioners have also been concerned with this issue. These associations have divided into two opposing camps – those insisting on a “pure” Ayurveda and those in favour of some integration of Western and indigenous practice. Before the 1960s, most Ayurvedic and Unani colleges integrated modern subjects, such as anatomy and physiology, into their curricula. The political care for indigenous medicine rested on its suitability for Indian culture, diet, and climate, and its claim to be providing services in rural areas that allopathic medicine was unwilling and unlikely to supply. However, students generally wanted more allopathic medicine, since they were often studying indigenous medicine as a second best option, having failed to get into allopathic medical colleges. Then, after training, they claimed that they were entitled to employment at the same scale of pay and on the same conditions as Western graduates. These contradictions were resolved in the early 1960s. Most indigenous colleges removed “modern” science from their curricula and followed the “pure” line. This position was also preferred by allopathic doctors because it might lead to a sharper delineation of the distinctions between the systems of medicine and a greater capacity to stop outsiders from encroaching on Western medical territory.  

But the dispute continued, the Editorial of JIMA noted “time and again, the IMA has been strongly opposing and condemning the practice of modern medicine by


untrained and unqualified persons and have been urging the Government authorities to act upon the existing laws to remove the existence of quacks in the country. In order to intensify our campaign against quackery, the National President, IMA decided in August 1996 that all State and Local Branches should observe 2nd October, the birthday of our beloved Father of the Nation Mahatma Gandhi who always stood against the evils of society, as Anti-Quackery Day."\(^{22}\)

The Annual Report of the year 1997 noted that “the Branches were asked to activate Anti-Quackery Cells for taking action against quacks. It is highly encouraging that the Delhi High Court in a Public Interest Litigation filed by IMA East Delhi Branch took cognisance of the existence of quacks without any valid degree and passed an order on 11th March 1997 directing various authorities within Delhi Government, concerned Health Departments, Commissioner of Police, Drug Controller, Medical Council of India etc. to take appropriate action in accordance with law to deal with such quacks.

IMA Headquarters also launched an intensive campaign against the setting up of the Mantra Shakti Healing Centre at Maulana Azad Medical College, New Delhi, which was inaugurated by the Chief Minister of Delhi on 1st August 1997, in the presence of the Health Minister, Government of NCT of Delhi. As a result of this campaign the Mantra Shakti Healing Centre was discontinued.\(^{23}\) The case of Mantra Shakti Healing Centre is an interesting one because on the one hand it shows the power of Indian Medical Association, that in spite of big names attached with the Centre it was closed down, on the other hand it also shows that reaction of the Association is only after the policy has been implemented. The opposition came at a later date not at the time of policy formulation.


Health Manpower Policy and Indian Medical Association

The evolution of the Indian health manpower policy has been characterised by two different models of health manpower development one model is based on primacy of quality considerations in design of health care programme, concentration of health personnel in urban areas, unwillingness to recognise indigenous medical practitioners as participants in the regular health care network, and opposition to delegation of the primary curative functions to para medical personnel. This can be called as “professional” model of health manpower development. An alternative model emphasises facilities in favour of rural and poorer sections of the society. This, in turn, requires a rapid increase in admissions to medical colleges, shortening the duration of medical courses and greater emphasis on the use of para professionals and indigenous medical practitioners in regular health organisation. The proponents of this model, however, argue that the twin criteria of quality and wider accessibility of health care cannot be fulfilled simultaneously at the present stage of development in poor countries such as India, and that accessibility must get precedence over quality for a certain transitional period of development. In contrast with the “professional” model, this can be called as “populist” model of health manpower development.

In India the professional model was the main framework for health policy until 1966. The populist model has gained increasing acceptance from the Ministry of Health and Family Planning during the late 1960s and early 1970s. Even during the period of prevalence of the professional model, certain elements of the popular model were grafted on it in a kind of uneasy alliance. The Journal of Indian Medical Association published an editorial on “Rural Health in India” which elaborated the position of the IMA. It listed unattractive terms of employment, unfavourable environment of the villages, poor prospects of private practice, lack of educational facilities and lack of facilities to practice the most advanced medical science as some of the most important reasons for doctor’s unwillingness to go to rural areas. The same editorial reflects the professional values that form the Western style physician’s orientation towards rural service and has guided the professional values of IMA towards health manpower policies.
Moreover, most of the young doctors are ambitious to attain high standards in respect of their qualifications, knowledge and experience and execution of diagnostic and therapeutic steps with the help of modern appliances, and they eagerly look forward for applications of their newly gained knowledge from teaching institutions and recent books and journals for which the village offers little prospects. If the instruments of precision and appliances of modern techniques are rendered available along with the current medical literature in the most peripheral villages, much of the disinclination of the young ambitious doctor to work in rural surroundings will melt away.24

It is interesting to note that the medical profession in India never seems to have attempted to do any soul searching. Most of the editorials of JIMA and addresses of the President of IMA repeat the same argument and reflect the same professional value. The one exception was the Presidential address delivered in 1967 by Dr. Bhola Nath, who for the first time recognised 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 recognised by them and our students are allowed to appear in their examination.”25

Given this confluence of interests and orientation between the medical profession and the Ministry of Health, the official policy was one of persuading the State Governments to provide better facilities to doctors serving in rural areas.


Although there was no dramatic departure from past policies, by the late sixties the Health Ministry had recognised the inadequacy of the professional model and, by the beginning of the Seventies; it came up with a plan for rural areas based on the populist model. 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. According to Dr. Subash Bhargava, "the increase in number of medical colleges is alarming and the number of doctors coming out from the medical colleges has reached a stage of threatening unemployment for doctors. At the same time, we are lacking paramedical staffs like nurses, laboratory technicians, x-ray technicians, etc. Actually we should have 15 paramedical staff for one doctor, like a prism; but at present the situation is like an inverted prism. This is mainly due to lack of health planning and it should be rectified immediately. Their curriculum also should be changed to suit the requirements of modern medical graduates and the developments in medical field." 

Again Dr. Rakesh Bansal said "Inspite of alerts from responsible quarters the doctor-nurse ratio has not much changed since the review by the Bhore Committee. The 1991 Health statistics reveal the doctor population ratio (excluding medical men deemed to be practising other modern medicine) as 1:2145 and nurse population ratio as 1:1657, whereas the latter should have been 1:600 in terms of WHO recommendations with 3 nurses per doctor. No report of health manpower of other categories is available. We have observed the enthusiasm of State and Central Governments in setting up new medical colleges however ill-equipped they may be and in introducing short-term medical courses however inadequate training it may impart. For why was this hurry? It is obviously to satisfy the vocal and powerful section of the community who wanted their children to be doctors rather than nurses.

