ROLE OF TECHNOCRATS AND PROFESSIONAL ORGANISATIONS IN HEALTH POLICY FRAMING IN INDIA

Dissertation submitted to the **Jawaharlal Nehru University** in partial fulfilment of the requirements for the award of the degree of

Master of Philosophy

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Dedicated to my

Parents

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CERTIFICATE

Certified that the dissertation entitled **ROLE OF TECHNOCRATS AND PROFESSIONAL ORGANISATIONS IN HEALTH POLICY FRAMING IN INDIA**, submitted by **VEDANSHU TRIPATHI** is in partial fulfilment of the requirements for the award of the degree of **MASTER OF PHILOSOPHY**. This dissertation has not been previously submitted for any other degree of this or any other University and is his own work.

We recommend that this dissertation may be placed before the examiners for evaluation.

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PREFACE

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

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

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

Looking at the importance enjoyed by doctors I have here looked at the role of technocrats and professional organisations in health policy framing in India.

The proposed study is divided into four main chapters. The first chapter is about the role of technocrats and professional organisations in policy framing. It discusses how public policy is framed, how do interest groups try to influence it, what is the role of committees, what is the difference between

technocracy and bureaucracy and how technocrats influence policy making and the role of technocrats in third world.

The second chapter discusses policy process in India. It deals with constitutional framework for policy making, the role of bureaucracy, Prime Minister office etc. in policy making, the role of Planning Commission, then non governmental institutions like political parties and pressure groups and it gives a critique of policy process in India.

The third chapter is about the context of health policy making after independence, it looks at position of ministry of health, planning machinery at various levels, role of Director General of Health Services and Central Council of Health. It goes on to see the role of professionals in policy making, their importance in various health committees, and the role of researcher as technocrats and the importance of research in policy making.

The fourth chapter is about the role of professional associations in policy making, it discusses the role of Indian Medical Association, Medical Council of India, ICMR and other associations and in the end discusses the role of NGO's in policy making.

The fifth chapter gives the conclusion of the dissertation.

The method followed in the study has been an empirical and analytical one. It is based on the reports of various committees, reports of working groups of Planning Commission on health. The study has looked at the recommendations of various professional organisations. For this various write-ups and articles in various newspapers, magazines and journals were also used as secondary material.

I am grateful to my supervisor Prof. Kuldeep Mathur who offered all kinds of help to me. He helped me to present my half-baked ideas in a concrete form

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CHAPTER 1

ROLE OF TECHNOCRATS AND PROFESSIONAL ORGANISATIONS IN POLICY FRAMING

In colloquial English, we might say that policy is "what politics is about". Etymologically, the same Greek root, polis, appears in three English words: policy, politics and police. Contemporary political scientists differ in the meaning they give to the word. The term policy can be used to refer to the intentions of politicians, or to the impact of government. (Rose, 1976).

Policy is defined as a course of action adopted and pursued by a government which conditions, influences or directs how any further series of decisions are to be made in matters concerned in the course of action decided upon. Policy prescribes the aims, the objectives, the targets that are to be achieved and methods that would be used to achieve the objectives. Operationally, the policy statement in this sense must specify the expected results from the measures for achieving them, and the mechanism or methods with which the results are expected to be achieved (Ali, 1992). Marshall Dimock defines policy as "the consciously acknowledged rules of conduct that guide administrative decisions" (quoted in Anderson, 1975).

Policy Making Theory: Several attempts have been made to classify how decisions are made in the political system. The most widely used general explanations are "society centred" or "state centred" (Grindle and Thomas, 1991). Within the first category fall the class approach (decision making is dominated by particular social classes and outcomes always favour those classes); pluralist approaches (no one elite dominates decisions, different groups compete, and policy outcomes are in the public interest); and public choice approaches (the state is not a neutral arbiter among competing groups, but a self interested actor itself, making alliances with other major interests, resulting in policies which are not necessarily in the public interest).

The state centred models concentrate more on the decision making process itself; the rational actor model derives from the position that policy makers make policy choices; the bureaucratic politics approach emphasises policy makers positions in organisations, and how this influences their choices of policy; and finally the state interests approach suggests that state policy makers are active decision makers who generate responses to problems and determine policy outcomes.

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

In another layer of analysis there are members of groups, of institutions, of political parties, of professions. Most of the analysis is focussed at this level, and looks at the actual processes of policy and the actors involved at each stage. We ask question about how problems are recognised, and turned into issues that get on to the policy agenda. How are policies formulated, implemented and evaluated? We ask how far the policy process is a rational search for the best possible solution to a particular problem, or whether, in fact policy is made up of small, incremental changes that are hardly even innovatory or revolutionary. And since processes do not have a life of their own, but are dependent on actors to give them expression, analysis of the policy process is interwoven with an exploration of which actors are involved, and how far each may be exerting influence on policy.

The political system provides the framework for people's participation in policy: it illustrates the mechanisms through which people are encouraged (or discouraged) to participate.

The Process of Policy Making: Policy is used to denote a series of more or less related activities and their intended and unintended consequences for those concerned, policy is usually directed towards the accomplishment of some purpose or goal and is defined as:

> "A purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern" (Anderson, 1975)

The six main normative models of policy making are the following:

1. The pure rationality model;
2. The economically rational model;
3. The sequential decision model;
4. The incremental change model;
5. The satisfying model; and
6. The extra rational process model (Y. Dror, 1968)

Several approaches have emerged about policy making (Anderson, 1975). One approach may be termed as the Political Systems Approach. In this approach public policy is viewed, as the response of a political system to demands arising from its environment. Political system as defined by scholars like David Easton is composed of those identifiable and interrelated institutions and activities in a society that make authoritative decisions which are binding on the society. The usefulness of the Systems Theory for public policy study is limited by its highly general nature. It does not, moreover, say much concerning how decisions are made and how policy is developed within the political system.

Another approach is based on the Group Theory. This theory rests on the contention that interaction and struggle among groups is the central fact of political life. Public policy at any given time will reflect the interest of the dominant groups. Yet another approach is the Elite Theory. According to this theory, public policy can be regarded as the values and preferences of a governing elite.

And finally there is the Functional Process Theory. Its basic approach is to focus on the various functional activities that occur in the policy process. According to its high priest Harold Lasswell (1956), there are seven categories of functional analysis viz.:

1. **Intelligence**: How information on policy matters is gathered and processed.

2. **Recommendation**: How the recommendations for dealing with a given issue are made and promoted.

3. **Prescription**: How the general rules are adopted or enacted and by whom.

4. **Invocation**: Who determines whether given behaviour contravenes rules or laws.

5. **Application**: How are laws and rules actually applied or enforced.

6. **Appraisal**: How the operation of policies is assessed or appraised.

7. **Termination**: How the original rules or laws are terminated.

The basic stages of policy making are broadly identified into the following:

1. The identification of the policy needs/problems.
2. Setting of policy objectives.
3. Identification of the alternative choices of policy.
4. Evaluation of the policy alternatives.
5. Choice of preferred alternatives.
6. Implementation of policy.
7. Monitoring and feed back of policy.
8. Review of policy.

While a considerable amount of theoretical writing has been devoted to the theory of choice, and perhaps rightly so, the problems of (a) values and (b) intelligence cannot be minimised. In all societies, especially ones like India, the issues of political values, that is the preferences of the society for a certain direction of development, are of paramount importance. It is these values, either latent or manifest, which determine the core of the policy directions in which the society wishes to move.

The identification or a study of the values is perhaps the most difficult but the most crucial component of the theory of policymaking, a component which is inadequately studied or researched into. Of no less significance is the intelligence in policy making. Basically intelligence refers to the information base of policy-making information which is necessary to develop the available policy options.

Several policy theorists have held that the intelligence function is the crux of choice formulation and that the information base will determine to a great extent the success or failure of public policy. It is for this reason that in recent years the greatest amount of attention has been focussed in many countries on informatics-information based essentially on computerised data processing (Panandiker, 1989).

Despite great advance in the theories of public policy making the experience of most of the countries on policy making has not been particularly neat. Even in the more advanced countries, it is quite apparent that the public policy process is a far more haphazard process in many critical areas. More often than not it is the whims and fancies, and even prejudices of political bosses, which determine the policy directions of these countries. Even so there are large areas of public policy, which have in recent years been subjected to rigorous analysis and formulation.

Broadly speaking, there seems to be in many societies two groups of public policy areas. One in which the rational theory is allowed a fair degree of policy especially in those fields where the dominant interest is not partisan. And

other area of power politics where the basic policy thrusts comes more from the political considerations rather than from rational policy choices.

Participation in Policy Making: A commonly held view of democracy is that there are many ways in which people can participate in the policy process and so influence governments to promote the policies they want. This view is not universal, however and some argue the opposite: that power is in the hands of a few, and most policy is decided by a small group of elites within government or even outside government.

The Pluralist View: The classical pluralist view is that power is diffused throughout society: that no one group holds total power over others (Smith, 1977). The expectation from a pluralist policy process is that policy outputs are wise and in the collective public interest because they have achieved majority support, and because the government is the unbiased arbiter between many competing interests. However, many question the view that the state (or government) is a neutral negotiator between different interests. For example public choice theorists argue that far from seeing the political system as one in which government holds the balance between different groups who jostle and bargain for their own interests, the government in fact has substantial power which is strongly linked to the interests of other powerful institutions such as the military, sources of capital, boards of banks, large or transnational corporations outside the state. These institutions form powerful coalitions of interests, and only promote policies that serve their own interests.

The Elitist View: Marxism provides the theoretical base for many elite theories, which suggest that policy choice and change is dominated by particular social classes, and that the primary function of the state is to ensure the continuing dominance of these classes.

Such theories are supported by some empirical evidence, which suggests that the links between certain classes in society and top policy-making positions are very close. Wright Mills (1956) theory could be regarded as a

form of corporatism which maintained that elected representatives have been losing power to institutional interests (by business, the military and, in some cases, the trade unions) and a small inner core of government policy makers (Hague Harrop and Breslin, 1992).

In many Third World countries, bureaucrats, businessmen, professionals, military and government make up tight policy circles that form, to all interests and purposes a ruling or dominant class. In some countries they may be so few in number that they can be recognised as elites by their family names. Elitists thus conclude that pluralist views of power and influence in the policy process are wrong.

However, in analysing the way policy develops, many believe that the elitist view of the political system overstates the capacity of elites to wield power. Non-elites do challenge elites - and government policies are so wide-ranging and cover so many areas that it is easy to observe there are multiple groups competing for attention on specific issues. Even in developing countries, where interest groups are not always sufficiently well organised to put effective pressure on government officials, certain groups will have access to government through, for instance, professional bodies. Hall et al (1975) suggests a compromise theory of power. Their notion of bounded pluralism suggests that issues of high politics largely economic questions - are decided within an elitist framework, but that most domestic, routine policies on health, education, transport and housing are likely to be developed along pluralist lines, with some participation of different groups at different stages of the policy process. It may be that with non-controversial issues there is room for manoeuvre in the policy process, and government may be open to influence from different sources as long as government policy makers perceive them as legitimate. Of course, it can be argued that even domestic policies are affected by economic policies, and that therefore ultimately all policy is in the hands of a ruling elite. However, this is such a strong negation of the ability of people to change policy that some support the notion of a bounded policy space in most liberal democracies and some other political systems in which there is room to manoeuvre, to challenge and change government policy.

Lindblom (1979) on this question says that policy issues are divided into two categories: those on ordinary questions of policy and those that constitute the grand issues pertaining to the fundamental structure of politico economic life. On the first set of issues he sees many groups actively participating. On the grand issues he suggests that participation is weak or even absent:

> "The treatment in politics of the grand issues is governed by a high degree of homogeneity of opinion - heavily indoctrinated I would add" (Lindblom, 1979).

The context of developing countries: An analysis of a policy is necessarily done against the backdrop of optional policymaking which assumes special and added significance in the context of developing countries where the widening scope of government responsibility has brought into existence many trends of a very complex nature, acting and interacting with each other and with the state giving rise to problems of a very peculiar character. Taking up of enormous responsibility by the state for bringing about positive changes in all spheres of life, has expanded the interaction between government and the people which has resulted in the emergence of contradictory perceptions: "government is perceived to be present everywhere, and yet it is perceived as increasingly ineffective (Saigal, 1982). In other words images are formed of a steady decline in performance capabilities leading to a situation where needs and demands are confused with one another and pressures for performance get generated on a structure straining to maintain itself. The result is that politico administrative system tends to lose their credibility, while the legitimacy of institutions and persons comes under critical review, saturating the situation with tension and suffusing expectations of the future with uncertainty. Problems of this nature compel state to accept guided national change in the form of planning which inevitably transforms the earlier understanding of the term "policy" by demanding of it not only a statement of intents and purposes, but something greater i.e. internal consistency, rationality and a wholistic or systematic approach. Now taking into consideration the rate and nature of change, it has become imperative to move from a conception of policy which focuses on corrective or stop gap

measures to a conception which anticipates emerging confirmations, and provides for active intervention in the social process. However, such a thing assumes special significance, as policy making in India has to take place in the context of a complex and variegated society. "Rising expectations and the goals set for itself by the state, when viewed in the context of the lack of resources, underline the need for attaining optimality in both the formulation and implementation of policy" (Saigal, 1982). Though the constraints to optional policy making are many like the norms of democracy, dynamics of a developing country, its poverty, size, population, under utilisation of resources etc., yet through proper policy analysis and rational policy formulation within the parameters of a consistent, judicious and wholistic approach, these constraints can be reduced to the manageable minimum. Here, it is important to mention that this criterion of "achieving optimality in policy formation" becomes more important in case of policies having technological bias, where any compromise on optimality for the sake of acceptability or any other criteria can create havoc.

Interest Groups in policy making: Most definitions of interest (or pressure) groups contain the following notions:

- they are voluntary bodies;
- they aim to achieve some desired goals;
- They do so without attempting to infiltrate the process of decision making to the point of adopting formal government roles (Walt, 1994).

Interest groups may have very inauspicious origins - they may start life simply as a group of people concerned about a particular issue. Sometimes several such groups are formed (including researchers, professionals, individuals with particular problems), and may become "social movements", a sociological concept which tries to capture an element of spontaneity and change that describes people coming together to promote or resist change in the society or groups of which they are a part.

Lindblom uses a rather broader definition of pressure group activities as, "all interaction through which individuals and private groups not holding

government authority seek to influence policy, together with those policy influencing interactions of government officials that go well beyond the direct use of their authority" (quoted in Jordan and Richardson, 1987).

Essentially Lindblom is using a much broader definition, because he is including parts of the government machine acting as interest groups - for example, the ministry of health trying to influence the ministry of trade and industry on tobacco policy. This is an unusually broad definition of interest groups, and while it is useful because it acknowledges that parts of government may, at any one time, act as interest groups to influence policy in another part of government, it is more usual to think of interest groups as organised groups which are outside government - although as we will see, they may have a very close relationship with government.