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26 Interview with Dr. Subash Bhargava, Chairman IMA Academy for Medical Specialities.
It is high time that a National Health Manpower Survey should be undertaken to determine the status of the health manpower of different categories and appropriate steps be introduced to make up the deficiency of nurses and other paramedical workers urgently. This is a prerequisite for implementation of any Primary Health Care Programme, success of which depends upon the availability of adequate number of each category of the health worker. A doctor cannot be expected to perform the functions of a nurse or a technician.27

For example the Pondicherry branch of the Indian Medical Association expressed concern over the “commercialisation of medical education” in Pondicherry. General Secretary R.V. Krishnakumar in a release said “Association’s executive committee meeting held here recently reviewed the situation in Pondicherry in the context of the government decision to permit two additional medical colleges in the private sector. There were four medical colleges in Pondicherry and Karikal.” 28

The Indian Medical Association has been divided between the need to maintain professional standards and the need to serve the people. Consequently, its opposition to the government’s policies lacked the past assurance and confidence. It did not oppose the National Service Bill and the development of indigenous medicine as a separate scientific tradition. However, when it came to the National Health Scheme for rural areas, the Association publicly protested because it threatened the very essence of its professional value system.

The Indian Medical Association opposed the National Health Scheme in the following words: “the Indian Medical Association is totally and fundamentally against the proposed scheme ..... whereas the qualified and trained medical practitioners in indigenous systems of medicine may be utilised in specially prepared schemes as pilot projects with the objective of providing relief within the scope of

27 Interview with Dr. Rakesh Bansal, Member IMA Working Committee, Delhi Medical Association.

28 The Hindu, 1 August 2005.
their individual systems, no ‘cocktail’ or mixing up of the system be allowed under any circumstances. The Indian Medical Association is totally against the continuance of practice of medicine by the unqualified quacks who are neither educated nor trained nor qualified.... Their being labelled as Rural Medical Practitioners with abbreviation ‘RMP’ would be nothing but throwing dust in the eyes of the people..... Their backdoor recognition is bad; their involvement in rural medical relief is worse.29

This verbal protest was followed by strikes and public protest marches by the doctors. This militant stand in the IMA’s public posture on the rural health issue must be placed within the context of changed economic prospects for doctors. The rapid increase in medical education had, by 1972, saturated most of the cities with medical graduates. Consequently, as stated by the President of the IMA, there were about 15,000 to 20,000 unemployed medical graduates in 1972.30 Another reason for unemployment was that while some states had a shortage of doctors, other were finding it difficult to employ all their graduates. The regional imbalance was further accentuated due to the lack of inter-state mobility. On the one hand doctors were unwilling to migrate to another region of the country where they may have had to face a different language and culture, on the other hand, many states were unable to employ outsiders due to local opposition. The Indian Medical Association, therefore, urged the government to “appoint a Commission to explore the possibility of nationalising health services on a phased basis.”31 This changed economic context of the medical profession, further strengthened the Medical Association’s opposition to the rural health scheme. Faced with unemployment, doctors were not prepared to let a whole new class of para-professionals enter medical practice and compete with them.


The National Health Scheme threatened the very essence of professional organisational interests.³²

The IMA's views on the National Health Scheme have considerably slowed down the process of decision-making. The President of the IMA was a member of the Planning Commission's Task Force on Medical Manpower. He also presided over the Study Group on the same Task Force which was entrusted with the task of examining the feasibility of the scheme. The Annual Report of the IMA for the year ending 30 September 1972 claims that "as a result of discussions, the scheme was considerably watered down"³³.

Even in the Nineties there was not much change in the attitude or professional values of Indian Medical Association. Speaking on the issue of lack of doctors in rural areas Dr. V.C. Patel said "the fact that our doctors have an acceptability in other countries, bear out that our medical education is satisfactory. However, the reality cannot be denied that our health care is unevenly distributed. The inadequate medical facilities in rural health care is squarely laid at the door of young doctors who graduate from the University and are blamed, not going to rural area for health care delivery. It is necessary to analyse the reluctance of young qualified doctor to join for Rural Health Care Services. The analysis reveals the lack of basic needs, viz., absence of satisfactory working environment, lack of job satisfaction, lack of paramedical assistance and lastly, lack of adequate transport and communication in rural area.

Doctor must be provided in rural area reasonably – satisfying environment in respect of housing, food, clothing and education for his family members. These must at least be provided by Government where health centres and hospitals are situated. This is

³² Morton Halperin has articulated the concept of organizational interests and organizational essence in his study of bureaucratic politics in American foreign policy, Halperin has suggested that most organizations – but more specifically mission oriented organizations, will fully resist any change that may affect their organizational essence, See Halperin, 'Why Bureaucrats Play Games', Foreign Policy, No.2, Spring 1971, p. 334.

more important as about 40% graduates are women, to whom social, family and personal security have to be guaranteed. Alternatively limiting admission to women to medical colleges may strike at ‘fundamental rights’. One solution can be ‘village service bond’ but more attractive is to give ‘village practice allowance’, which should cover increased transport and education expense for the children. This will redistribute excess unemployed urban doctors, amongst villages not having doctors.34

Policy of Reservation and the Stand of Indian Medical Association

One area of health manpower policy where there has been a consistent opposition from Indian Medical Association is the policy of reservation. Speaking on the issue Dr. T.N. Mehrotra said “all of us are aware of the falling standards of medical education over the years, which includes (1) Reservations in admission, (2) Reservation in appointing teachers, (3) Inability of the Government to provide funds to modernise our institutions, (4) Political interference.

IMA welcomes the judgment of Supreme Court that in admission for super specialisation there shall be no reservation, i.e. selection shall be based only on merit.

Friends, I may convey that I am as much concerned for the upliftment of weaker section of the society as my politician friends. I however have strong conviction that much better way of helping them is by raising their standard of education.

Government has passed a Bill extending reservation in its present form for next 10 years. I hope that in the interest of the Nation’s growth and development the Government will consider my proposal of uplifting the remaining economically weak students in our country. I strongly feel that in medical education, as it deals with human life we should not compromise with the quality in any form.35

34 Dr. V.C. Patel, Presidential Address, 74th All India Medical Conference, Hyderabad, 1998.

35 Dr. T.N. Mehrotra, Presidential Address, op.cit.
Speaking on the same issue Dr. P.V. George said "being a most strenuous and difficult course, only the best students should be allowed to take up the medical education. The main reason for decreasing the standard of medical education is the dilution in the criteria for selection of students. When the best students remain outside, average students are entering the medical colleges. The same reservation is followed in appointments and promotions, leading to dissatisfaction and disappointment among the best of our talents. When these reservations are followed from selection of students, appointments and promotions, only less than 5% chance is there, for a talented person to reach the top of the hierarchy.\textsuperscript{36}

**Private Practice by Government Doctors and Position of Indian Medical Association**

The Bhore Committee, which was set up prior to independence, prepared the blueprint for health services development in the country. A survey of medical institutions by this Committee revealed that 92 percent of the institutions were maintained on public funds and the remaining 8 percent were wholly maintained by private agencies.\textsuperscript{37} The proportion of allopathic doctors in private practice was as high as 73 percent and the remaining 27 percent were employed in government service.\textsuperscript{38}

Although the proportion of private institutions was small, the percentage of individual practitioners was indeed large. The Bhore Committee took an ambiguous position on how to deal with these private interests. The authors did not mention the role of private institutions in health services but as far as private practice by doctors in government service was concerned, the committee was of the opinion that:

\textsuperscript{36} Dr. P.V. George, *Presidential Address*, op.cit.


\textsuperscript{38} Ibid., pp.42-43.
"prohibition of private practice is essential to ensure that the poor man in both rural and urban areas received equal attention with his richer neighbour." 39

Although the Committee had categorically stated that private practice by government doctors must be prohibited and did not visualise a role of independent private practitioners in government hospitals; a shift in policy could be seen as early as 1961 in the report of the Mudaliar Committee. This committee took note of the fact that nearly 40-70 percent of doctors in different states were private practitioners. 40

The position the committee took vis-à-vis private practitioners was that since there was a shortage of manpower; they should be encouraged to provide both curative and preventive services. It further stated that private practitioners should be "given opportunities to serve in government hospitals on a part-time or honorary basis and hospital authorities should encourage them to admit their patients needing in patient care." 41 Thus the Committee not only recognised the presence of a large number of private practitioners, but also visualised a role for them in government service. It went further to state that: "independent practitioners have to be considered as a separate entity whose legitimate interests must be protected." 42

During the 1960s there was also no serious effort to prevent government doctors from having private practice. The Bhore Committee had strongly recommended a ban on private practice by government doctors and the Second Five Year Plan also reinforced this need due to the negative impact of private practice on teaching and research in medical colleges. However, these recommendations proved to be difficult to

39 Ibid., pp.43-44.


41 Ibid., p.136.

42 Ibid., p.135.
implement because efforts at banning private practice were short lived due to the lobbying power of the private doctors.

The Jungalwalla Committee Report in 1967 did not mention individual private practitioners but did observe that a large percentage of doctors in government service were practising privately. It stated that: "no government medical officer should normally be allowed to do private practice. Elimination of private practice is, however, beset with many problems, financial and administrative. Judicious and more reasonable procedures would be to eliminate private practice on a phased basis, beginning with teaching or research post health officer, health centre doctor and supervisory posts at the state headquarters and district levels. Compensation for loss of private practice should however be reasonable."

The inability of the State to curb or eliminate private practice by government doctors was indicative of its widespread prevalence. Whenever any State government has tried banning private practice by government doctors, it has met with a great deal of opposition from them often resulting in the ban being revoked. In Andhra Pradesh for example there were two attempts at banning private practice, once in 1968 and again in 1984. During both times there was tremendous opposition to the ban which resulted in its revocation. Similarly, in Uttar Pradesh the government banned private practice in 1975. A number of top specialists protested and threatened to resign and as a result the ban was revoked. Since 1975 the government has tried to impose a ban twice but on both occasions it met with opposition and was withdrawn. The Government of Bihar banned private practice by doctors employed in medical college hospitals in October 1986. Since then doctors have filed Writ Petitions challenging the governments ban but the High Court has upheld it. More recently, the Government of New Delhi and Madhya Pradesh have banned private practice and this

44 The Times of India, 7 April, 1987.
has resulted in an exodus of doctors from the public to the private sector. 45 These instances show that doctors contribute an important political pressure group and have lobbied with political parties to protect their interests. This is by no means peculiar to India because in Britain and America, members of the medical profession have played an influential role in shaping medical policy in their respective countries and have resisted any attempt by the government to challenge their interests. 46

In our survey when the question was asked from IMA member doctors “should the government doctor’s private practice be regularised”? Then the response was

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<th>Should the government doctors private practice be regularized</th>
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<tbody>
<tr>
<td>□ Yes</td>
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<tr>
<td>□ No</td>
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<tr>
<td>□ Don’t know</td>
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Yes = 39%
No = 49.5%
Don’t know = 11.4%

Thus the response was that at least half the doctors were opposed to government doctor’s private practice being regularised. This response could be because in the survey the overwhelming majority was of private practitioners i.e. 80 and there were only 15 government doctors, 6 doctors had refused to answer the question. Also the fact is that 61 doctors had told that before starting private practice they were employed by the government. This shows the bias of private doctors against their private colleagues and also reflects on the position of IMA which is dominated mostly by private doctors.

Indian Medical Association’s Influence on State Governments

Health being the State item, the Indian Medical Association has also tried to influence State governments. Although these attempts have not been very successful. The State governments were much more receptive to the indigenous systems of medicine and, by 1957, many of them had established Boards of Ayurvedic Medicine or Departments, (Bureau of Indian Medicine Registration Acts) were also passed to set standards for the practice of indigenous medicine. There were fifty teaching institutions and 5,469 hospitals of Ayurveda and Unani medicine in 1957 which were supported by various State governments. The Governments of Madras, Orissa, and Uttar Pradesh started colleges of integrated medicine (both Ayurveda and allopathic)\(^\text{17}\). Most of these integrated courses were discontinued in the early Sixties when the Central Government adopted a new policy of encouraging Shuddha Ayurveda. There were three reasons for the encouragement given to indigenous systems of medicine by the State governments. First, the top political elites in many of the States were less Westernised than the elites at the Centre. Second, health being a State subject, States which were short of qualified doctors were more willing to use indigenous practitioners than the Central government and those States which had an adequate number of doctors. Third, historically, popularly elected ministries were formed in India in 1938 when the British granted limited provincial autonomy. In this pre-independence environment of a strong nationalistic revival, the leaders of Congress ministries in the States recognised Indian systems of medicine and enacted legislation to support them\(^\text{48}\).

While the States continued to encourage Ayurveda, Unani and Homoeopathy, the Central government followed a policy of verbal support but gave little material support. As a result of this policy, the Central Health Ministry and the Indian Medical Association supported research in Indian medicine for the most part of the fifties, but discouraged any official recognition of degree in Indian medicine. Both the IMA and

\(^{17}\) Government of India, Annual Report of the Director General of Health Services, Central Bureau of Health Intelligence, 1957, Chapter 14.

the Health Minister Amrit Kaur were of the opinion that anyone who wanted to practice medicine must first obtain a basic degree in allopathic medicine, and then if he/she wished to pursue further studies in Indian medicine, that should be done through specialisation at the post-graduate level.

The Indian Medical Association has also been complaining that State governments do not spend enough money on health. The editorial of JIMA wrote, “Some years back a policy decision was taken that all State governments should utilise 9% of their budget for health. But this has never materialised and the maximum that some States spend in health is about 50% of the target. People are not aware of this limitation of the government and they think, and sometimes the political bosses also say, that the State is spending the money but it is the insincerity of the medical profession that the benefit of health are not reaching the people. It is a move directed against us only to hide their own limitations of inefficiencies. There has been a very clever attempt on the part of politicians to cover up their own deficiency by pointing a finger towards us.”

Speaking on the same issue Dr. V.K. Kohli said “health being a State item it will be easier for us to convince the respective Governments – to formulate and enunciate a uniform policy throughout the country which is likely to be beneficial for all. If we can convince the State Governments, whatever may be their political identity, we can make the task easier for the government at the Centre to work out a National Health Policy, which will be easily accepted by all the States.” Dr. Arinjaya Jain pointed out “no State Government, up-till now, has made the minimum allocation for the health budget as part of the National Health Policy. The allocation at the most has been only 50% of the amount as suggested in the National Health Policy. In many states it has been even lower than that.” Thus, although, IMA has been trying to influence State Governments, but has not been very successful in it.