So the main characteristic of interest groups is that they attempt to influence public policy but they do not seek political power.

What sorts of interest groups exist? : The political science literature abounds with a great variation of classifications of interest groups defined by their goals and membership. For example, Duverger (quoted in Jordan and Richardson, 1987) says interest groups are either:

- partial groups whose main goal is to protect the interests of their membership, and who only attempt to exert political pressure as a secondary aim (for example the Trade Union Congress, the Confederation of Indian Industry); or

- Exclusive groups, which exist primarily to pressurise on particular issue - peace, abortion, the environment and so on.

The two main categories that can be taken for differentiation are sectional and cause groups.

Sectional Groups the First Group: The partial-interest, producer or sectional group - is a collection of individuals who have a similar productive role within society, and they are able to bargain with government using sectional pressure. In other words, they are often relatively strong, and if they do not like what government is doing they are able to challenge policy. For example, trade unions, particularly public sector unions, can persuade their members to withdraw their labour, so inflicting harm on the economy. Obviously this depends on their strength: in many Third World countries trade unions are divided along ideological lines, supporting particular political parties. They are often quite weak: few members pay dues, and there is insufficient funding for training leaders or for communication with members. Their ability to enter into collective bargaining (over wages or broader economic policy, for instance) is therefore relatively limited.

Cause Groups the Second Group: The exclusive, cause, consumer or promotional groups - draw their membership from a wide range of people within society and aim to emphasise or promote concerns that are general, and not specific to the group itself, although this is not always true. For example, a group of disabled people, or people suffering from a particular disease such as AIDS, or a group of women, may form a pressure group to try to influence policy directly related to them. But a British pressure group such as the campaign for Nuclear disarmament (CND) will be made up of a broad range of people who may sympathise with any of the political parties in Britain or may be strongly religious or atheists. They join CND because they want to ban the use of nuclear weapons. A consumer council, formed to protect the interests of a wide range of consumers, will campaign on a range of issues such as appropriate labelling of pharmaceuticals or safety of food products. The Medical Action Group in the Philippines, the Medico Friends circle in India, the former National Medical and Dental Association in South Africa have all campaigned on the link between poverty and health. The Society for the Promotion of Asia Resource Centres deals with issues relating to shelter for pavement dwellers in Bombay.

Networks of influence - Policy communities: Governments are affected by many forces that shape their knowledge base, as well as by shifting currents and fashions that turn their attention from old to new problems. These emanate from policy communities, which are networks of individuals, from various institutions, disciplines, or professions.

The main feature of a policy community is that there is a constant exchange of information about activities and ideas, and that some of these reach government policy makers. Policy communities provide a number of different fora in which the early stages of opinion formation and consensus building among experts takes place (scientific meetings, journals, newspapers) although it may take years for ideas to diffuse broadly especially where they are critical of existing policy. Policy networks are made up of different, perhaps overlapping policy communities both within and outside government, which may affect government thinking.

Although the policy environment in many Third World countries has not been conducive to much exchange between government and outside groups, many tend to overlook how, many NGOs, can, and do, influence government thinking on policy. If opportunities for civil society increases opportunities for exchange may also be increased.

Committees and Policymaking: There are two major approaches to policy development in government. One approach is represented by those who believe that policies are made through the process of political bargaining and represent adjustments and accommodations among competing demands and pressures. Therefore, policies can neither be anticipated nor drastically changed, but only modified in limited ways. The second approach to policy development is presented by those who believe in the possibility of discerning patterns and trends in human affairs and advocate injection of greater rationality in the management of national affairs so as to be able to steer national systems in desired directions. Such a course would require anticipation of events as well as policy planning to meet emerging eventualities. The Indian government with its ambitious goals, low resource

base and slow historical rates of change has no option but to adopt the second approach and to accept the validity of policy analysis and development to strive for the maximum possible degree of optimality in policy formulation and implementation (Saigal, 1982).

But if we look at the policy formulation process of the Indian government which involves extensive advice and consultation revolving around the committee systems, we can clearly see the balance tilted in favour of the first approach, thereby putting the issue of optionality to a ridiculous low. As found out by Dayal, Mathur and others (1975) from their studies of six cases, the basic policy choice is invariably given by a committee appointed for the purpose. After reviewing the policy formulation process in Government of India, Dayal (1975) and his colleague's sum it up as follows:

> "The style of policy formulation involves extensive advice and consultation. The outstanding feature of policy making is characterised by accommodation and settlement involving the political, administrative and specialist groups as far as possible".

Such a system is regarded by them as a major strength as the pooling of knowledge, experience and expertise in a committee situation can result in sound, realistic recommendations. The reputation and public standing of the chairman and the members would also enhance the acceptability of the recommendations thereby facilitating its implementation; public administration being an open system, credibility of a decision and appearance of impartiality by the government are important for administrative action, government becomes able to gauge public reaction to recommendation on vital issues before taking a decision etc. Side by side with these advantages, the authors were not far behind in pointing out the weakness of such an approach.

According to them,

> "The system however has certain inbuilt shortcomings in policy formulation which causes on occasion, sub optional policy

> recommendations. By its very nature a committee has to seek compromises among its members especially when its composition is diverse and the problems complex. The recommendations must be acceptable to its members. There may be other solutions that would perhaps yield better approaches. While acceptability among members may be an essential condition it may not be a sufficient condition in policy formulation".

So seeing the way committee system works, radical policies become difficult to formulate, nor do they easily attract acceptance, radical policies seem to come out of the initiative of top political leadership and not through the formal machinery that is set up for the purpose. However at this point it is worth mentioning that, while taking up policy initiative, the political leadership should go on a logical, rational and scientific evaluation of the entire scenario and not give vent to partisan politics to fiddle with the process. The government decision should not be politically motivated and influenced. The political influence in the present consideration refers to something beyond what is contained in the party manifesto. The political motive here refers to special patronage, yielding to the pressure of various vested interests and taking a decision based on things other than national considerations. The appearance of impartiality and credibility that the appointment of special committees are supposed to give to government decisions, have come to be affected seriously by highly politically motivated and considered appointment of committees.

Again committee invariably try to seek agreement among its members and attempt to find a common basis among them which tends to perpetuate the existing difficulties rather than offer new policy options. According to Ishwar Dayal (1975) the tendency on the part of members towards compromise and accommodation has cultural relevance as in our relationships, social and work roles are rarely distinguished. Disagreements in specific work situations are often extended in all other areas of social interaction. In meetings, unless for other specific reasons, a member ordinarily tries to minimise anything that gives the impression of being "difficult" or "hostile" unless his role justifies it.

In such situations the member often withdraws either by writing a minute of dissent or resigning from his membership. However, it is also not unusual to find serious disagreements eroding the committee's process resulting in the submission of separate reports. It has also often been noticed that members who seem to be difficult, are dropped from membership of other committees and even sometimes follow up actions are taken against them. At times committees given recommendations that are unrealistically "radical" as often seen in international gatherings, saying, as if, that effect is more important than substance. Thus the dynamics of committee functioning is complex and the quality of their outcome depends upon a number of factors. In a developing country such as India, where radical approaches are necessary to tackle serious social and economic problems, the prevailing strategy for policy formulation is not always satisfactory. Again,

> "The committee set up to provide basic policy choice do not provide operational details but generally give a detailed rationale of the recommendations or alternative solutions that they might have considered. Rarely does a committee discuss alternatives and why they were rejected in preference to what the committee had recommended. It is only when the recommendations are accepted by the concerned ministry that it works on the operational details".

A committee by its very nature functions within the defined boundaries of the subject matter assigned to it. Partly due to this and partly due to the way it functions, public policy suffers from lack of a clear wholistic perspective, a systems view.

The Difference between Technocracy and Bureaucracy:

The word technocracy implies rule on government by administrative managers (after the separation of legal ownership from effective control) who oversee and direct younger bureaucratic line and staff personnel with more recent technical training. At the same time, the job of these managers is highly "political" whether it is carried out in public or private sector organisations. The word was first used by W.H. Smyth who defined it as "the

organisation of the social order based on principles established by technical experts", echoing the long tradition of French positivist thinking (quoted in Meynaud, 1965).

A major presumption of technocracy, which Smyth's definition only serves to underscore, is that there exists a phenomenon called "objective" knowledge, that it can be grasped and applied directly to social and economic, as well as technical, problems and that technocrats are able to combine such knowledge with organisational and managerial skills. Technocrats are the ones who can best be trusted to realise and maintain this type of social order. Organisationally, it ignores the ongoing serious tension between line and staff, generalist and specialist, which one finds in all established bureaucratic structures, whether in putatively "capitalist" or "socialist" societies, or in public-sector or private sector organisations. Technocracy (and those who endorse its goals and methods) also tends to play down or ignore the consequences of such thinking - and the practice that is alleged to issue from it - for legitimate concerns about the accountability of non-elected to elected officials and the responsibility of elected officials to their electors in representative democracies functioning under the rule of law.

What all too often follows from technocratic presumptions and preferences is the view that political problems are really administrative and managerial in nature, or that ideally they should be reduced to this in order to maintain continuity and resist "destabilising" tendencies brought about by political parties, campaigns and elections. Technocrats prefer infrequent plebiscitary elections characterised by short campaigns where at least one other team is in place ready to take over the symbolic positions associated with democratic governance in the event that the existing group of politicians is defeated. The social order is comprehended, in the ideal case, as a machine (or "system") which can operate in various ways, from maximum efficiency at one extreme to gross inefficiency at the other. Furthermore, it is a machine (or system) which, once established on the preferred criteria, can be presumed to require only incremental and piecemeal tinkering to maintain it.

The ideal of controlling the discretion of unelected officials is irretrievably compromised with the rise of the view - favoured by business and management training programmes in North America, Western Europe and the British Commonwealth - that there is objective knowledge, that experts can grasp it and that it can be applied directly to social, political and economic problems by the proper blending of technical, managerial and political "skills".

Technocracy has serious consequences not only for representative democracy, and the rule of law that it presupposes, but also for the more liberal bias of established bureaucracies in those countries. This is why technocrats prefer conservative parties in power and a conservative agenda, because these latter favour stability, order, efficiency, privatisation, deregulation and depoliticisation (Giddens, 1973).

On the other hand in bureaucrats, liberal social science saw them as faceless occupants of government offices, administering public policy more or less rationally. In this role bureaucracy needed to be insulated from social and political turmoil because it could function well only if it was neutral and functionally professional. Politician and administrator conflicts were seen in an individualistic perspective and as dependent on the attitudes, values and perceptions of the actors concerned. Similarly, poor bureaucratic performance was blamed on inappropriate behavioural characteristics of the bureaucrats themselves.

Within the Marxist tradition, two views of bureaucracy emerged. One linked it closely with the state and made it the instrument of the state to protect interests of the dominant class, while the other viewed it essentially as an instrument of power, enabling the state to regulate class conflict with a measure of autonomy from the dominant class. In both views, bureaucracy was located within a class context rather than in the constitutional or institutional context (Mathur, 1991).

The question of relative autonomy of the state and ability of bureaucrats to play a more distinctive role is central in the recent literature that has called for

"bringing the state back in" to the analysis of the political (Peter Evans, quoted in Mathur, 1991). This state centred approach, opens the possibility of variation in state capacities as reflected in the behaviour of state actions and how they serve the interests of state actors. The power of the state actors in society can be measured by their capacity to enforce their preferences and interests. Bureaucrats, as one of the state actors, like all social actors, work for their self-interests and attempt to maximise their utilities. In this process, they have to contend with other state actors, such as politicians, and social forces based on class, caste, ethnicity, or region.

Bureaucrats also figure prominently in the new political economy approach that has been used to analyse India's development experience. Undoubtedly, the planned strategy of development has considerably helped the bureaucrats to acquire administrative and political power, which expanded their role in the economy, permitting them greater opportunities to satisfy their self-interests. Mathur's assumption (1991) that bureaucrats are rational actors - choosing actions that maximise their utility - does not reduce them to anti-social or asocial creatures, lacking regard for others, rather it treats them like any other social actor.

Role of Technocrats in Policy Framing:

Although the twentieth century has been characterised by massive advances in science and technology, few development studies have examined technocratic factors in policy formation and policy implementation. Instead, analysts have described and attempted to explain development policy plans and results as the products of social, political, and (most often) economic factors. While the latter triad is undoubtedly significant and cannot be dismissed, analyses of policy options and choices must examine technocratic actors and roles as well (Bjorkman, 1995).

The focus here is on the developmental role of technocrats, people who dispose of what is called by some as cultural capital, by other means of persuasion.

Three Views of the Experts Role in Policy making

Systems Analysis: The preference of systems analysis is to be working near the top of an organisation. The systems analyst is concerned with the output of the organisation; he makes recommendations as to the most effective utilisation of resources to get a desired effect on the environment. His view of the inside of the organisation tends to assume that information is the main thing moving upward, while decisions about objectives, alternatives, and perhaps even techniques move downward. The following are the characteristics of the systems analytic approach:

1. There is a tendency towards elitism and/or centralisation.

2. The organisation is primarily viewed as acting on its external environment.

3. Systems analysts usually do not talk about helping a client; rather they talk of improving decision making. They tend to see themselves not as agents of the client organisation but as agents of the broader polity interested in the public welfare. In private, and sometimes in public, they talk of influencing the organisation and are willing to take sides and accept allies in internal conflicts.

4. They stress best results for least until cost or, "economic rationality". They are interested in the effectiveness of a decision.

5. If the client does not accept their recommendations, they tend to assume the client is of lower intelligence than they are or that he is responding to narrow, parochial interests. Sometimes they blame lack of implementation on bureaucratic inertia.

Disjointed Incrementalism: Lindblom (1959) argues that the synoptic approach sets an impossible task for the specialist working on complex policy

problems because it asks him to look at everything relevant and "everything relevant" is an unmanageable amount.

As an alternative Lindblom suggests the strategy of disjointed incrementalism, a refinement of what he earlier referred to as "muddling through". In this approach, the expert seeks remedial rather than utopian objectives. He examines only those alternatives, which differ incrementally from current policy and from each other. He does not analyse all the consequences of even these limited alternatives. And there is interaction between, leading to a continuous restructuring of, data, means and ends.

The preceding remarks specify the expert's role, but Lindblom's "strategy" involves more than an analyst and a client. It also includes the social and political context in which they operate. He assumes that policy making is serial, that is proceeds through long chains of political and analytical steps, and that policy analysis and evaluation are socially fragmented, that is, varied analyses are simultaneously conducted at a large number of centres throughout society.