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50 *Interview* with Dr. V.K. Kohli, State Executive Committee Member, Delhi Medical Association.

51 *Interview* with Dr. Arinjaya Jain, State Executive Committee Member, Delhi Medical Association.
Indian Medical Association’s Role in Government Programmes

One of the ways to see the influence professional associations have on health policy framing in India is by looking at some of the government programmes.

The schemes like polio immunisation programme on T.B. 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 who were opposed to the principles of sharing power and the distribution of resources and especially to moving away from a bio-medical 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. 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.

Indian Medical Association has always taken an active interest in National Health Programmes. Dr. R. Jayachandra Reddy in his Presidential Address said “the National Health Programmes which are implemented only at the Government level cannot be called national programmes without the active involvement of an organisation such as IMA. There is no organisation better organised than the Indian Medical Association with a country-wide network of its own and with the right motivation to involve the large private sector in the implementation of National Health Programmes. This is

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51 Ibid., p.935.
one of the greatest responsibilities of the IMA and the whole country is looking up towards this association for the effective execution of the programmes. I will try my best to see that we would start and motivate network programmes, so as to make private sector fully involved in various national programmes. This year we would like to concentrate on the preventive aspect of the communicable diseases such as AIDS, hepatitis-B, malaria, poliomyelitis, diphtheria, whooping cough, tetanus, measles and other diseases." 54

The Editorial of Journal of Indian Medical Association observed, “Though, the public sector is primarily responsible for health care delivery, which includes control of infectious diseases, in the present health scenario, it is not possible for the public sector alone to meet the challenge of new emerging and re-emerging infectious diseases. The private sector with its immense potential is capable of supplementing and complementing public sector activities." 55 Thus the view of Indian Medical Association has been that private sector is responsible for a sizeable amount of health care in the country but it is mostly medical care component of health care system. The concept of “Private and Public Mix” is being promoted for better delivery of health care. This concept of “private and public mix” is based on the presumption that the private sector is free from political and administrative constraints associated with the public sector. If the private sector takes off the load from the public sector, then the scarce resources freed to that extent from public sector, could be utilised in other areas for better health care delivery among the poorer section. But there are apprehensions in the public sector that privatisation leads to greater cost for medical care, which would serve mostly the elite, and less the weaker sections of the society. This dichotomy of health care, including that for infectious diseases, would accentuate further the gap between the elite and weaker sections who are most likely to be victims of infectious diseases. In the present context of infectious diseases, a

54 Dr. R. Jayachandra Reddy, Presidential Address, op.cit.

joint effort both by public and private sectors is essential for which there should be mutual trust.

There should be collaboration between the medical practitioners in private and public sectors from district to national level. There are many recognised fora of medical practitioners in private sector in all countries in the region, for example, in India; the Indian Medical Association has member strength of over one lakh spread over 22 States with about 1356 branches country-wide. The State/public sector should explore effective collaboration through such recognised fora in the private sector. Such collaboration would create a trust between public and private sectors. In the absence of such collaboration, not only health care delivery suffers but also misinformation spreads in the community, mostly from the private sector thereby hampering control activities.

Dr. I.P. Dhalla said “IMA has invariably been a participant in the execution of National Health Programme in the preventive, promotive and curative medicine. This includes Malaria Eradication Programme, Tuberculosis Control Programme, Leprosy Eradication Programme and National AIDS Control Programmes. The Government of India therefore must involve IMA in many national programme activities like blood transfusion activities, substitute therapy, AIDS workshops, STD’s management, mega eye camps, health melas in rural and urban slums, health camps, RCH programme, polio eradication programme etc. It is a matter of fact that 70% of the health care in India is delivered by private sector, 30% of health care is delivered by Government sector and most of the preventive medical services are rendered by Government. I am glad to say that National Health Programme with large fund upto 600 crores is offered by Central Government to IMA to deliver health care to masses through about 1400 branches of IMA of a membership strength of 1.3 lakh doctors. The curative and preventive health care may be delivered through private nursing homes and clinics managed through IMA be given to needy people by daily attendance on OPD basis and monthly medical camp.56

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56 *Interview* with Dr. I.P. Dhalla.
In our own survey of doctors when the question was asked “have you ever taken part in Governments immunisation programme”? The response was

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<th>Question</th>
<th>Yes</th>
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<td>90.5%</td>
<td>9.5%</td>
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Thus an overwhelming majority of doctors had taken part in the Government’s immunisation programmes and are thus very interested in furthering its cause.

National Programme for Control of Tuberculosis

Tuberculosis is a communicable disease due to infection with Mycobacterium Tuberculosis. It is an ancient disease and in India it has been known since the Vedic ages that is about 5000 years ago. It is worldwide in distribution and strikes all the races and both sexes but mainly poor socio economic group. It commonly affects the lungs but can affect all part of the human body. The patients with pulmonary tuberculosis excreted TB bacilli with sputum through coughing, sneezing etc. The germs thus excreted, enter the healthy person through airborne droplet nuclei from sputum of persons with infections tuberculosis. The entry of the tuberculosis germs into the body does not always lead to disease. Only a few infected persons suffer with the disease process due to a number of factors which are both intrinsic and extraneous. The intrinsic factor is poor natural resistance or poor inborn immunity, which is genetic one. Extraneous factors are many, like poor living conditions, low socio economic status, inadequate food or nourishment of the body, psychological and temperamental status of the person and affliction by some other diseases like
diabetics, measles, cancer etc. Now tuberculosis is treatable, curable and preventable.\textsuperscript{57}

**National Tuberculosis Programme**

The National Tuberculosis Program (NTP) was introduced in India in 1962 with the aim of systematic reduction of tuberculosis in the community within the available resources and within a reasonable time.\textsuperscript{58} Its operational objectives were:

1. To detect maximum number of tuberculosis cases in the community and to treat them efficiently and in doing so, to give priority to sputum positive patients.
2. To provide case finding and treatment facilities through as many general health institutions as was operationally feasible.

The epidemiological dimensions were quantified by undertaking a country-wide sample survey. It was realised that the most cost-effective way to deal with the tuberculosis (TB) problem would be to have a widespread service network for integrated case-finding activity—coupled with the facilities for treatment of the cases found as near to their homes as possible. Simplification of technology and its appropriateness were to be the cornerstone of success. The most notable aspect of the NTP (even 35 years later, is its attempt to operate the service network through the existing general medical and public health institutions.

Though the programme has been in operation since 1962, it had not made any significant epidemiological impact on problem of T.B. The Programme was reviewed by an Expert Committee in 1992. Based on the findings and recommendations of the Review, the Government of India evolved a revised Programme based on Directly

\textsuperscript{57} Dr. P.N. Sehgal, *National Health Programme*, Occasional Publication from VHAI: New Delhi, VHAI, 1990, p.3.