Experts are seen as working at diverse points, outside as well as inside the policy agency. Pressures are exerted on policy makers from many points both within and outside the organisation. Analysis and evaluations tend to be considered as one form that pressures may take. Again decision making moves downward in the organisation and data moves up. But data comes in from the outside as well, and pressures from the outside are transmitted up alongwith information. As compared to the systems analyst, the incrementalist is more likely to see himself as the agent of a particular group in the society; at least, it is easier for him to justify the taking of a partisan or parochial view. Analysis is seen as contributing to bargaining power, but in the incrementalist view it tends to be seen as less important than other factors in the power equation. Non acceptance of expert recommendations is explained in this way.

Implications of the Difference: Lindblom's view of the policy making process has been more influential than his view of the analysts role. Thus a synthesis between systems analysis and incrementalism, which some would call policy analysis, seems to be moving in the direction of the analyst taking more account of internal and external politics and being more aware of the partial nature of any analysis, rather than in the direction of the analyst welcoming a partisan role and becoming more sanguine about arbitrary omissions. Even Lindblom appears to grant the non-partisan expert more elbowroom than formerly.

The Third Approach: The third approach that Archibald (1970) discusses places organisational problems at the centre of its concerns. Its objective is to build, or, more accurately, to grow better organisations.

The expert is usually referred to as a "change agent"; his objective is to enter into a collaborative relationship with a "client system" and produce "planned change" in that client system. This approach which has been used most often in industrial organisations, has a strong tie to T-groups and sensitivity training although this may be more a matter of inte'lectual history than of logical inevitability.

Policy problems have no natural boundaries. They exist in a never-never land of conflicting objectives, linked consequences, and interdependent open systems. All three approaches systems analysis, incrementalism and the clinical approach recognise this. They all see the environment of the policy agency (i.e. the habitat of policy problems) as messy and chaotic and each has to figure out some way of making the experts task manageable. Where they differ is in their solutions to this manageability problem. Systems analysis squarely faces the challenge of the inhospitable analytic environment and attempts to create some semblance of order useful for action purposes, Incrementalism, on the other hand, absolves the analyst of much of the worry by assuring him that politics can serve as a sort of putty plugging up the holes in his analysis.

The clinical approach has a completely different solution. The clinical expert uses the boundaries of the client systems to define the boundaries of his task. This is a rather neat trick. The client system - for our purposes, the policy agency - is treated as a closed system whole functioning can be improved. The clinical expert ignores the messiness of the world himself; instead he attempts to service the client so that the client is better able to cope with it. All environmental problems are turned into problems of perception, of values, and of skills - they can then be conveniently located inside the client system. What the clinical expert, or "change agent" as he is likely to call himself, attempts to do is to change structure and processes within the client system.

Role of Technocrats in the third World: Meynaud (1968), in his classic study of technocracy, states that "the debatable aspect of this movement in relation to the democratic ideal is not the search for efficiency, but the absence or insufficient amount of control wielded over its methods by the elected representations. With respect to the industrialised Western countries it has been suggested that, within politics and policy making, holders of the requisite technical and organisational knowledge have somehow been ale to withdraw from political control: democracy, it is stated, has become technocracy". Gouldner (1979) saw the owners of cultural capital as the new ruling class, in the capitalist as well the socialist countries. However, most observers of the technocratic phenomenon regard an academic education as a necessary, but not a sufficient condition for people to become technocrats. The assumption that technocracy entails a direct conversion of cultural power into political power seems unwarranted. Those who fear technocracy appear to err in their assessment of the weight, or strength of political power. The ability of political leaders to take disastrous decisions and have them implemented is grossly underestimated.

Quite another aspect of the technocracy argument refers to the question of, to what extent the political system is still the system where the most important decisions with regard to the future direction of a society are taken. The technocratic character of other systems, notably the economy and science, entails that politics, in short, is increasingly reduced to the technically oriented

task of keeping the machine running. Politics only adjusts society to ongoing economic and technological changes. This seems to be a restatement of Marx's proposition that the material structure of a society ultimately determines its superstructure.

In developing countries this aspect is even less philosophical: a crucial question for these societies is whether different development goals, such as economic growth and the institutionalisation of a democratic political regime, can be realised at the same time as voters unaware of a possible dialectical relation might prefer or have to be tackled in a certain order.

A third set of basic questions deals with the use, or misuse, which the holders of the kinds of knowledge, information or skills that are in high demand make of their "market" position, either as individuals or as a collective actor. Cultural power may be used to obtain economic advantage in terms of salary or other perquisites or it may be used to acquire a high position in a bureaucracy.

Looking at the bulk of development studies produced in the last two decades, it can easily be verified the scant attention scholars have paid to the holders of cultural power in the third world. Instead, the vast majority of social analysts have focussed on actors such as large landowners, entrepreneurs, the peasantry shantytown dwellers, and the military or political leaders. Time and again, they have avoided analysing the role which intellectuals and technocrats play in the development process (Galijart and Silva, 1995).

The principal channels by which the professionals influence the governmental action are:

1) through the election or more usually, appointment of professionals to high office;

2) through the effective control, often a near monopoly, of the significant managerial positions of administrative agencies by individual professions, positions that need not be at the very pinnacle of an

agency's organisation-chart, but must occupy its secondary and tertiary levels;

3) through professionals who operate within agencies which they do not directly dominate (a subset of the previous channel);

4) through pressure brought to bear on political executives and/or on legislative bodies by indirect means, that is, by professional associations, mobilised experts, lobbying, the media, publication of research results, and so forth; and

5) Through the network of professional ties ("old boy" links, schools, associations) across the boundaries of separate government agencies and organisations. (Bjorkman, 1995).

Technocrats and the Consolidation of the State: The growing number of economic functions of the state, as many countries adopted state led nationalist economic models, resulted in a huge expansion of the state apparatus. The creation of new ministries, specialised state agencies, and state owned enterprises and the development of the national infrastructure (roads, bridges, electricity plants), exploitation of natural resources, and so forth generated a growing demand for technically trained personnel (economists, engineers and all kinds of technicians). This was made possible by the steady expansion of the national higher education system, and the intensification of academic training abroad. In many developing countries this led to the formation of a technocratically oriented intelligentsia who gradually took charge of technical and financial affairs of the state (concentrated in ministries of economic affairs, finance, the central bank, and other such institutions). Notwithstanding the increasing importance of the technocrat at the highest level of policy making, they would remain a "hidden actor" for a while. In a climate of strong ideologisation, the figure of the technocrat was often officially ignored as a result of its negative, elitist implication. Instead, most third World governments adopted a rather populist discourse, which stressed the popular basis of the regimes.

A radical re-evaluation of the technocrats role in governmental policy making took place. No longer neglected, the incorporation of technocrats at the highest level of decision making was presented as a guarantee for the application of modern, rational, efficient and apolitical government policies. But even in these early cases in which technocrats occupied visible position in third world governments their relative power and influence within governmental circles has still not found a direct translation into the main ideological models which were at the base of regimes such as the "New Order", the Doctrine of National Security" and so forth. (Patricio Silva, 1995).

Technocrats and the Administration of the State: The increasing influence obtained by technocrats since the mid 1970s at the highest level of policy making in many developing countries has been the result of a complex interaction of international factors and internal political developments.

After the oil crisis in an increasing number of countries leading economists and financial experts were invited by the governments to take command of the ministries and state agencies and were put in charge of the formulation and implementation of economic policy. From these state institutions they formulated relatively orthodox economic plans directed towards the reduction of government expenditure, inflation, commercial deficits, and the like. In conjunction with this, these technocrats conducted negotiations with industrialised countries in order to reschedule existing debts and to obtain new credits and financial aid (Patricio Silva, 1995).

State technocrats believed that the economic problems had to be solved by experts without the interference of the citizenry, which would represent an obstacle for the achievement of the economic goals. However, the application of stabilisation programmes has provoked severe social tensions and mass protest against it in several developing countries.

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CHAPTER 2

STRUCTURES AND ORGANISATIONS INVOLVED IN POLICY FORMULATION IN INDIA

Public policy making has come to acquire widespread attention of late and today both scholars and practitioners have begun to attach importance to this field. This is the trend in India too. Here also, emphasis on policy making has of late been increasing. In - service-training programmes on policy making have begun to be organised for civil servants and are in demand; and universities have also started introducing policy sciences in their syllabi.

Normative Framework of Policy Making in India: Public policy making is necessarily shaped within the framework of a country's constitutional system of which three features stand out most prominently in the case of India: the parliamentary form of government, federalism and a broad band of social, economic and political philosophy articulated in the preamble, the directive principles of state policy and the fundamental rights (Maheshwari, 1987).

In the overwhelming majority of countries constitution states that the legislature is the expression of popular sovereignty and the top decision making body of the country. Most legislatures are supposed to have three functions: to represent the people, to enact legislation, and to oversee the executive (the top leadership). The legislature is the location of constitutionally established responsibilities for elected representatives. It is the body through which the government's policies are enacted and enshrined in law. And finally it is the body, which scrutinises executive performance, or questions specific plans or actions of the executive.

India has adopted the parliamentary form of government alongwith federalism as its ordering constitutional framework but of the two features, parliamentarism in more solidly entrenched. Broadly patterned after the Westminister model, the political executive is composed of members of

Parliament and is accountable to the latter, the Parliament being the font of executive power, subject only to the constitution. The five-year plan of the country acquires finality only after Parliament has accorded its approval. Similarly, Parliament has over a period of time passed a number of policy resolutions such as the Industrial Policy Resolution, National Education Policy etc. and these policies thus come to acquire sanctity of the highest level.

Legislatures everywhere are on the decline, and Indian Parliament is no exception. Five main reasons are give for this, some of which apply elsewhere. First, there is such a strict control of proceedings by the party machine and the executive that this represents a stranglehold on the ability of ordinary elected representatives to exercise much control over, or even to examine, major policy decisions. Second, the executive uses a system of patronage and party discipline to reinforce executive domination. Third, radio and television have taken debate away from legislative chambers, into a world of television studios, confidential briefings and editorial conferences. Fourth, bureaucratic power has expanded so much that much decision making operates outside the legislature. And finally, the globalisation of the world means that supranational bodies such as the EC or the IMF limit or foreclose parliamentary policy choices.

However, while there is a great deal of pessimism about the role of legislatures and the extent to which they can perform their three vital functions, they nevertheless survive. They survive because they have great symbolic value, and uphold the idea of democratic representativeness.

Policy-making process in India has equally to contend with the federal form of the country's policy. Indian federalism, which has evolved out of extreme unitarism, is marked by some unique features. While the constitution attempts a division of functions between the two levels of government all "line" or substantive functions remain entrusted with the state government. Most subjects, which constitute the ingredients of development administration are constitutionally within the states direct jurisdiction: agriculture, education,

housing, industries, while many others like electricity, labour, economic and social planning etc., are in the concurrent list, subject to state as well as central jurisdiction with the centre exercising overriding power but effective one nonetheless remaining with the states. Because the financial resources are concentrated in the Central Government the states have necessarily axiomatic, according to the Centre's mode of thinking, that one who provides money also exercises control, and the states are thus made to look to the centre more and more, especially since the adoption of socio-economic planning in the fifties.

The social, political and economic message of the Indian Constitution is orchestrated in the preamble, the fundamental rights and the directive principle of state policy. Indeed, the articulations in them are the potential stuff out of which public policies at both the levels of the government in the federal system are to be made (Vidya Rao, 1994).

Policy Making: Institutions: Although the Indian polity is federal in character, the administrative system is highly integrated, the state governments acting as implementing agencies of the centre in a large variety of matters. The point to be emphasised is that policy makers must take an integrated view of their task. Since India's single most notorious weakness lies in implementation, the views and experiences of the states and field agencies must be fully fed into policy making processes; and in Indian administration, this is sought to be done through the mechanism of the secretariat.

Public policy cannot be made by one or few individuals however exalted be their stations. Nor can it be separated from an administration. Public policy necessarily involves a large number of persons and institutions operating in hierarchical order or otherwise such as ministers, civil servants, parliamentarians, politicians, pressure groups, professionals etc. Policymaking is a series of continuing dynamic processes, which are plural and composite. In the central government, the principal policy making

functionaries are the Prime Minister and his office including advisers, ministers and the secretaries. In India there are nearly 400 public policy makers at the central level and another 400 in the states. In all, the policy community has a total strength of nearly one thousand (Mukarji, quoted in Mehshwari, 1987), of which 125 may be said to be the top ones. The membership of the group is subject to change but with the remarkable constancy in the pattern of its thought and action. The main bodies engaged in policy formulation and co-ordination in India are the Cabinet, Prime Minister's Office, Cabinet Secretariat, Secretariat, Planning Commission, National Development Council etc. Note has also to be taken of many others including the network of consultative and advisory system created to advise the Government on policy making. Consultations with the state governments take place on a wide variety of matters all the time; and committees are formed, conferences convened to develop consensus and acceptances, so necessary in a federal system (Maheshwari, 1987).

In the Indian system the **cabinet** is the highest political and administrative policy institution. The role of the cabinet in this policy process has grown enormously in the post independence era.

On the one hand we have the system operating in a fairly open collegiate fashion in which the cabinet as a whole discusses and decides on the major policy issues - whether at the Central or the State level. On the other hand we have ample evidence especially in recent years that the cabinet system operates entirely at the behest of the Prime Minister thus moving from the collegiate policy process to a more executive process.

Formally, however, the policy proposals come from the concerned ministry or the minister and the cabinet agenda consists of what the sectoral ministries put up as policy proposals. The process itself is simple but what transpires between the minister and the Prime Minister is not recorded. Similarly, what policy advice the Prime Minister's secretariat renders, as stated earlier, is also

not recorded. The process, however, operates fairly systematically and often in fairly decisive manner.

The policy relationship between cabinet ministers and their secretaries exist in an institutional framework. The channel through which a minister must operate is the secretariat, which is organised pyramidically, with the secretary to the ministry acting as the principal policy advisers to the minister.

To co-ordinate the work of the secretaries so that contradictions in advice do not occur, there is a cabinet secretary, who is the senior most civil servant in the country. He presides over the Committee of Secretaries, which examines inter ministry matters as well as issues that concern the government as a whole. Often the cabinet refers matters to it for comment and advice.

The cabinet secretary is present at all meetings of the cabinet and its committees. He is responsible for preparing the agenda, the priorities of items, and the allocations of subjects to cabinet committees. Although these are approved by the Prime Minister, the cabinet secretary must exercise his judgement, taking into account national priorities as well as what the ministers consider important. The cabinet minutes are prepared by the cabinet secretary and decisions are communicated to the minister by him (Mathur and Bjorkman, 1994).

The **PMO** is essentially an extension of the political role of the Prime Minister and that so much depends on how a Prime Minister prefers this role to be played. Secondly the PMO does not seek advice that may or may not be professional; rather it seeks advice that is trustworthy. These two features of the PMO determine the relationship sought to be established with the cabinet secretariat. It can be productive to the extent that the congruence between the two functions leads to galvanising policy inputs from the government and outside.

The PMO is a reflection of a Prime Minister's personality. Mrs. Gandhi needed a political secretary upon whom she could rely for evolving policies that would establish a pre-eminent role for her in both her party and the government. The prime minister's secretary became her strategist as well as tactician and advised her in the formulation of such public policies as would secure the prestige needed to return to power in the first elections held. But the PMO lost its political lustre when Mrs. Gandhi shifted her trust to another set of policy advisors who were led by her younger son and who were not in the formal set up of the government (Mathur and Bjorkman, 1994).

The interventionist image of the PMO is strengthened as Prime ministers attempt to make their influence all pervasive. One way for this to happen is through controlling all crucial appointments in the government.

The PMO has taken policy initiatives that may be termed innovative. Policies that strengthened Mrs Gandhi's political power, such as the abolition of privy purses, bank nationalisation and garibi hatao (abolish poverty) emanated from the PMO. Similarly, Rajiv Gandhi had a secretary in the PMO who did not belong to the civil service in the conventional sense but was a professional technocrat instead. He expanded the PMO to include professional advisors who had his trust and who promoted the technological thrust, which he favoured.

There is another side to the picture. While the PMO has undoubtedly become a source of powerful influence policy matters some centralisation has occured due to the way the cabinet itself has functioned. Cabinet ministers have increasingly become subservient to the wishes of the Prime Minister because of the latter's preponderant role in their party.

The PMO can organise alternative sources of policy inputs. When the Prime Minister intends to initiate innovative policies or is interested in certain issues that have wider implications, then she or he can include advisors of her/his choice and professional background in the PMO. Mrs Gandhi used the PMO

to retain professionals who would offer her the "balancing" opposite view (Basu, quoted in Mathur, 1996).

The Planning Commission: In India, most of the elements of European practices in forward planning and forecasting, and policy making exist. The planning process is more formalised and incorporates the overall and sectoral components. The Planning commission has the responsibility to perform several tasks in formulating development policy (Dayal, 1996).

The Planning Commission has to analyse economic, financial, social and political situations, diagnose reason for successes and failures in performance, evaluate capabilities to execute and recommend improvements. One important component of its task is policy formulation. In carrying out its assigned tasks, the Planning Commission appoints a large number of technical, sectoral and special committees involving experts, administrators and public men in the framing of national plans. The notes and papers for the guidance of the committees are generally prepared by the special staff of the Planning Commission. The plans lay down the national goals to be achieved and the strategy to be followed.

The Planning Commission has no direct involvement in non-development policies. The ministries formulate policies in their area of responsibility. Some best talents available in their area of expertise seem to contribute very little to policy formulation. By and large the structure of the commission and the dynamics of how it functions preclude decisive contribution by the members (Dayal, 1996).

Sectoral policies in major areas are formulated in two distinct ways:

1. Commissions are appointed to review and recommend a policy frame; and

2. The concerned ministry puts up recommendations to the minister out of a necessity to handle day to day problems.

At times the need for a policy is pointed out by the Cabinet. Based on certain events or recurring issues at the centre or in the states, the minister may ask for a fresh approach or policy in that area. Most ministries have economic advisers whose role is determined by the minister or the secretary from time to time. It is rare for them to perform a critical role in policy formulation, except, perhaps, in the Finance or Commerce Ministries.

In public matters, however, committees would always have an important role in the examination of certain types of problems such as the following:

(a) issues where several interest groups have to collaborate to arrive at solutions;

(b) reviewing work carried out by government, or by projects, etc., and

(c) examination of certain alternative action choices, especially when public acceptance of the decision is important.

On technical issues, however, committees have worked with less success than was anticipated.

Organisation for Policy Making: The Planning Commission is a vast body but its contribution to policy formulation would hardly justify its existence. That such a body is needed in a country like India is not a matter of conjecture. If it were a compact body consisting of independent people with strong research support, it would be able to help in the task of policy formulation. In the present context, it is mainly an extension of the government. The question may will be raised whether it can be transformed to serve the policy formulation function. Judging from the experience of reform in administration

brought about by the government from time to time, it is most doubtful that the government can deal with fundamental changes in administration.

Over the years, the Planning Commission has broadly functioned as a wing of the government. Many efforts have been made to reorganise the Commission, but it has become so unwieldy, as indeed is the government system, that every effort has achieved only marginal changes which have soon been wiped out under the weight of its internal dynamics (Dayal, 1996).

The Secretariat: Of the policy making organs in the Government of India, the secretariat stands at an exceptionally high pedestal. Indeed, it is designed as the policy making organ, being the seat of the Government of India. It was the considered British policy right since the beginning to keep policy making structurally separate from implementation, and the body to engage in it was given the name of secretariat. At the same time, no effort was spared to think it with the implementing agencies and this was secured through the staffing policy for the secretariat, an arrangement which, in its concept, is still in operation (Maheshwari, 1987).

Technically speaking, the Government of India does not possess a permanent civil service of its own, except the Central Secretariat service. It has always been the official policy to fill the middle and higher management level positions at the headquarters of the Government - the secretariat - by deputation of officers from the state governments as well as from the various central services, controlled as they are by their respective departments, the only exceptions being the External Affairs, Railways and Post and Telegraphs Ministries. Such an arrangement was always defended, and even when the federation - creating Government of India Act, 1935 was enacted, no departure was permitted.

The principal argument advanced in favour of the staffing arrangement is that higher civil servants engaged in policy-making and advising ministries must possess first-hand as well as fresh experience of working in the field to keep

the actions and decisions of the Central Government as close to reality and as meaningful to the people as possible. This is precisely what the tenure principle seeks to do. At any rate, the background of most problems dealt within the Secretariat cannot be understood or appreciated in a vast and diversified country like India unless the public servants concerned have direct experience of working in the States and field agencies. Having worked in the secretariat the civil servants get directly acquainted with the objectives underlying policies and programmes, which they have to execute. In the process, implementation does not lose sight of the objectives of a given programme, contributing thereby to its success. Also, each level of government comes to gain direct insight into each others constraints and concerns, and this itself facilitates reaching a healthy equilibrium in a federal system. The secretariat of the Government of India is a collective noun as it were, and today it includes as many as sixty ministers and departments.

The identification of major policy-making organs in the Government, is not a sure proof of their compulsory involvement in the exercise. The perceived gravity of a proposed policy is a factor, but not the only one, determining which agencies are to be consulted, in which order and with what weightage. Sponsorship is itself critically important: if the Prime Minister or his office proposes a policy it may not be thoroughly discussed in all the units on this network and in the process some organs many even get completely bypassed, their consent having been assumed. Behind policy making operate many interests, many factors, many perceptions and the map is not necessarily the same or similar even with the same or similar problem emerging again. The definitions of rationality is ever varying (Maheshwari, 1987).

Policy-making experiences additional constraint under a coalition. The chief executive does not occupy that commanding height nor can his writ run all over the government, he being viewed more in the nature of a chairman or primus inter pares. A coalition government generally leaves out for policy-making those areas where the collaborating parties have disagreements.

Non-Governmental Institutions: There is no single process of policy-making in India and perhaps nowhere in the world. By its very nature the process is polyarchal and perhaps justifiably so as no two major policy issues either emerge in the same fashion or do they develop policy decision in the same manner (Panandiker, 1989).

The political process originates from diverse sources but most importantly from the political parties. The **Political Parties** in a country like India are continually involved in studying and articulating the demands of their existing and potential constituencies. Basically thus the policy process becomes the key ingredient of the power game.

The political parties are not always geared to a very careful or deliberate process of policy evolution. Indeed very few parties are organised enough to establish special groups or secretariats to deal with the policy articulation process. Even so the process does take place in better or worse fashion. The political parties role in this respect comes into much greater focus at the time of the election and in the election manifesto. The election manifesto is traditionally considered a party's political programme, in other words the policy frame governing its governmental decision making.

So much for the theory of election manifestos. As the experience in India in recent years shows, the manifestos of most of the national political parties are remarkably similar and in any case none of the parties takes the manifestos very seriously after they are elected to power except to the extent that a specific item in the manifestos suits the party in power at a given point of time.

Curtis (1990) describes the Janata (People's) Party which was founded in 1977 in India, through the amalgamation of a number of smaller parties, which was able to promulgate a credible programme in 1977 that satisfied its constituent groups and their members. Most important was the common opposition to the emergency rule introduced by the Prime Minister Mrs. Indira

Gandhi, with its limitations on the judiciary, suspension of civil rights, press censorship and forced sterilisation. The Janata Party said it would introduce policies that encouraged self-reliance, the alleviation of poverty and redistribution of wealth. However, once it was in power, and it was unable to meet the promise it had made as a political party: some leaders wanted to press forward toward rapid economic development; others considered modernity the ultimate expression of spiritual corruption, and sought instead to favour home industries and agriculture. One group wished to assimilate the science and technology of the West; another group rejected Western materialism and resolved instead to revive and fortify Hindu Culture.

The role of **Pressure Groups** is also very important in policy framing. Myron Weiner (1963) has observed that, "nothing can be more destructive of democratic culture than a conception of national interest which deprives special interests of the opportunity to bargain, to be heard, to enter creatively into the flow of demands and policies of the political process.

The development of pressure groups in India's political system is generally regarded as a vital element in the process of political modernisation, insofar as it represents a response to increasing functional differentiation and to the breakdown of traditional types of authority. Since independence, after the adoption of modern political system, the most dominant interest articulators in India have not been the social and economic interests but their still pervasive caste, community, regional, religious and language antecedents (Kochanek, 1970). Many observers however feel that the Indian political system is moving towards a period in which the aggregation of political demands of all sectors, modern and traditional, will come to play a much more significant role than in the past.

For analytical purposes, the interest groups can broadly divided into the following types: organised interest groups comparable to similar formations which exist in Western industrial societies, such as trade unions, professional associations of government employees, and the like; "demand groups",

defined as broad categories of people who have been mobilised from time to time in movements of one sort or another, such as "students" or "peasants" (Rudolph & Rudolph, 1987), and influence groups, which operate in non-public arenas such as parliament or the state legislatures or come into being at critical moments such as a succession.

In the first category of organised interest groups, most of which have apex associations and central offices, are the trade unions, business associations, professional associations, and associations of government employees of various types. In addition to these nationally organised interest associations, which organise groups and have names which are similar to those which exist in Western industrial societies, there are myriad national, state, and local associations of merchants and tradesmen whose existence is noted by journalists or scholars only when a major policy issue affects their interests and precipitates a public agitation. They include associations of food grain traders, cloth merchants, goldsmiths, and the like (Brass, 1992).

Such organised interests operate within only a small segment of Indian society, namely, in the sectors dominated by large-scale bureaucratic organisations: factories, urban trade associations, professional groups, and civil servants whose constituencies comprise no more than 10 percent of the population of the country (Rudolph & Rudolph, 1987). These organised groups, moreover, have much less influence than their Western counterparts in the formulation of broad policies and legislation, which has been dominated since independence by the Prime Minister, the Prime Minister's Secretariat, the Cabinet at times, and the Planning Commission. It is largely after the passage of legislation and after the formulation of rules and regulations that interest representation - as opposed to outright blockage of government legislation - matters in India and it then becomes highly individualised or localised rather than a matter of general policy formulation and implementation. It is the application of general rules to particular cases which matters most for business, for example, and the mediation of labour tribunals

in local labour-management conflicts that matters for labour on a day-to-day basis, for another example (Rudolph & Rudolph, 1987).

A further feature of the large apex organisations in India is that they are often paper organisation which cannot mobilise their memberships or they cancel each other out in such a way as to leave only the organisation recognised by the state with influence or to leave none with influence at the highest levels of government. Finally, there is a general tendency at all levels within even the "organised" sectors of Indian society toward multiplication and fragmentation of organisations: in the case of labour, for example, from the national to the state to the factory level so that, at base, what one has in the factories themselves is often no effective organisation at all.

The second broad type of interest formation in India has been given the name "demand group" by the Rudolphs (1987) to describe the movements which arise from time to time to make demands on behalf of persons in the relatively less organised and bureaucratised sectors of society, such as "students" or "peasants" or whole religious or language or regional groups rather than specific functional groups.

The third general type of interest association in India is the influence group with informal leaders or elites at its head who are presumed to be able to mobilise larger numbers of people for specific purposes. Examples of this type are caucuses of Muslim or Scheduled Caste MPs in Parliament, who may seek specific concessions from government or generally influence government policies on matters of concern to their constituencies simply by their evident pressure or may intervene through their leaders at crisis points such as a succession (Brass, 1992).

No aspect of more vigorous and persistent controversy than that of the role of pressure groups. Carl J. Friedrich (1966) has aptly observed: "Such groups were viewed with moral indignation and alarm by the last generation. They were held up to scorn both by muckrakers and by sane students of policies.

They were the sinister force growing at the foundations of modern democracy, of representative government, and the word lobby supposedly comprehended a whole congeries of abuses, corruption, fraud and the like". The activities and nature of Indian pressure groups have been criticised on the ground that they are selfish organisations, which seek to advance the interests of small segments of the society at the expense of the general public interest. The business and caste groups have used the power of Government to promote their own narrow interests. The activities of pressure groups are kept secret and the general public is not aware of the extent of their influence in decision making. They privately consult civil servants and can manipulate them easily. Members of parliament are under no obligation to reveal their association with various group members, especially when direct financial interests are involved. At times these organised groups use every corrupt method available including bribes in dealing with bureaucrats. The degree of success a particular group can achieve in influencing the Government often determined, not by the strength of its case, but on its size and wealth, the larger and richer a group is, the more likely it is to succeed in influencing the Government, Myron Weiner (1963) observes: "The popular belief that non-western organised groups or diffuse mobs often use violence to influence public policy has some measure of truth.... however much of the violence that occurs is neither sporadic nor anomic, but organised and planned". Violence and mass movements leads to anarchy, chaos and are a threat to existing political institutions. It has become fashionable for white-collar workers and their associations to go on strikes, demonstrations and resort to violence. All stoppage of work by Government employees inconveniences the general public. They find that the Government works only when pressure is exerted on it. They thus misuse the right of collective bargaining. Moreover, pressure groups in India are habitual in putting forward irresponsible demands on the administration and ignore the Government's constraints and difficulties.

The industrial, farm, and labour lobbies and interest groups are some of the best organised ones in the country whose basic role and function is to exert

the minimum possible pressure towards adoption of policy steps suited to their interests and requirements.

The pressures on the political system also come from other groups. In particular the press and the academia. The **press** has been, in several instances, a focal point of policy pressures in a variety of dimensions of national life - whether political, economic or social. The press, by its very nature, is diverse and therefore cannot function but in a plural manner. It does so both in the sectoral fields of the national life as well as in terms of the regional coverage.