Observed Treatment Short Course (DOTS) strategy with the objective of curing at least 85% of new sputum positive patients and detecting at least 70% of such patients.

Under the DOTS strategy, patients swallow the drugs under direct observation of the health worker viz. the DOT provider. The selection of the DOT provider is not restricted to medical personnel. Any responsible person of the locality/community except a family member can function as DOTS provider. The patient is required to visit the designated DOTS centre and consume the medicine in the presence of the DOT provider. In case the patient drops out/fails to attend the health facilities in the scheduled day, then it is the responsibility of the DOT provider to retrieve the patient to the system and ensure completion of the treatment regimen.

One of the unique features of this programme is the fact that patient wise treatment boxes are available with the DOT provider with the full regimen of drugs needed to complete the treatment. This facility ensures uninterrupted supply of medicines to any patient.

The RNTCP is implemented through TB societies at the State and District levels. There is a State TB Officer and District TB Officer who is responsible for the effective implementation of the programme in the States and Districts respectively. The District TB Societies are headed by the District Collectors while the State level society is headed by the State Health Secretary. This revised strategy was initially pilot tested in 1993 in a population of 2.35 million and it showed remarkable success. The RNTCP was then extended to a population of 13.85 million to address its operational feasibility.

Indian Medical Association and Tuberculosis Control in India
Indian Medical Association has been taking active interest in tuberculosis control in the country. The editorial of Journal of Indian Medical Association in its special issue on Tuberculosis said, "Although TB patients formed nearly 1% of the total consultations of private practitioners but, in total they are treating more than 50% of
the TB patients in our country. National Tuberculosis Control Programme cannot be successful without involving the private practitioners. Government policy to involve private practitioners needs to be on a partnership basis.\textsuperscript{59}

The position of IMA has been that diagnosis, treatment and management of TB with majority of private providers both individuals and institutions are not based on the guidelines and recommendation approved by the Government in this country. It is not because of the ignorance on the part of private providers but more so because of lack of coordination between the public and private providers. Qualified private practitioners very well know that sputum positive patient spreads disease in the community and x-ray diagnosis for tuberculosis without sputum examination for AFB can often be wrong. Improper drug combination, improper doses, irregularity in drug intake by the patient, etc. can lead to treatment failure and emergence of drug resistant cases. Lack of participation and coordination between government and private practitioners and no clearly defined role and responsibilities of private practitioners in the existing programme are the areas required to be tackled on a war footing.

Revised National Tuberculosis Control Programme (RNTCP) by Government of India is being implemented in a phased manner throughout the country with the financial support from World Bank and WHO. RNTCP has clear cut plans to make judicious use of both sectors i.e. public and private practitioners in the programme so as to achieve the desired goal of 85% cure rate and more than 70% case finding among smear positive cases in a community.

Indian Medical Association feels\textsuperscript{60} as a frontline organisation it can contribute a lot in achieving accomplished task of TB Control in our country. It has a crucial role to play, educate, convince, participate and make all practitioners feel responsible to fight the problem of tuberculosis. To make programme IMA has to educate all general practitioners.


\textsuperscript{60} Ibid., p.703.
practitioners about tuberculosis disease, its diagnosis, treatment and control measures. Special educational programmes such as Continuing Medical Education (CME) and seminars, workshop, lectures, conferences, etc., on tuberculosis should be conducted. Printed material and other literature concerning tuberculosis update and government programme policies need to be circulated among all involved in providing health care. These activities should not restrict to cities and big town but should reach every nook and corner of the country.

IMA has said it is committed to support government endeavour and its policy to control and eradicate tuberculosis in India and is happy to go with Ministry of Health Government of India, in achieving this objective. Dr. P.V. George in his Presidential address said, “we are trying to control the debilitating disease of tuberculosis, but India still remains with the maximum number of patients in the world. With proper detection and treatment, and surveillance, I am sure, we can eradicate tuberculosis from our country. IMA is actively cooperating with the revised RNTCP of Government of India and I am glad to note that doctors in private sector are given due importance in this programme. I request the government to extend it throughout India and IMA will provide all the help in implementing this programme.”

**Shift in Health Policy**

It is argued that with the introduction of RNTCP, there has been a major shift in the direction the NTP was representing. This is so not only for TB control, but for health care as such in the overall context. The NTP was designed to be developing on the lines of integration of health services. Improvements in its functioning should have logically been made to guide it along that course in a rational manner as per suggestions made by the ICORCI. A strong group of health scientists, spearheaded by the doyen among social scientists in India, see in the RNTCP the very negation of the principle of health care for all and a turnaround from the conceptual progress

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61 Dr. P.V. George, *Presidential Address*, op.cit.

made in that direction. Other intellectuals resent the centralised impositions made in a bureaucratic manner on the instruments of local self-governance, e.g., panchayati raj, especially when these are at the behest of international agencies. Voluntary health groups like the Voluntary Health Association of India (VHAI) and the Tuberculosis Association of India (TAI) are averse, and harbour major reservations on the directional change RNTCP represents, especially in the context of this country. Considering the continued intransigence, nay failure, of the Indian Government to bring about necessary corrections/revisions in the NTP in time and in accordance with the monitoring/evaluation reports, one would find it hard to accept the summary changes made in its principles and functioning in the garb of RNTCP. It appears that the revolutionary sociological concepts and the principles of management of the programme on the basis of continued or, as embodied in the NTP framework, have been rejected by the government and the RNTCP is being introduced at the behest of foreign agencies.

FRCH conducted a ten year experiment in 30 villages of north Alibag district known popularly as the Mandwa Project. Since neither the public nor the private health sector could provide the services needed by the villagers, one woman for each village was trained to undertake as many health functions as possible. About 80% of all health needs could be met by them even for diseases like malaria, leprosy, gastroenteritis including tuberculosis.

Surprisingly they could detect tuberculosis in the early stages most effectively by observing the conditional symptoms. Following confirmation of diagnosis by the FRCH doctor they not only ensured regular treatment including the giving of streptomycin injections but also convinced the patients to take precautions for spread

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64 N.H. Antia, ‘World Bank and India’s Health’, Economic and Political Weekly, 28 (52), 1993, pp. 2883-2887.
of the disease to others like disposal of sputum and sleeping away from the other family members. They also detected new cases in the family in the earlier stages.

While the vast infrastructure of the public health care system fails to ensure early detection and regularity of treatment and the private practitioners over charge the poor who eventually default, there exits in every village the potential for the early detections and regular treatment and prevention of dissemination of tuberculosis as of many other major diseases at very low cost.

For this the medical profession needs to develop respect for the intelligence and ability of village folk, to give them information in a simple manner and language which they can understand and encourage and support them to undertake those functions which are within their capacity and yet beyond the reach of the health professionals, not to mystify and create fear about health and illness.

Since it is virtually impossible for a patient to have regular access to the available health services and self help is feasible in health it is time to move from the top down delivery of health to a people’s own programme in which the medical profession participated in the manner required by the people. Why cannot the village health workers be trained to give streptomycin in injection for tuberculosis and for immunisation as done in Mandwa.

**Pulse Polio Immunisation Programme**

In May 1988, World Health Assembly passed a resolution to eradicate polio by the year 2000. The Government of India decided to adopt the strategy of National Immunisation Days (NIDs) to administer pulse polio drops, to achieve the goal of total polio eradication by the year 2000. The nationwide programme started in 1995-96 and is called the Pulse Polio Immunisation Programme (PPI). The Universal Immunisation Programme has been able to achieve over 90% coverage of Oral Polio Vaccine (OPV) among infants for five successive years.
India has successfully completed three rounds of NIDs in its pursuit towards the eradication of poliomyelitis. These have been unprecedented public health developments. Accomplishments of the programme can be attributed to the unique management skills used in the PPI campaign and sustained political commitment at the highest level to the challenge of polio eradication.

The three pillars of primary health care are decentralisation of health services, community participation, and inter-sectoral coordination. Lack of community involvement and coordination among implementation agencies have been commonly cited as the factors for less than optimal achievement of objectives of the primary health care.

PPI has involved mass social mobilisation and has been an elaborate management exercise of coordination at all levels to ensure vaccine supply and administration to the beneficiaries on the NIDs. Encouraged by the success of PPI, a similar implementation strategy is being considered for the recently conceived Reproductive and Child Health (RCH) programme.

Although the Alma-Ata documents strongly emphasised that a limited number of priorities should be lightly sequenced to serve as an entry point for other activities, there has been considerable uncare about whether targeted public health activities like PPI interfere with general development of primary health care. Mass social mobilisation and better intersectoral coordination achieved during such activities are likely to have a positive influence on the delivery of the other public health services, as well as improvement of the credibility of the health department among the beneficiaries. On the other hand, to ensure the success of a highly visible public health activity, resources and personnel are likely to be relocated away from other programmes for the achievement of the PPI objectives. “Community fatigue” is another potential factor that might surface with repeated cycle of PPI.
Impact of Pulse Polio Immunisation on Other Health Programmes

There was a uniform opinion among the providers that the image and credibility of health system had been enhanced since the onset of PPI. People are now more familiar with activities of the health department. Relation between the health workers and community had improved due to increased frequency of their interaction. A majority of community stakeholders confirmed these perceptions.

In the opinion of most of the providers at all levels, existing health services and the indicator health programmes chosen for the evaluation project (i.e. universal immunisation programme, and antenatal care services) were either not influenced or had shown some improvement. That mothers and pregnant women were potential users of these services also echoed some feelings.

There was a temporary relocation of resources (personnel and material) from all participating departments for carrying out NID activities. Vehicles were requisitioned from a large number of departments and private sources for up to four weeks in connection with the two NIDs.

Most of the health workers said that their routine and specific activities were adversely affected due to their participation in the PPI but the magnitude of this impact was not defined.

Indian Medical Association has been taking active interest in Pulse Polio Immunisation Programme. The editorial of Journal of Indian Medical Association wrote, "to make a polio free world the WHO has come forward and its experts are engaging themselves very actively. The task is gigantic and the challenge is crushing. But the work has been taken up in right earnest. The Government and the people have joined hands to make a dream come true – "Polio-free earth"! In their efforts IMA has joined hands and has proved themselves of rendering very valuable services for the people all over the country. We have taken it up with a firm and determined promise and have arranged various seminars, camps and vaccine giving centres. We have tried
to take the message to distant corners of the country, through our members and certainly we feel that the IMA has rightly played its role for the national cause. Without the wholehearted participation of the IMA and its members it would not have been possible to vaccinate 88 million under five-year children in one day. Perhaps lot remains to be done and the IMA promises to help the Government and the people in such noble efforts. Speaking on the same issue Dr. V.K. Kohli said, “The Indian Medical Association initiated the programme of pulse polio few years back in Delhi which was adopted by the National Government to be taken up all over the country. Unfortunately, there has been less participation observed by the private practitioners in the programme and also it has been observed that many of the patients are not going to pulse polio booths and thus affecting the goal of hundred percent immunisation. As part of the participation in the campaign it is proposed that every practising doctor in the country should participate by making his clinic/centre as a pulse polio immunisation centre on the days of nationwide pulse polio immunisation. Thus IMA has been encouraging its member doctors to participate in such government programmes and wants these programmes to be successful. It has even shown worry at times when the participation of doctor’s was not upto the expectation.

The Community Health Workers Scheme

The Community Health Workers Scheme is the most important scheme as far as rural health and people’s participation are concerned. It was announced by Raj Narain—the controversial health minister in the newly elected Janata Government—on 20 April 1977 soon after he took charge. Narain announced the Community Health Workers Scheme whereby one male or female worker per village or per 1000 people would be trained to administer medicines for minor ailments as well as carry out promotional and preventive health care within the village. Said to be India’s version of the “barefoot doctor” in China, some hailed this radial scheme while others questioned the feasibility of training such a large number of people in so short a time.

In its 1977 annual conference the Indian Medical Association (IMA), openly registered its oppositions to the scheme. A spate of editorials and articles in newspapers and magazines appeared which suggested that the Government was ‘abandoning the health of the rural poor to quacks’. Deliberations at the IMA conference suggested that medical doctors were the only persons competent to take care of the health of the people; if doctors were unwilling to serve in rural areas under existing conditions, larger financial incentives should be provided.

The medical fraternity was not alone in expressing negative views. Even those agencies chosen to implement this experiment were somewhat sceptical. In the words of one District Health Officer: “The scheme (for community health workers) is a premature baby. Its survival requires a lot of special care, but who can give that kind of care? We in the health department barely have enough time to supervise our own staff.... the idea is good, no doubt, but a seed is only as good as the soil into which it is put. Someone should be there for the weeding.”

Such pessimism on the part of the authorities who were to implement the Scheme may have been warranted due to the haste with which the Scheme was announced and due to the “crash programme” through which it was implemented.

But the fact remains that Karan Singh, the Health Minister in the Congress Ministry before the Janata Government came to power in 1977, had shown interest in the successful experiments by a number of voluntary organisations in the effective training and utilisation of village health workers. Thus, Raj Narain only accelerated something already being planned by the Health Ministry for possible implementation. Of course, had it not been for the sudden announcement and associated political prodding, it may have taken much longer for the bureaucracy to come up with something to implement.

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As often occurs with hurried efforts, the Community Health Worker Scheme did not really succeed as planned. The Janata Government itself was in power only for thirty months. A number of evaluation studies noted that the scheme, though well intentioned and with great potential, had serious problems. Women comprised less than ten percent of the community health volunteers selected and trained which made it difficult to reach the main target groups in rural health care–women and children. Less attention was being paid to prevention, promotion, maternal and child health, nutrition and health education, with greater attention going to family planning. Thus, the main impact of community health volunteers was in the area of family planning persuasion.