The issues of concern to the press being diverse, the form of these pressures also comes in diverse ways. Except in the case like the Bihar Press Bill when the press has taken a direct agitational role, the policy influence of the press comes in the form of shaping public opinion. In that sense the press or the media in general play a major long term function of influencing the values of the society and in turn the policy concerns and processes in the country.

Somewhat akin to the process is the role of the **academia**; especially that section which is concerned with the social sciences and the policy fields in the country. Admittedly a great deal of the academic work is not directly related to the policy issues.

But, over the years, especially with the advent of planning in the country, considerable academic work has take place on direct policy problems and issues.

There has been a great deal in the economic and social fields affecting planned development. But it has also influenced a great deal the substantial issues in the country in areas like centralisation, decentralisation, political participation, electoral reforms, party organisation and host of other issues, which impinge on the basic political policy framework.

By its character, the academia is not exactly geared to this role of policy advice and formulation. Hence its impact is not so formally visible except to the extent as in recent years with the involvement of the academia in the official policy apparatus especially the Planning Commission at the Centre and the State Planning Boards in the States (Panandiker, 1989).

External Influencing Agencies: Public policies are everywhere being conditioned by the external environment. It is impossible to separate the external environmental factors as they invariably influence the political processes and policy outcomes. The influence, being brought to bear on socio-economic problems of our country by agencies such as the United Nations and its allied agencies (WHO, ILO, UNEP, UNDP etc.), the World Bank, the International Monetary Fund, the Organisation for Economic Co-operation and Development (OECD) and the European/Asian Bank for Reconstruction and Development, etc. is of critical importance in shaping policy outcomes. India has started implementing IMF supported programmes for macro-economic stabilisation. It is crucial that these programmes are complemented by structural reforms, such as privatising and restructuring State owned enterprises, and increasing competition.

The question that arises here is - in what ways has the availability of foreign aid influenced the development strategy that India has followed? To what extent have the terms and volume of available aid helped her to achieve major development objectives or deflected her from pursuing them? There are important questions. However, India is not the best example of the "dependency" thesis, which limits the art of the possible to what external agencies allow to happen. It is time that in India at times, external constraints have played an important part in shaping policies that have been followed on the whole, except for certain periods, say of the devaluation of the rupee in 1966, they have not been the dominant constraints. Due to a number of factors, the size of the economy, the nationalist part, an initial endowment of a certain industrial and educational infrastructure, the geopolitics of the region, India has been allowed a degree of freedom over choice of policy denied

many developing countries, such that the extent to which she would have relied on foreign resources of capital and technology becomes a matter of more than idle curiosity. Arguably, control over foreign resources has been an important instrument of policy in the hands of the government. It has neither been the driving force behind policy nor the core of its power and interests.

Policy making Process: A Critique: A weak point in policy formulation is the lack of interdependence in some important areas of public policy. The understanding of issues by the implementing departments may be different and the sequencing of the various programmes may become distorted or, the follow up may receive inadequate attention. What's more, midcourse correction is rarely possible if the results are not being achieved. For the policy to serve its purpose, the set of activities and programmes has to be seen as a package and reviewed as such. The integration of components is necessary at several stages of policy formulation including those of identifying problem areas, developing policy goals, formulating a policy, planning programmes and projects and reviewing the policy. This task cannot be carried out fully at the level of the individual ministry. In the present system, the Planning Commission is expected to perform an integrative role with respect to development projects, but in fact the job rarely gets done. There are two reasons for this: (a) organisationally the Planning Commission is itself fragmented into functional divisions and is in no way better equipped to handle this task than the ministries in the government and (b) the programmes and projects are framed by the individual ministry concerned, which is likely to go by its own priorities. Because the job was poorly done by the Planning Commission, a new Ministry of Plan implementation was created. There is no evidence that the new ministry has contributed anything significant to either policy formulation or policy review. "I believe that the problem of poor achievement of results lies in the areas mentioned earlier and that the creation of new bureau can hardly improve the results" (Dayal, 1996).

The use of experts in policy formulation in government is inadequate. On the part of members of a committee, the effort is invariably to find agreed solutions rather than to apply expertise in the search for the best action alternatives. Diverse groups set up to look into problems and suggest solutions often find it difficult to get out of the existing frame; the suggested solutions end up perpetuating the problems, perhaps in another form, instead of offering workable radical changes.

A more useful way of using experts is to get them to analyse and diagnose the problems in hand and to seek alternative action choices by applying their particular knowledge and training to this search. This approach is being increasingly used to advantage in the United States and some countries in Western Europe.

Another major difficulty thrown up by the lack of an organisation for systematic policy formulation is that up-to-date data on the areas under examination are not easily available. For each single problem the data have to be gathered from several sources. Massive data generated by committees in their deliberations, or data used for purposes of planning, are shelved after the committees finish their deliberations and are not easily found. Most of the information on which policies at higher levels are made emanates from the district collector and this may not be trustworthy (Maheshwari, 1987).

The structure of government is such that the inter-linking of policies presents a perpetual problem. The work of the government is organised on a functional basis, each minister being independently responsible for the subject of his ministry. The co-ordinating point for decisions is the cabinet and its committees. With the increase in work and the complexities of problems, cabinet's examination can exert minute care only on those that are selected as the most important policy issues. There is considerable informal consultation among ministries, especially with respect to development policies; there is dialogue with the Planning Commission and the finance ministry. Formal co-ordination on certain policy issues is provided by the

committee of secretaries; but a large number of issues that do have a significant impact on the totality of national development remain primarily within the functional purview of the ministry concerned. Hence the structure of the organisation itself, and the size of each ministry makes co-ordination difficult. Special ways have to be found to bring closer examination of the inter-linkages between ministries in policy formulation (Dayal, 1996).

In India there is no organ for detailed, inter-disciplinary study necessary for policy making and what prevails is generally ad-hocism in policy formulation and a hand to mouth policy making process, which admittedly is an unsatisfactory state of affairs. Search for alternatives, an essential exercise in policy making, is extremely limited and incrementalism appears to be the policy for policy making. In view of increasing complexity of tasks facing a modern government, India must be rescued from such a situation. Provision must at the earliest be made in each department for enquiry, research and reflection before a policy is defined and put into operation. The necessary research and enquiry should be carried out or supervised by a separate department specially charged with this responsibility but working in the closest collaboration with the administrative departments concerned with its activities. Also special attention should be paid to the recruitment methods of personnel for such specialised work. Equally necessary, the senior officers in all departments must devote, which they presently do not do, an adequate amount of time to enquiry, research and reflection and initiate meaningful interaction with researchers, which at present is negligible (Maheshwari, 1987).

There is also centralism in policy making. In the Indian federal system the states carry nearly all-programmatic responsibilities, and no less significant is the fact that the centre itself depends on them for implementation of many of its own tasks. Broadly speaking, the state governments, are the implementing agencies of the centre. It is here, moreover, that impact of public administration is felt and the policies tested out. Truly speaking, the embargo of basis public policies is born and takes shape in the states. All India

Services are common to both the levels of government; and the Indian Administrative Service is manifestly designed to occupy policy-making positions at both the centre and in the states. One may thus note that India's administrative system is an integrated and unified one even though the country's polity is federal.

The felt problems and concerns of the field get hardly taken into full account while making policies, which has contributed to an element of unrealism in our policies. Field administration in India has remained weak and more and more programmes continue to get entrusted to the same over-worked machinery.

A consequence of the present centralist cult is that the national objectives are not always defined in clear terms and policies suffer from deliberately planted ambiguity and ambivalence. Local needs remain unaccounted for in policy-making; and local resources, both men and material, remain neglected. Inevitably, the policy so conceived is destined to be a failure, to cover up which another set of policies, again employing the same worn out methodology, gets formulated. Often, we hope from one failure to another and rarely look back at the feed back. A genuine effort must be made to strengthen state, district and block administration; and popular local level popular institutions must be endowed with adequate resources and power.

Implementation of policies is also lackadaisical and is deeply enmeshed in local politics. In India, the pressure groups are not as vocal and active at the stage of policy making as at that of implementation. Very often, this strategy pays them also. A consequence could be that implementation of socio-economic policies gets ultimately determined by local political interests and pressures and in the process the underlying policy remains frustrated and benefits get cornered by other than the target groups. Monitoring of programme implementation is weak (Maheshwari, 1987).

Thus the policy process in India emerges in a mixed form. In some cases where process is placed through a careful grill such as in some of the sectoral areas of the development plan, the policy output is relatively neat and rational. But in large number of cases, the process is indeed very haphazard and problematic. It is little consolation for us in India that the process is equally haphazard in many countries, developing or developed (Panandiker, 1989). Quite clearly, however, the present set of confused policy processes will continue to dominate the policy making in India for quite sometime to come.

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CHAPTER 3

HEALTH POLICY FRAMING IN INDIA AND THE ROLE OF TECHNOCRATS

Health policy embraces courses of action that affect the set of institutions, organisations, services and funding arrangements of the health care system. It goes beyond health services, however, and includes actions or intended actions by public, private and voluntary organisations that have an impact on health. This means that health policy is concerned with environmental and socio-economic effects on health as well as with health care provision. However, many books on health policy focus narrowly on the health care system only. Nancy Milio (1987) prefers to talk about healthy public policy in order to differentiate the broader definition from the narrow.

The context of Health Policy-making in India after independence:

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

The Bhore Committee was part of the World War II planning apparatus and published its four volume report (GOI, 1946) which, in the tradition of British Committee Reports, gave a detailed analysis of available data, evidence of expert witnesses and recommendations produced by a secretariat. However, alternative proposals were also available, emanating from the Congress party itself. Congress established a National Planning Committee (NPC) in 1938, under Nehru's prompting. Nehru's socialism was essentially Fabian and involved national planning for a mixed economy, but his more radical ideas were ground after independence and his interest in the NPC seems to have evaporated. The Committee Report on Public Health (NPC, 1946) was shorter less well argued and costed, and drew on far less detailed analysis of the existing situation than the Bhore Report. Without a supporting secretariat or any political power base within the Congress party, it disappeared with very

few traces. Thus the Bhore report provided the framework for most health decision making (Jeffery, 1988).

Health policy making after independence was constrained by essentially the same federal structure as that created by the Montagu Chelmsford Reforms of 1919 and slightly amended in 1935, a structure giving primary responsibility in health matters to the states. The centre only kept control over international aspects - quarantine etc. - and over a limited range of all India matters, including the regulation of standards of medical education (to permit medical personnel to practice throughout the country) and the control of communicable diseases.

The Position of the Ministry of Health: In the hierarchy the ministry of health will usually come after the ministries of finance, defence, foreign affairs, industry, planning and education. Although the ministry of health, as with education, is a high expenditure department, largely because of the salaries paid to its workers, it nevertheless has relatively low status in the departmental hierarchy (Walt, 1994).

The minister himself or herself may or may not be a member of the executive and because of its relatively low status, the ministry does not always attract the high fliers among politicians.

The extent to which health commands any attention on the government's policy agenda therefore depends to some extent on the skills of the minister to argue for competing claims on the governments budget, and to put across the needs for, and implications of a new direction of health policy. However, it is unlikely that health issues appear very often on the agenda for meetings of the executive except at times of crisis: and although there may be a crisis about epidemics such as cholera or AIDS, economic crises are more likely to force discussions about the financing of medicines or high technology, or the introduction of user's fees in previously free health clinics.

The relatively low status of the ministry of health has implications for its relations with other ministries, whose policies also affect people's health. Most ministers become absorbed with and bound by their own policy sectors, rather than being concerned with contributing to collective decision making within government. Departments with responsibilities for water, agriculture and education all have their own goals to pursue and while not unsympathetic to health issues may not be prepared to take on active roles in policy and planning for health (Walt, 1994).

Formulation of Health Plan in India

Planning Machinery at various levels: At the central level, a Health Planning Section was created in the Employment and Social Services Division of the Planning Commission in October 1951. In 1956 it was made a separate and independent division. As a subject division it helps the Planning Commission in the formulation of the health programmes and projects to be incorporated in the five years and annual plans. It assists in evaluating performance. It carries out studies of special interest to health planning e.g. manpower requirements of health programmes. The division works in close co-operation with the Ministry of Health and Family Welfare so that there may be an intimate relation between planners and those who carry out policies. Each division utilises working or expert group for the preparation of the plan in their respective fields. The directions given to working groups are of a general nature in the beginning but become much more specific as the preparation of a five-year plan proceeds towards completion. The planning unit in the Ministry of Health and Family Welfare has the following functions:

(a) compilation of national five year health plan and supporting material;

(b) development of strategy for getting plans accepted and financed;

(c) preparation of the central, annual health plan and discussions with the Planning Commission and the Ministry of Finance;

(d) discussion and co-ordination with states on matters relating to planning developments and the financing and implementation of plans; and

(e) submission of progress reports on planing schemes to the Planning Commission.

Thus, the health plans prepared by the Division in collaboration with the Ministry of Health and Family Welfare is reviewed by the members of the Planning Commission and is integrated with the total plan.

Most of the health work is carried out at the State level. Health services are primarily the responsibility of the State. State Planning Boards have been set up in many parts of India. These Boards are to prepare the draft state plans by bringing about consultations between the experts, ministers, and other decision-makers as well as by seeking the views and demands of the district administration and other organisations. Except in a few States, the State Planning Boards have, however, yet to establish their role in a meaningful manner. They lack adequate expertise and creativity. Their position as the "thinking tank" of the Government on social and economic problems has yet to be demonstrated and proved (Goel, 1984).

The programme advisers are responsible for co-ordination and co-operation between the Union Ministry of the Health and Family Welfare, the Planning Boards at the State level, the Planning Bureau of the State Departments of the Health, especially as regards the allocation of resources and the determination of priorities during the five year plan. The various groups concerned have strong preferences and influences. The programme advisors have to reconcile these conflicting interests without much friction. The Planning Commission submits the plan to the National Development Council.