When Indira Gandhi returned to power in 1980, this ‘trademark’ programme of the Janata Party could have been terminated. Instead, it was renamed and integrated into the 1982 National Health Policy. The Annual Report of the Ministry of Health and Family Welfare, 1981-82, quietly noted: “During 1981, as a result of evaluation and concurrent reviews, the Community Health Volunteer Scheme has been completely restructured and revised and (is) now known as the ‘Health Guides Scheme’. In the revised scheme, greater emphasis has been laid on the involvement of the community. Provision has been made for the establishment of a Village Health Committee for each village. It is envisaged that this Committee would take an active part in implementation of Health and Family Welfare and MCH programmes. Emphasis has been laid on selecting women as Health guides”.

Most States have preferred the Scheme of having one male and one female health worker per village. Uttar Pradesh alone appointed only women as health workers. By 1989, almost all the primary health centres of the country were covered under this

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scheme and 410,000 health guides had been trained. The introduction of these volunteers in villages may well have contributed to the decline in infant mortality rates in India from 127 per 1000 live births in 1978 to 80 in 1993. Furthermore, the emphasis of the Government on appointing more women as health guides is an encouraging thing as it is now widely accepted that greater involvement by women is associated with significant improvements in the health status of a village community.

National Rural Health Mission
The Government of India has launched a National Rural Health Mission on 12th April 2005. The Mission covers the entire country with special focus on 18 States where the challenge of strengthening weak public health system and improving key health indicators is the highest. These States include Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan, Orissa, Uttarakhand, Jharkhand, Chhattisgarh, Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, Jammu & Kashmir and Himachal Pradesh. The Mission aims at provision of integrated comprehensive and effective primary health care to the poor and vulnerable and marginalised sections of the society, especially women and children by improving access, availability, quality and accountability of public health services. The duration of the Mission is 7 years i.e. from 2005 to 2012.

The key strategies of the Rural Health Mission include, ensuring intra and inter sectoral convergence, strengthening public health infrastructure, increasing community ownership, creating a village level cadre of health workers, fostering public-private partnerships, emphasising quality services and enhanced programme management inputs. The Mission has also suggested certain convergence measures. For instance, inter-sectoral convergence is proposed to be achieved by establishing yet another organisation, this time probably a quasi-government society at the State and district level. The public health infrastructure will be strengthened by several

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measures; a few of them would probably script the demise of the public sector. These include the engagement of private doctors and health communities with the power to charge user fees, etc. Community participation will be enhanced by giving functional responsibilities and powers to the Panchayat Raj Institutions, apart from creating a cadre of voluntary accredited social health activities, and drug and contraceptive depot at the village. The public-private partnership aspect is most controversial. The actions proposed are largely for family planning services and include social marketing and social franchising of services, such as institutional maternity care, immunisation services and provision of bank loans for setting up family welfare clinics. It also suggests the addition of other curative services and the gradual evolution of reproductive and child health to a community insurance programme. The mission will also use management experts, CA’s, MBA’s and GIS specialists for its management units.

The Mission expects that, through this strategy, the communicable disease burden and disability adjusted life years can be reduced and that the level of universal immunisation can be increased from 50 to 90 percent. The proposed private participation in institutional deliveries is expected to improve the infant mortality rate and maternal mortality ratio. This is indeed wishful thinking!

The Bhere committee had recommended that a health committee consisting of five to seven individuals should be established in all villages. However, this was largely ignored. The need for universality, equity and comprehensiveness of health care was also underlined by the committee. Henry Signet’s quote in the Bhere Committee Report reflects the vision which prevailed at that time: “health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health accessible to all, free of charge; medicine like education is then no longer a trade, it becomes a public function of the state.”

A few studies on the health services system in the country, and especially on primary care institutions, reveal the overwhelming preference of people for government healthcare. Some of these studies show that accessibility and availability of healthcare are mediated by structural issues such as institutional inadequacies and inefficiencies in the system and influenced by various social, political and economic factors. The Planning Commission’s study on Community Health Centres (CHC) is another which finds incompleteness in the availability of services as the main reason for the underutilisation.

The Government has also given in to the pressure of international donor agencies to adopt what can be called as the ‘one by one approach’ or the categorical approach that takes up disease eradication programmes concentrating on one disease at a time. The Mudaliar Committee had noted that the method of dealing with diseases individually, through mass campaigns is not conducive to the organisation of unified efforts needed for the promotion of total healthcare. These costly drives are undertaken by mobilising the entire health service system leading to a neglect of all other programmes, including other immunisations. Implicitly it means that India is not capable of eradicating diseases through an integrated and complete package of primary health services. The community is also made to believe that this is the programme that is going to save the lives of their children.

Cost-effective interventions such as the rational distribution of financial and medical resources, including drugs, effective manpower distribution and primary healthcare approaches, should be part of the vision. These are often brushed aside for ushering in the privatisation logic.

Strengthening the sub-centre and equipping the Government’s own health workers (instead of adding posts) would be epidemiologically and economically more effective. States should be allowed to define their own priorities and planned programmes. At present the public health scenario is extremely nebulous and the
differential pattern across States is so glaring that it does not allow the imposition of pan Indian solutions.

Apart from this, there is also a need to equip and enable elected representatives at the village and block level for handling health issues. Presently, health programmes are beyond the reach of people who are supposed to govern under the decentralised form of government as these are often considered technical subjects. There is a need to remove the confusion among representatives and officials at the panchayat level about the roles and responsibilities around health services.

**Rural Medical Relief and Indian Medical Association**

Indian Medical Association organised a workshop seminar on rural medical relief on 26-27 September, 1970. IMA has continuously maintained the same position on rural medical relief as it had done in that seminar. Dr. D.S. Mehra had said “The Indian Medical Association has always been concerned about the state of health services in our rural areas. It shares with the authorities their concern about the nonavailability of medical and para-medical staffs for our primary health centres. The Association has made its own assessment of various factors that act as deterrents to recruiting doctors and para-medical staff for service in villages. We have also given suggestions. Study has also been made of other problems of health, sanitation, water supply, communication, health education, etc.

It is the wish of the Indian Medical Association that rural population should revive medical aid that should in no way be inferior to what is available to the urban population, although it may be argued that what is available for the urban population is also not the best.”

Dr. G.V. Joshi in the same workshop said “The Indian Medical Association has developed a scheme for rendering medical relief in rural areas and we thought it wise

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to get the help and co-operation of the Government and other agencies connected
with the same to sit and discuss.

The Indian Medical Association does not concern itself with the affairs of the medical
profession only but also is interested in the health problems of people at large. It has
never failed to give its own views on the five year plans where they dealt with health
matters. It has formulated a comprehensive scheme on "School Health," its branches
celebrate "Health Weeks" to convey to the lay masses the messages of healthy living
and is actively involved in the National Family Planning Programme. In the matter of
healthcare for our teeming millions that live in the villages, the Indian Medical
Association thinks enough is not being achieved although much was planned to be
done as we learn from the previous Five Year Plans.73

The Indian Medical Association’s views can broadly be enlisted as:
1. The Government should run the centres by enlisting the services of local
doctors on part time basis and on appropriate remuneration.

2. The IMA can play an important role in the setting up of preventive centres
from which prophylactic measures in respect of small pox, malaria, tuberculosis and
other communicable and water borne diseases can be carried out. The respective
vaccines may be made freely available to private practitioners through the Branches
of the Association for participation in preventive measures.