Health Care Administration at the Federal/Union Level Genesis, Growth and the Organisational Structure

Role of the Union Government: According to the constitution, the Central Government is concerned only with international health matters, assisting and co-ordinating state activities, establishing standards and promoting research and professional education. Most other health matters are thus reserved for the States and their health departments, though a few, such as mental health, food adulteration, drugs and vital statistics are on the concurrent list. The 42nd Amendment to the Constitution has made "Population Control and Family Planning" as concurrent subject and this provision has been made effective from January, 1977. The two Health Survey Committees (Bhore and Mudaliar) reporting in 1946 and 1961, did not recommend an amendment to the Constitution although it was stressed that the Central Government should have greater powers to co-ordinate the activities of the State authorities dealing with health. Many persons from time to time have stressed that the Ministry of Health should be given more powers to deal with health matters. Pt. Jawaharlal Nehru said:

> "The Central Health ministry is the pivot round which all the major schemes for improving the standards of health of the nation revolve. All major schemes have necessarily to be sponsored and encouraged by the Central Ministry" (Borkar, 1961)

Speaking about the role of the Central Health Ministry, Rajkumari Amrit Kaur, Minister for Health (1947-57) observed:

> "Health in India is a State subject and the Union Government has mainly an advisory and co-ordinating function to discharge. The Central ministry of Health in pursuit of its objective, health for all, has had to initiate countrywide programmes and to co-ordinate the activities of the various participating States and to see that no State

> lags behind for lack of central aid whether in the matter of material or human resources or of technical know how. In doing this, the centre has not arrogated to itself any power of overall control but has maintained the co-ordinating and advisory function through the Central Council of Health." (ibid, 1961)

The Union Ministry of Health and Family Welfare plays a vital role in the governmental effort to live a healthier and better life. The functions of this Ministry have been increasing to a great extent through all these years because of the limited resources and expertise available with the State health departments and the need of co-ordination among the states, as the diseases know no barriers (Goel, 1984).

Structural Growth and the Present set up: Before 1947, the medical and health services at the centre were administered by two separate departments, one under the Director General of IMS and the other under the Commissioner of Public Health. After independence these two offices were amalgamated under the Director General of Health Services and the post of Commissioner of Public Health was abolished. The Union Ministry of Health was vested with several additional responsibilities, namely, Family Planning, Works and Housing and Urban Development. The functions of Works and Housing and Urban Development were transferred from this Ministry. Family Planning was raised to the status of a full-fledged department in 1966, and the Ministry was designated as the Ministry of Health and the Family Planning. It is known at present as "Ministry of Health and Family Welfare".

The Union Ministry of Health and Family Welfare is headed by a Cabinet Minister, a Minister of State and a Deputy Health Minister. There are two departments of the Ministry - Department of Health and Department of Family Welfare. The Health department is headed by a Secretary to the Government of India as its executive head, assisted by five Joint Secretaries, Five Deputy

Secretaries, one Director Administration, a Controller of Accounts and a large administrative staff. The Department has one attached office - Director General of Health Services with 70 subordinate offices and one subordinate office - Homeopathic Pharmacopoeia Laboratory, Ghaziabad, directly under the Department.

The Department of Health deals with medical and public health matters, including drug control and prevention of food adulteration. The Department has the sole executive responsibility for the subjects included in the Union list and has concurrent legislative responsibility with the States for the subjects contained in the concurrent list. Technical advice on all medical and public health matters is rendered to the Department by the Director General of Health Services.

The Secretary to the Government of India in the Ministry of Health and Family Welfare is in overall charge of the Department of Family Welfare. He is assisted by an Additional Secretary and Commissioner (F.W.), who heads the Family Welfare structure, assisted by one Joint Secretary. The Additional Secretary and Commissioner (F.W.) supervises the programme implementation in the States and co-ordinates the activities and functions of the Technical Divisions and the Secretariat side of the Department of Family Welfare.

Organisation and Functions of Director General of Health Services: The Director General of Health Services is an attached office under which there are 70 subordinate offices. The Director General of Health Services is the principal advisor to the Union Government in both Medical and Public Health matters. He is assisted by an Additional Director General, two Deputy Director Generals - one for Medical and the other for Public Health - and a Director of Administration. Under them there are a large number of administrative staff to carry out the work of this organisation.

The general functions are of Planning, Co-ordination, Programming and appraisal of all health matters in the country.

Central Council of Health: The Central Council of Health was established under the provision of Article 263, by a Presidential Order in August, 1952, in pursuance of the decisions of the Health Ministers Conference held in August, 1950. The Council consists of:

(a)(i) The union Minister for Health and Family Planning (Chairman);

(ii) The Minister of State in the Ministry of Health and Family Planning (Members);

(iii) The Ministers in-charge of the Ministries of Health in the State.

(b) Experts and technical advisors to the Central Government and State Governments shall not be members of the Council and shall not have any right to vote when a decision is taken by it but shall, if so required by the Council, be in attendance at its meetings;

(c) The Council shall have a secretariat staff consisting of a Secretary and such officers and servants as the Chairman may, with the approval of the Central Government, think fit to appoint.

Functions of the Council: The Council has a wide field of functioning

(i) To consider and recommend broad lines in regard to matters concerning health in all its aspects such as the provisions of remedial and preventive care, environmental hygiene, nutrition, health, education and the promotion of facilities for training and research.

(ii) To make proposals for legislation in fields of activity relating to medical and public health matters, laying down the pattern of development for the country as a whole.

(iii) To examine the whole field of possible co-operation on a wide basis in regard to inter-state quarantine during times of festivals, outbreaks of epidemics, diseases and serious calamities, such as earthquakes and famines, to draw up a common programme of action.

(iv) To make recommendations to the Central Government regarding distribution of available grants in aid for health purposes, to the states and to review periodically the work accomplished in different areas through the utilisation of these grants-in-aid.

(v) To establish any organisation or organisations invested with appropriate functions for promoting and maintaining co-operation between the Central and State health administration.

Professionals in Health Policy Framing: The professionals who provide health (medical) services have critical roles in the whole health system. As long as health care remains invasive, of dyadic relationships, the medical professionals will continue to dominate the health sector. Some of the providers of health care are "less professional" in the sense that they have less training and greater interchangeability; but all providers (1) aspire to, if they are not already recognised as holding, professional status; and (2) are the point of first contact for a patient in the health system. That is to say, whether curing or helping or even just caring, the health providers occupy the centre of the system. Try as they will, the politicians and the bureaucrats cannot replace the functions of the health professional; and this centrality of function is a source of power over all other actors, (Bjorkman, 1995).

In sociological terms, the medical profession is a community within the larger society. If people of any modern society are asked to rate professions, physicians come, in most cases, at the top. Historically, medicine was one of the first groups to gain professional recognition and power in the sense the term "profession" is now being used. It is so because a physician is a member of some "formalised organisation" in most cases, has undergone a relatively long and highly specialised training and enjoys autonomy in his work while ideally sharing a professional commitment to rules of competence and public service (Bhat, 1990).

Professional status of any scientifically managed activity or service is achieved generally after long training, ordinarily in a manner prescribed by the profession itself, and is enforced by the ruling authority. A chief purpose of such training is to "indoctrinate" the candidate with a set of professional attitudes for "conscientious performance and service". A profession thus claims and aims to become a moral unit with a socially defined and especially determinate service. Modern medicine is an ideal example of this concept of profession.

Medicine as a client centred profession has its share of problems in terms of integration of key social values. While accepting the medical profession as an extremely important profession in achieving the overall community development, especially in the context of LCD's we think it worth our while to carefully consider the role of medical profession as an interest group. Going, it may be proposed that the role of professional medicine as a pressure group interest group is one of the key factors in shaping and changing public health policies both in the developed and developing countries (Bhat, 1990).

By moving medical care from the "home" (as in the case of "Ayurveda" or "Sidha" systems of traditional Indian medicine) into the market place and converting it into a commodity in the typical Western pattern, Indian physicians transformed a relatively weak traditional profession of minor economic significance into a strong "interest group". Doctors exploited

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

In the Indian context medical profession as an interest group has certain definite features. It is basically represented by the elites in the profession, placed in responsible position of authority in government organisations or running lucrative private practice. These members are linked by bonds of concern and advantage related to their professional practice. Such a group is organised to include continuing role performance by majority members. Its tactics and goals are mostly recognised as legitimate in our society. Control over vital information by the medical profession in a semi literate society strengthens its hand, and the decision makers perception of the consequence of the rejection of demands is essentially helpful to the interests of the profession. The Indian scenario, while different from the Western situation in several respects has common threads of linkage in its general dimensions.

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

restricted (Bhat, 1990). A study of medical practice as a semi-political pressure group becomes vital in the light of this critical observation.

The politics of specialisation and the struggle for power within the ranks of the profession itself is an eye opener. While there is a scarcity of qualified medical practitioners in general, certain types of doctors most urgently needed to the community are not produced in sufficient number. The reason is not difficult to gauge; in the status hierarchy, a specialist is a "high caste" member whereas a generalist is treated as low. Mathur (quoted in Bhat, 1990) made an attempt to estimate the likely imbalance between supply and demand in the generalist doctors in India using the secondary data. His study indicated that the likely supply of generalist doctors by 2000 A.D. will be about 3,91,000 whereas the minimum requirement of doctors by then will be of the magnitude varying from 4,50,000 to 5,84,000. This likely shortage of general duty doctors is not solely because of the increasing population which is beyond the proportioned increase in the medical manpower but it is largely due to the preferential treatment certain medical specialists get as they are linked to the financial and "power seats".

The Struggle between Western medicine and indigenous systems: Medical bureaucrats became more self confidently hostile to indigenous medicine at the turn of the nineteenth century. The cream of Western doctors in India - the IMS was more conscious of its claims to scientific legitimacy. The number of Indian medical graduates and licence holders was substantial and they were offering a real challenge to the primacy of indigenous healers in the major towns, while the growth of a new Indian middle class provided new financial opportunities for both groups (Jeffery, 1979). At the end of World War I medical advisers to the provincial governments asserted that the Indian systems of medicine were archaic incapable of advance, and based on unsound principles.

Most of these administrative doctors equated the Indian systems with quackery and imposture, but they appreciated the political reasons it could not be said. The Director General of the IMS noted that the indigenous systems were relatively cheap, with low fees and low cost education; but this would not justify diverting funds from "scientific medicine". However, he recognised the nationalists support for these systems and argued that their view that the only reason for the decline of the Indian systems was the effect of European rule, should be countered by asserting the greater efficacy of Western medicine. But the imperial government was not united in its views. Some of its members wanted to maximise the distance between themselves and the "superstitious mumbo-jumbo" of indigenous medicine. Others, however, lent their prestige to new private medical schools, some of which combined indigenous and Western techniques in integrated courses, in order to "raise" the standard of indigenous medical techniques.

The position of vaids and hakims, however, was simultaneously being threatened by Medical Registration Acts, passed in all the provinces between 1912 and 1919, and by a Medical Degrees Act, restricting the use of the title "Doctor". In part these were aimed at private Western style and homeopathic medical colleges that had been established in Bengal in the early years of the century. But they also threatened the "integrated" training of indigenous practitioners since Western doctors who collaborated with indigenous practitioners, either in the new colleges or in daily practice, offended the imported British ethical codes and were threatened with de-registration (Steinthal as quoted in Jeffery, 1988).

The political balance was tipped back slightly towards the indigenous practitioners by the Montagu Chelmsford reforms of 1919. Nationalist politicians could now implement policies over the opposition of their medical advisers. The British expected the Indian ministers of health and education to try to support indigenous medicine, since the Indian National Congress had begun to pass resolutions in its support. Ayurvedic revivalists tried to reform Ayurveda by bringing up to date its use of basic science and its institutional

base. Ayurvedic medical colleges and hospitals were established and courses in anatomy and physiology were added to traditional subjects, such as the study of classic texts. They then claimed that historical Ayurveda was superior both to present-day practice and to Western medicine. In 1907 the revivalists established a national representative body called the All India Ayurveda Mahasammelan, and soon afterward Hakim Ajmal Khan became a prominent leader of hakims on the national political stage. By 1920 both groups were involved in congress, but modernisers like Nehru supported the spread of Western scientific medicine and Western style doctors also joined congress, some (like Dr. M.A. Ansari) rising to senior positions (Brass, 1972). Congress and non-congress parties never committed themselves exclusively to one side or the other, as became clear during the 1920s.

After independence the Health Ministry and the political leaders cherished the idea of synthesising the middle level physicians and the paramedical trained people into a new single system of medical science. However, this goal was interpreted differently by different elite groups. The political leaders, mainly members of parliament and state leaders, saw integration as a process of mutual learning on the part of practitioners of both systems. The medical professionals, on the other hand, emphasised the reform of the indigenous medical system. As the later interpretation was shared by the Ministry of Health, it placed state run institutions of indigenous medicine under the leadership of Western style physicians. Indigenous medical practitioners saw this development as a threat to their own identity and, therefore, advocated a change in the government policy. By the late 1950s, they brought pressure on the government to stop integration and promote shuddha (literally, "pure") Ayurved. This proposal was accepted by the Health Ministry in the early 1960s.

Both due to professional competition and the pressure to keep up with international standards in medical education, medical professionals consistently opposed the use of Western medicine by indigenous practitioners (Maru, 1985). The competition with indigenous practitioners was cited as an

important factor by the President of the Indian Medical Association in 1960 when he observed that "one of our main problems today is quackery and competition we have from Ayurvedists, hakims, homeopaths and quacks ..." (JIMA, 1960). Many statements can be cited to bring out the medical profession's concern with Western standards. However the following extracts from an address by the President of the IMA is representative of the professional view, referring to the demand for giving condensed courses in Western medicine to students who had qualified in indigenous medicines, he warned that "there is great danger that our medical qualifications may face a great deal of difficulty for recognition by the other countries in the world" (JIMA, 1961).

Importance of Technocrats in Health Committees: According to Bjorkman (1995), in India physicians have dominated every major health commission since independence. Some of the important committees and their major recommendations are:

Bhore Committee (1946): The Government of India appointed this committee in 1943 to survey the then existing health conditions and health organisations in the country and to make recommendation for the future development.

The health of the nation (British India), as it stood in 1946, was reviewed by the Health Survey and Development Committee (Bhore Committee). The committee reviewed the nation's health under:

1) Public Health
2) Medical Relief
3) Professional Education
4) Medical Research
5) International Health.

The report of the Bhore Committee was published in 1946 on the eve of India's independence, and the proposals for the health programmes were made to provide, among others, the following

(a) No individual shall fail to secure adequate medical care because of inability to pay for it.

(b) In view of the complexity of modern medical practice, the health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment.

(c) The health problem must from the beginning lay special emphasis on preventive work.

(d) The need is urgent for providing medical relief and preventive health care to the vast rural population of the country.

(e) The health services should be placed as close to the people as possible in order to ensure the maximum benefit to the community to be served.

(f) It is essential to secure the active co-operation of the people in the development of the health programme.

(g) The report in this long-term programme recommended a primary health unit for a population of 20,000, a secondary unit for a population of 6,00,000 and a district headquarters organisation for a population of three million. The committee in its short-term programme recommended a primary unit for a population of 40,000, a secondary unit for a population of one and a half million (and a district headquarters organisation for a population of three million).

(h) Recommended a three months training in preventive and social medicine to prepare social physicians who would guide the people to a healthier and happier life.

This report still continues to be an important document in the field of health care administration.

Mudaliar Committee (1962): The committee was appointed by the Ministry of Health to undertake a review of the developments since the publication of the health Survey and Development Committee Report in 1946, and to formulate further health programmes for the third and subsequent five year plan periods. The committee, which consisted of fifteen medical professionals and only one non-medical member, over whelmingly, presented the view of medical professionals.

The Mudaliar Committee found the quality of services provided by the primary health centres inadequate and stressed the need to strengthen the existing primary health centres before new centres are created. It also stressed the need to strengthen sub-divisional and district hospitals so that these could effectively function as referral centres. The main recommendations of the Mudaliar Committee were:

(a) consolidation of advances, efforts achievements made in the first two five year plans in the field of health.

(b) Equipping district hospitals with specialist services.

(c) Need of regionalisation of health services i.e. setting up of regional structures between the State and District headquarters.

(d) Each primary health centre should serve out more than 40,000 people.

(e) The quality of care provided by the primary health centre needs improvement.

(f) Integration of medical and health services should be achieved as already suggested by the Bhore Committee.

(g) Constitution of an All India Health services on the pattern of Indian Administrative Service.

The Bhore and Mudaliar Committees invariably insisted on highly trained physicians. An analysis of these reports indicates their concern for high quality medical services; the resistance's from medical profession, an anxiety to maintain international standard in medical profession and education.

Jungalwala Committee (1967): The Committee on "Integration of Health Services" was appointed in 1964 under the Chairmanship of Dr. N. Jungalwala, the then Director of National Institute of Health Administration and Education, New Delhi, to examine the various problems including those of service conditions. The major recommendations made by the committee were:

(a) Integration of organisations and personnel in the field of health from the highest to the lowest level in the service through:

(1) Unified cadre;
(2) Common seniority;
(3) Recognition of extra qualifications;
(4) Equal pay for equal work;
(5) Special pay for specialised work;
(6) No private practice but good service conditions.

The Committee did not spell out steps and programme for the integration recommended by it and left the matter to the states to work out the set up. It, however, defined the integrated health service as:

(a) Service with a unified approach for all problems instead of segmented approach for different problems.

(b) Medical care of sick and conventional public health programmes functioning under a single administrator and operating in a unified manner at all levels of hierarchy with due priority for each programme obtaining at a point of time.

Shrivastava Group Report (1975): The most significant policy changes followed the report of the Group on Medical Education and Support manpower, established in 1974, and chaired by Dr. J.B. Shrivastava, then Director General of Health Services. Its membership included directors of the Indian Council for Medical Research, the Post Graduate Institute in Chandigarh, The All India Institute in New Delhi as well as the member secretary of the Indian Council of Social Science Research and administrator from the Central Ministry, and a Deputy Director General of Health Services as member secretary. Notably absent were members from state governments. The major recommendations of the group were:

(a) A nation-wide network of efficient and effective services suitable for our conditions, limitations, and potentialities should be evolved.

(b) Steps should be taken to create bands of para professional or semi professional health workers from the community itself to provide simple, protective, preventive and curative services, which are needed by the community.

(c) Between the community and the primary health centre, there should be two cadres - health workers and health assistants. (1) Health workers

should be trained and equipped to give simple specified remedies for day-today illness. (2) Health assistants would work as intermediaries between the health workers and the Primary Health Centre. The Health assistants should be located at the sub-centres. Like the health workers, they should also be trained and equipped to give specific remedies for simple day to day health problems. While they will have a supervisory role over the health workers, they would also function as health worker in their own areas and carry out the same duties and responsibilities, but at a higher level of technical competence.

(d) The Primary Health Centre should be provided with an additional doctor and a nurse to look after the maternal and child health services.

(e) The possibility of utilising the service of senior doctors at the medical college, regional, district or taluka hospitals for brief periods at primary health centre should be explored.

(f) The Primary Health Centre as well as taluka, Tehsil, district, regional and medical college hospitals should each develop living and direct links with the community around them, as well as with one another within a total referral services complex.

(g) The Government of India should constitute under an Act of Parliament a Medical and Health Education Commission for co-ordination and maintaining standards in medical and health education on the pattern of University Grants Commission.

Thus the Shrivastava Committee repeated the story. It maintained that our medical system is borrowed from the industrially advanced and consumption oriented societies of the West and pleaded for the new model which "places greater emphasis on human efforts ... rather than on monetary inputs".

The Committee however, concluded" "what we need even for rural areas is a better-trained doctor" and found ".... no justification to make any change in the policy of producing an adequately trained general practitioner".

Thus, the recommendations, as they appear, are essentially status quoits when it comes to the interests of the dominant allopathic system. Though it understands the disjunction between the allopathic system of medicine and the community and advocates that "health service should be provided within the community itself", but does not attempt an onslaught on its alienation, rooted in the elite background of the practitioners and their own professionalisation, viewed from the perspectives of the needs and interests of the masses.

Ramalingaswami Committee Report (1981): It is also called ICSSR - ICMR report. It correctly notes that in the last thirty years the capacity for change and progress was wrongly equated in India with our capacity to reproduce the Western type institution, services and values. It suggests that health cannot be achieved through a linear expansion of the existing system and even by tinkering with it through minor reforms. But, at the same time we find a near exclusive emphasis on allopathic system, which is certainly western in origin. All the health professionals, recommended for the Community Health Centre are allopaths or para professionals, trained as support manpower to sustain the allopathic system. All the essential drugs identified are Western. On the contemplated Medical and Health Education Commission of India only allopaths are to be represented. In none of these contexts the non-western or indigenous system of medicines or their practitioners are visible. What committee means by a national health policy is but the collaborative and co-operative responsibility of individuals, families, local communities and state apparatus in rendering the health delivery system more efficient and effective. However, it is reasonable to assume that an authentic national policy is one, which is rooted, in our cultural ethos drawing upon the traditional knowledge, experience, expertise, skills and practices. But this was not to be. What accounts for this bias? One of the reasons seems to be the very background

of the committee members. Notwithstanding all the anti west and pro-national pretensions, the team which produced the report is a group of western educated, urban middle class professionals. There was hardly any representative of the indigenous systems of medicines on the committee.

One may infer from the above analysis that the reports perpetuate the interests of the elite and elitism. It debars students from low-income group from seeking long training in medicine, as it required heavy expenditure. Though no rational argument can be put forward against the need for high quality medical service the constraints of limited resources, as recognised by these reports, cannot be wished away and the exigencies created by a crisis situation (acute shortage of medical personnel in rural areas) cannot await long term even if sound measures. Insistence on high quality without regard to extending the minimum facilities to all concerned will defeat the very social purpose and philosophy of socialised medicine. The anxiety to maintain international standards results in brain drain from India, thereby, accelerating the impoverishment of our health system. The situation worsens because the para medical personnel cannot be a functional alternative because of their inadequate and qualitatively different training. The medical personnel, who are the products of this elitist system, are trained as professionals who look upon patients as clients not as partners. The overall result is break down of health service system.

Health Administrators and Planning: The Health administrators lack the art of health planning (Goel, 1984). This results in giving low priority to the programmes directly or indirectly affecting health services. In the past, the health administrator has rarely made a contribution in the planning process to the totality of the plan. He has been advocating only for expenditure on health services without realising that the programmes of education, agriculture, community development etc., also contribute indirectly to the health of the people. To quote Myrdal (1968):

> "From the planning point of view the effect of any particular policy measure in the health field depends on all other policy measures and is, by itself, indeterminate. This means that it is impossible to impute to any single measure on set of measures a definite return in terms of improved health conditions. A generalised model, in aggregate financial terms, visualising a sum of inputs of preventive and curative measures giving rise to an output of improved health conditions, cannot be of any help in planning".

Thus, there is a need of training health administrators in the art of planning. The WHO has been encouraging the training of health administrators in institutes of health administration. Strangely enough, it was found that most of the health experts trained in the art of planning were not engaged on this activity resulting in the wastage of the resources of the sponsoring organisation and the training institution. It is suggested that the young people from the health departments may be selected, trained and made responsible for planning. In the developing world the senior positions are occupied by older people who do not want to be trained. Thus, there is a need to create a special cadre for health planners besides imparting general training for health planning to all. The training institutions should not be satisfied with their passive role of training health experts in the art of health planning but should see that the knowledge provided during training is being made use of effectively, and the situation is improving.

The health administrators lack the techniques of management and personal qualities, which are essential for successful health planning. Planning is a complicated and complex process and health administrators have to convince all concerned for developing meaningful health planning. There are still a number of problems requiring solutions with regard to co-ordination, communication and interrelationships between the many individuals and organisations involved. The head of the health planning team and the health project officers will have to develop considerable skill in the political,

administrative and technical areas. The health administrators will have to work hard in preparing health plans acceptable to policy makers (Goel, 1984).

Researcher as Technocrat: The role of research in policy making: Research is generally understood as a systematic process for generating new knowledge. One definition suggests that research uses the scientific method to discover facts and their interrelationships and then applies this new knowledge in practical settings (Commission on Health Research for Development, 1990). Health research may therefore focus on parasitology or human behaviour, be conducted in scientific laboratories or rural villages, and use tools from many different disciplines, from the biological and molecular sciences as well as from the social sciences.

In the hierarchy that dominates Western scientific models, basic physical and biological sciences occupy the top positions. The social sciences (including health services research) are relegated to a lower position and indigenous, unsystematised or unprofessional knowledge (herbal or homeopathic remedies, for example) disappear off the hierarchical ladder altogether. Policy makers in particular are attracted to scientific certainty and demonstrable relationships. They have in the past subjected social and economic research to a fairly strong barrage of criticism for being too academic and theoretical, and of too little practical use. Whether this is fair or not, social scientists have hit back at their critics and today are less often called in as a last resort, to explain why projects have failed. They have also made real attempts to adopt their methods to give more rapid answers to problems.

How do research and evaluation affect policy?: In this two schools of thought are apparent. Pointing to the social sciences in particular, the pessimists argue that there are few empirical examples that show a direct link between research results and policy. Looking at health services research two researchers conclude: In the United States, as in the United Kingdom, the relationship between research findings, however conclusive and

organisational and policy change is a tenuous one. There is certainly no automatic translation of research into policy (Hunter and Pollitt, 1992).

The optimists reject this view as hidebound and too narrow a conceptualisation of how policy is made. They argue that new information and knowledge percolate through the political environment and become part of policy makers thinking, not in a clear linear fashion (this particular piece of research led to this particular policy), but in a much more diffused fashion.

Disseminating Information: Just as researchers are not necessarily only scientists and academics (research may also be undertaken by government officials, NGO's and sometimes communities), so policy networks are made up of many different groups. Walker (1981) talks of communities of policy experts who may be civil servants, academics, publishers or editors of professional journals, journalists, elected officials or members of parliament, and lobbyists among others. Through a common concern with policy issues, they constantly exchange information about activities and ideas, doing this in part to win approval or recognition from other members of the policy community. On the whole, ideas that conform to currently established professional consensus will be rewarded with esteem and recognition.

So, in looking for ways in which to judge whether research affects policy, it is important to look at the networks of influence, over time, and how they are communicating. How do policy makers find out about research, for example: Do they commission it and pay for it? Or do they respond to it? The process of dissemination can be described as deliberate or diffused. In the first case, policy makers actively seek out information from researchers. They may tender for research to answer a particular problem; or to protect a specific position which is under threat; or to show concern (we have commissioned research on that subject ..... We are waiting for results"). In the second case, policy makers become aware of, and attend to, information derived from research. This may be through professional or scientific meetings or participation in grant giving bodies, or through publications, evaluations and

so on. The process may be very diffuse-researchers do not necessarily publicise their findings through the mass media, and it may take time for results reported in scientific, peer reviewed journals to find their way into the policy environment (Walt, 1994). For example the positive relationship between women's education and child health in the Third World took years to percolate from reported research to the consciousness of policy makers at the international and national levels.

In order to assess how far policy is affected by research, Weiss (1991) suggests it is important to ask how research is disseminated and to define the form it comes in: as data and findings; as ideas and criticisms; or as briefs and arguments for action. Each form has its underlying image, strengths and weaknesses and there may be certain conditions in which one form is more useful than another. For example, research as data is the most technocratic, and is common in the biomedical field, where researchers provide statistics and surveys to inform policy. Such data are not unbiased in either collection or source, and will be affected like all other actions of researchers, by the social constructs of the world they live and work in. Although policy makers and researchers may share the same view of normality and reality, there is no guarantee that policy makers will act when faced with such data. They may respond to acute problems, such as cholera, epidemics, but neglect statistics that show persistent inequities in morality and morbidity between social classes.

Information as ideas and criticisms is more fluid: ideas come and go policy makers choose and remember such information selectively. This illustrates the way the enlightenment model works with ideas seeping through in known and unknown ways to policy makers. Research may alter the way issues are defined and understood, but it may be difficult to pinpoint direct links to policy.

Finally information as argument is altogether more adversarial, more political, with research taking the role of Advocates, and putting specific options to policy makers. Research-as-argument may have advantages to policy

makers, by saving time, by clearly stating interests. Thus interest groups may produce research to support the case they are trying to make. As long as the research is methodologically sound, and is perceived to be of high quality, policy makers may well turn to such groups because they have information and ideas on what options for change exist. Table gives an indication of the forms of research and the conditions under which it may be used:

Table: Conditions under which research may be used

Characteristics of research	Underlying images	Conditions when useful
Data (apparently objective)	Technocratic (i.e. vaccination or screening); short terms academic	Consensus situations; clear problems exists; alternatives feasible.
Ideas (diffused)	Enlightenment long term; policy networks	Uncertainty exists; pluralism of discussion and action; multiple alternatives.
Argument (social impact)	Political; adversarial; interest groups and policy networks.	Conflict is high; research taken up selectively.

Source: Adopted from Weiss, 1991.

According to table, research may be used depending on what sort of questions the research addresses (its characteristics), what sort of images it has and who it is done by, and the prevailing political context into which it is introduced. So research which is primarily addressing a clearly defined, and relatively specific problem (for example, the value of screening for breast

cancer) will be used if it is a recognisable problem on the policy agenda. Much evaluation research may come into this category, even if it is not data dependent, if it is clearly defined, and posed to address specific programme concerns. If the research has not been identified as something policy makers should concern themselves with, researchers may take on the role of advocacy, but this is relatively unusual in the case of research based on data and undertaken in academic institutions (Walt, 1994).

In the case of research as ideas, the field is more open. Research may be sponsored or undertaken as part of strategic planning or new analysis, rather than posing a direct question about a particular problem. Those involved cover a wide spectrum of public and private bodies, and the way the research is presented, disseminated and discussed will vary. An open, pluralistic system in which policy networks communicate and overlap with each other is essential.

Research used as argument requires taking an aggressive approach to dissemination and use of results: how far it influences policy makers will depend on the political and ideological climate of the day, the extent to which the research is seen as qualitatively legitimate and the lobbying and dissemination skills of the researchers. Many interest groups have employed people to undertake research, and may use such research both to protect and to demonstrate a particular position.