3. In the matter of health education also and particularly motivation for family
planning, the IMA has offered its cooperation.

4. The IMA had formulated a comprehensive School Health Scheme which was
applicable to rural conditions. Here again Branches of the Association extended their
hand of cooperation.

73 Dr. G.V. Joshi, Welcome Address, President IMA at Ibid.
5. The Branches of the Association have further been advised to conduct surveys of rural areas in their respective jurisdiction with regard to health conditions and facilities available for healthcare and to what extent members of the Association can participate in official, semi-official and IMA's own programmes.

6. The IMA suggested formation of Joint Council of the IMA and government bodies for the formulations and implementation of various schemes in connection with rural health matters.

On the question of why doctors are reluctant to go to the villages, IMA has felt that the problem is both one of persuading doctors to serve in villages and of administrative re-distribution of medical manpower. The first part of the problem cannot be solved by financial means alone; even if impressive financial inducements are offered to doctors to attract them to villages that are other barriers that discourage them.

Over the years, Indian Medical Association has suggested the following measures for sending doctors to rural areas:

i) Eventual merger of rural and urban health services.

ii) The IMA has made recommendations about the salary scales and allowances etc for various categories of doctors.

iii) Doctors in rural areas complain of a sense of professional and social isolation. This problem can be overcome by posting groups of doctors rather than single physicians in such areas. Establishment of such groups would also make possible a rotation system, providing each physician with off days and vacation. Such a system would also make possible a general scheme for the continued specialised training for rural doctors in regional hospitals.
If with doctors incumbents such as engineers and administrative officers also live in the village, social isolation would not be a problem.

iv) Employment of senior doctors or re-employment of retired doctors for service in rural areas rather than annum for recurring expenditure and when the recruiting fresh medical graduate for service in rural areas.

v) Transportation facilities for personal needs at minimum costs.

vi) Free furnished housing with protected water supply, reasonable sanitary facilities, with water, seal latrine, wash basin etc. all within the house; electrified if there is electricity in the village; free electricity or lighting allowance.

vii) Priority over others in urban areas for allotment of cars, scooters, cycles, etc.

viii) Education allowance for children and hostel allowance;

ix) Supply of medical and public health journals and publications free to primary health centres;

x) Facilities of regular in-service training and short refresher courses in the knowledge of medicine at district level for a period of one month for every two complete years of rural service.

xi) Rural areas be graded and for areas of maximum isolation such as remote and difficult hill areas there should be additional augmentation of incentives.

xii) A conference of rural health workers should be organised preferably annually.
xiii) Another way of attracting doctors to rural areas is to offer young graduated loans repayable on easy terms, for starting practices and settling down in villages. The sum lent will initially be required for acquiring a house, a clinic and essential equipment.

Thus most of the prescriptions of Indian Medical Association for better rural relief are related with better working conditions for allopathic doctors. There has never been any mention of rural medical practitioners or community health workers.

In our survey of IMA member doctors when the question was asked “should it be compulsory for every doctor to serve in rural areas for particular number of years”? Then the response was

Should it be compulsory for every doctor to serve in rural areas for particular number of years

A = 53.3%, Yes
B = 43.8%, No
C = 2.9% Did not answer the question

Thus doctors are very well aware of the fact that their need is greatest in rural areas and also feel that doctors should be going to rural areas but due to bad working conditions are reluctant to go.
But when the question was asked “do you think it is correct for IMA to oppose village health worker’s scheme”? The response was

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<tr>
<th>Option</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>A (Yes)</td>
<td>40</td>
</tr>
<tr>
<td>B (No)</td>
<td>36</td>
</tr>
<tr>
<td>C (Don’t Know)</td>
<td>26</td>
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<tr>
<td>D (Did not answer the question)</td>
<td>3</td>
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Thus most of the doctors either opposed Village Health Worker’s Scheme, or were not ready to answer but here also surprisingly 38.1% doctors had maintained that it was wrong for IMA to oppose village health workers scheme.

**The Aao Gaon Chalen Project of Indian Medical Association**

Indian Medical Association says it has taken “Aao Gaon Chalen” project to shoulder the responsibility of providing positive health to every village in the country. The project will enable medical professionals to develop a vision and undertake innovations to improve rural health as envisaged in the National Health Policy.

The Project aims to target the 75% of the population which lives in the villages and also the popular myth in the public mind that doctors do not want to serve in rural areas. “Under this Project each State unit of IMA will adopt 5 villages to begin with and undertake promotive health free of cost. The idea is to slowly make the existing
healthcare available in every nook and corner of India,” said Dr. Ketan Desai, Chairman of the project.\textsuperscript{74}

The major emphasis will be on the control of epidemics and endemics, maternal and child health, geriatric care and adolescent health. “The IMA with its reach and dedication can make a big difference to the rural health scenario and this step from the medical fraternity will amount to a giant leap for the whole country,” Dr. Desai added.\textsuperscript{75}

“Emphasis will be laid on increasing orientation of health professionals towards the needs of rural population and provide primary care to them on a regular basis at their doorsteps,” said Dr. Vinay Aggarwal, Secretary General, IMA.\textsuperscript{76}

What the Project will achieve
The project wishes to achieve
- Orientation of professionals to village health;
- Health awareness generation;
- Provision and strengthening of promotive, preventive, curative and rehabilitative services;
- Community involvement and participation in health care;
- Public/private partnership in rural health care;
- Coordination to strengthen referral linkages in the health care delivery system;
- An improved image of IMA and the medical profession.\textsuperscript{77}

Proposed Activities in the Project
- Community health meetings;

\textsuperscript{74} The Hindu, 23 November 2004.

\textsuperscript{75} Ibid.

\textsuperscript{76} Ibid.

\textsuperscript{77} Recommendations of Health Facilitators Training Workshop on Aao Gaon Chalen held on 30-31\textsuperscript{st} October 2004 at New Delhi.
- Debates, posters and painting competitions in the schools;
- Puppet shows and magic shows;
- Nukkad Natak;
- Health camps providing multi disciplinary care;
- Special clinics for expectant mothers, children and elderly people;
- Cataract/sterilization camps;
- Immunization services;
- Adolescent guidance and counseling services;
- Family welfare services;
- Cancer detection clinics;
- Distribution of wheel chairs, artificial limbs and other required services to handicapped people, amongst a host of other welfare activities.  

The project is very ambitious but how successful it will be depends on two very important factors one the interest of IMA member doctors and whether they are ready to participate in it for a long period of time, secondly there should be enough funds to run it.

In our survey of IMA member doctors when the question was asked “are you ready to be part of IMA’s Aao Gaon Chalen programme”? Then the response was

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<th>A</th>
<th>B</th>
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<tr>
<td>A</td>
<td>75.2% Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>23.8% No</td>
<td></td>
<td></td>
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<tr>
<td>C</td>
<td>1% Did not answer the question</td>
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Ibid.
Thus an overwhelming majority of doctors want to be part of the project but how much is the gap between intention and action only future can tell.