Political Factors: Politics is also often a problem when it comes to the use of results of evaluations and research. For example, who initiates the evaluation may determine how far it is likely to be used by policy makers. In the Third World, many evaluations focus on accountability to donors who are supporting a particular programme. They are often a condition of support, and are more for external than internal consumption. Donors may also want independent advice on weaknesses and strengths, whether the particular programme should continue to receive support, or whether funds should be withdrawn, However, they are seldom neutral about programmes, and may

make it clear to evaluators what they expect, more or less to come out of the evaluation. If that is not what they get, they are likely to ignore the results and not hire the same evaluators again.

Evaluations may also be used to settle conflicts within a programme, legitimising change by calling in external professional evaluators. Their results may also be used as tools, to persuade others that the programme is worthwhile, and should continue to be supported, or that changes need to be made.

Conception of risk: Individual conceptions of risk may also impede the influence of science on health policies.

Reluctance to take risks is also important in relation to public health measures affecting large numbers of people. Policy makers and scientists may take different roles. On the one hand, policy makers may be willing to act more quickly than scientists who demand high standards of reliability and validity of results. On the other hand, policy makers are sometimes unwilling to act even where scientists believe the evidence is clear and risks of action few.

Public health research may suffer because governments are lobbied by powerful groups more attracted to basic science or science, which depends on high technology and apparently, diminishes risks. Research which recommends investment in preventive public health. Investment in public health research is less visible and has only long term results; research resulting in high technology can be visited, photographed and may have immediate diagnostic advantages.

Perceptions of the usefulness of research: Policy makers are often critical of research for, inter-alia, taking too long, not being sufficiently applicable, or not addressing primary concerns. There is little doubt that one of the results of the ascendancy of issues about economic efficiency and effectiveness, plus past criticism of much social science research, has been an attempt by

many researchers to make this research more useful. Social scientists themselves have been highly critical of early efforts at research.

Timing and Communication factors: Certainly in the health field, there has been a huge growth in the number of economists, sociologists and anthropologists employed in research and evaluation of programmes, witness to the acknowledgement that their methods and approaches help to understand complex behaviour and relationships in health. They have helped to draw policy maker's attention to neglected issues such as maternal mortality. Modest achievements from research have been recorded.

The picture, then, of whether research influences policy is a complex one, and there are no clear answers. The role and potential contribution of research varies according to the nature of the policy environment and the stages of the policy process, among other things. Where major change takes place, or is imposed, research appears to be more useful because so much is unknown and therefore contested. It seems that policies of macro or "high" and micro or "low" politics come into play again. Research that is system-oriented, that introduces new paradigms, new ways of thinking, will be ignored unless it fits with policy makers ideology, in which case it may play an enlightenment role (Walt, 1994).

Although considerable scepticism has been expressed about the extent to which research and evaluations have been used to inform policy partly because critics used a linear model and looked for direct examples of research influencing policy - but policy is affected by research. However the process of influence must be seen not directly, but as a process of enlightenment - many research ideas filtering through to policy makers. Other factors affect how far research is taken up at any particular time. For example, the process of use will also be affected by the nature and intimacy of the links between policy makers and researches, and the role the media play in research dissemination. Use of research will also depend on timing and mode of communication.

There are also many impediments to research or evaluations being taken seriously and used by policy makers: these include political factors or ideological factors, conceptual confusion and uncertainty about research results, uncertainty about the usefulness of research, timing and communicability. Research and evaluation may not be the centre stage in the policy process, but they certainly play a part, albeit often off-stage.

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CHAPTER 4

ROLE OF PROFESSIONAL ORGANISATIONS IN HEALTH POLICY FRAMING IN INDIA

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

Literature on medical profession as an interest group in the West, unlike the Asian or African context, is by no measure scanty. Various studies by the Western scholars bring home the fact that professional medical associations in industrially developed countries today have an overpowering say in formulating health policies and structuring health practices. While commenting on American Medical Association's political activities, Friedman observes:

> "The American Medical Association is perhaps the strongest trade union in the United States... It renders the average quality of practice low by reducing the number of physicians, by reducing the aggregate numbers of hours available from trained physicians for more rather than less important tasks and by reducing the incentives for research and development" (quoted in Bhat, 1990).

In the case of Britain, for instance, the medical profession has been an established lobby since mid 1950s in pressing for what it thinks to be the right kind of decisions in the field of medicare. What Eckstein (1960) writes on British Medical Association holds true also in the Indian context. According to him:

> "There exists in the British Medical Association a body of leaders (both representative and bureaucratic leaders) at least as powerful- exercising at least as much discretion - as the government officials with whom they deal. Like the latter, they function in a framework of publicity and control ... one of the more weightily considerations the Ministry of Health can exert when interdepartmental questions do arise is that it has the approval of the medical profession for, or its instance upon, a certain action. Both the Ministry and the Association, therefore are encouraged to establish the closest possible relations and to seek agreement wherever possible".

Almost all-medical and paramedical personnel have some association to join, but those for paramedical staff are much weaker than those for doctors, whether western or indigenous. The most political of the medical associations is the Indian Medical Association but other notable associations of Western doctors are those of specialists (surgeons, physicians etc.) and of doctors in specified employment (by the Employees' State Insurance Scheme, coal mines, etc.). Groupings for "integrated " doctors (with joint training) and for Ayurvedic and Unani practitioners are less stable. There is even an association for those who practice Western medicine without formal qualifications (the Private Medical Practitioners Association of India). By far the best documented is the IMA.

Indian Medical Association: Early organisations of doctors in India either admitted only European doctors, or were dominated by them; they were often affiliated with the British Medical Association (BMA). A Bengal branch of the British Medical Association, established in 1863, broke up in 1867 over the reading of a homeopathic paper. Several other Indian branches were short lived until separate membership for officers in the IMS became popular in the 1890s. But there were also more academic medical societies. In Bombay in the 1880s a Grant Medical College Society (open to Indian and European doctors) and a Bombay Medical and Physical Society (apparently restricted to

members of the IMS and Royal Army Medical Corps) predated the Bombay branch of the BMA in 1889.

Indian doctors began to establish alternative societies (e.g. the Bombay Medical Union, dating from 1883), which also received fluctuating support. These societies were often active on political issues, presenting memorials and sending witnesses to appear before royal commissions that considered medical matters in London or in India. They lacked a stable all India organisation until regular All India Medical Conferences were held in the mid 1920s and the IMA was founded in 1928 as a coalition of local medical associations. Its original membership of 200 doctors grew steadily to over 3,000 ten years later.

The IMA was closely linked to the nationalist movement (Jeffery, 1987). M.A. Ansari, who was on the founding executive committee, has been President of the Congress Session of 1921.

In 1936, when Congress policy changed from opposition to the reforms of the 1935 Government of India Act to willingness to contest elections and enter assemblies, the IMA also became involved with the work of the Indian Medical Council. B.C. Roy was a member of the Council and was later its chair. By 1945 he argued against maintaining licentiate qualifications, though he still held the view that licentiate doctors should be registered on the all India Register with graduate doctors (Roy, 1964). But it was always clear that close association with indigenous practitioners would be incompatible with international recognition, and this ensured that barriers between the Western and indigenous doctors would be reinforced.

This record of nationalistic opposition to British rule, and the links between the Congress party and prominent members of the IMA might suggest that the association was well placed after 1947 to influence policy. Dr. B.C. Roy after all, became Chief Minister in Bengal in the 1950s. However, the IMA has not

been very influential, and its leaders claim that they have had little importance Jeffery, 1988).

First the IMA has attracted a membership of no more than about 35 percent of Western doctors in the country. Membership at independence was about 10,000 reaching 18,000 in mid 1950s, 26,000 in 1965 and 41,000 in 1975 (IMA [Annual Report] various years). In the 1960s the IMA attempted to draw the associations of specialists into a closer relationship, preferably under its own speciality wing, but this was largely unsuccessful. Doctors in employees associations have occasionally sought the IMA's assistance. Some campaigns (such as the agitation against "quackery" and for improvements in service conditions in 1969) have been jointly organised. But longer-term relationships have been resisted.

Second, the medical association is identified with the interests of private practitioners. Early government hostility left a residual bias against membership on the part of doctors in the public sector. Also, the benefits offered by the association tend to be directed towards private practitioners. Most local branch activities are organised at the convenience of private practitioners, taking place in the afternoons when most private clinics are closed but when employed doctors probably have to attend to their duties (Jeffery, 1988).

Nonetheless, the IMA is the largest association of doctors and has attempted to present its views on medical policies as widely as possible. Its headquarters were moved from Calcutta to Delhi in 1948 to be nearer the centre of power, and the IMA has worked constantly to be "taken into confidence" by politicians and medical civil servants. Its representatives attend a wide range of committees - the Annual Report for 1973-74 lists 18 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.

Association officials, however, generally complain that they are not taken into official confidence in medical decision making. During the 1960s the IMA made a concerted attempt to enhance its influence. A public relations standing committee was established in 1963; its rationale was the progress of modern medicine and the enlightenment of layman. The IMA was to study proposed legislation and publicise its views in the press and "through personal approach to the legislators or health department officials, administrators and others directly concerned" (IMA [Annual Report: 1963/1964). 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" (ibid). IMA's office holders visit ministers with memoranda about policy proposals; they hold conferences on topics such as rural medical relief, and invite politicians to open or close the proceedings and medical civil servants to give papers or chair scientific sessions; and they use contacts (such as doctors who are members of Parliament) to improve relationships with governments. Perhaps it is surprising that the IMA has not followed a clear cut policy of promoting private medicine; for a period during the 1970s it favoured a complete nationalisation of medical services as a way of dealing with the problems of over-crowding in medicine (Jeffery, 1988).

Health Manpower Policies and the role of Indian Medical Association: 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 doctors unwillingness to go to rural areas. The same editorial reflects the professional values that form the western style physician's orientation towards rural service:

> "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 instruments of precision and appliances of modern techniques are rendered available alongwith 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" (J IMA, 1963).

It is interesting to note that the medical profession in India never seems to have attempted to do any soul searching. All the addresses of the Presidents of IMA during the last two decades, with one exception, repeat the same argument and reflect the same professional values. The one exception was the Presidential address delivered in 1967 by Dr. Bhola Nath, who for the first time 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 examinations" (J IMA, 1967).

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 degrees in Indian medicine. Both the IMA and the Health Minister Amrit Kaur were of the opinion that anyone who wanted to practice medicine must first obtain a basic degree in Western 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.

In the face of growing pressure for the redistribution of health manpower, the Indian Medical Association faced a serious dilemma. Although it opposed the governments 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. In 1971, there were many cases of public assaults on doctors for failure to attend emergencies and provide adequate services, or for excessive fees. The President of the Indian Medical Association, Dr. A.K.N. Sinha, voiced this concern at the Forty Sixth All India Medical Conference at Bikaner in 1970:

> "Everyday we are subjected to criticisms and have often been called "murderers", "traders in flesh", "demons", etc.... Sometimes our members are at fault too. Some of us practice while holding non practising posts, neglect patients, earn money by unfair or unethical means.... It will be, however, unwise to condemn the entire medical profession for the faults of a few misguided persons" (J IMA, 1971).

The IMA, therefore, was divided between the need to maintain the 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 every essence of its professional value system.

Despite the changes mentioned above, except for the development of the indigenous systems of medicine, other policies have either faced stiff

opposition from the medical profession, as they have not been implemented effectively. IMA opposed the National Health Scheme for Rural Areas. It said:

> "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 scheme as pilot projects with the objective of providing relief within the scope of 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" (JIMA, 1973).

This verbal protest was followed by strikes and public protest marches by the doctors. This militant strand 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. Another reason for unemployment was that while some states had a shortage of doctors, others 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. 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 every essence of professional organisational interests (Maru, 1985).

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 of 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" (JIMA, 1973). In addition, some states opposed the scheme. Pubjab, for example, argued that it had enough western doctors, and Rajasthan sponsored a discussion of its "problem of increasing members of unemployed doctors".

This coalition was sufficient to prevent the scheme from being implemented, even as a pilot project, although Mrs. Gandhi addressed gatherings of vaids and hakims in 1973 and talked of the need to use all available medical resources (JIMA, 1973). But D.P. Chattopadhyaya, Minister of State for Health, left the ministry, and without his personal support the proposal died. The IMA was able to call off its proposed Black Day of action, April 16, 1973.

There are other ways also by which IMA tries to influence health policy for example during the1998 elections IMA brought its election manifesto, which clearly brings out its main concerns. Some of the features of manifesto are:

(i) IMA being conscious about its responsibility, places population control programmes at the highest priority in its National Health Agenda and in its Manifesto to be persuaded by all political parties, the succeeding

governments and membership at large, to make people fully conscious of the need and to adopt measures to stop further population growth;

(ii) IMA demands potable water, to be declared as civil right and the total responsibility of the state, to be provided to every citizen in this country and puts it in the highest priority in its Manifesto for the various political parties for the ensuing Lok Sabha elections.

(iii) The IMA strongly demands increase in allocations in the National Budget and also grant of incentives, like, tax-free period, soft loans and financial grants for health investors especially in the backward and rural areas to be given top most priority in the future budgets.

(iv) Inspite of various laws on the statute book, a very large army of unqualified persons are practising medicine playing havoc with the lives of millions of gullible people and fleecing them of their hard earned money. Whereas the elite and the politicians rush to the best and the most modern hospitals and nursing homes in the country and abroad for their ailments, the poor people of the country are at the mercy of the quacks.

IMA calls upon all the political parties and the future Government to take strict and urgent measures to completely eradicate and abolish quackery in our country.

(v) **Uniform Wages and Service Conditions Policy for Medical Professional**: The whole of the medical profession is divided in various cadres and doctors are employed in various service conditions.

In Government service, doctors of the same level have different pay scales, promotional avenues and are even on part-time or contractual basis. It is a shame that many medical professionals are still on adhoc

basis even after 20 years of service and many a time they even retire without even receiving a single promotion.

There is strong unrest among the medical professionals and paramedics all over the country, which is resulting in creating various strikes. Strikes are dealt in totally adhoc managerial way and are broken without solving the issues. The repeated strikes by the medical professionals and paramedics are causing havoc in the health of our country.

Indian Medical Association urges that a Health Service Commission be instituted to create a uniform wage and promotion policy for the whole country and places it at the topmost priority in its manifesto.

(vi) **Consumer Protection Act**: the inclusion of medical professionals under the Consumer Protection Act has created great apprehensions and anxieties amongst the medical fraternity. The doctors, medical professionals, service is distinct from commercial goods and services. The Indian Medical Association maintains that any judgement on a doctor's professional peers who by their training and experience understand the complexities of the medical issues involved. Any procedures for considering complaints from patients or for compensating patients which is not based upon good faith and evaluation of the doctor's action or omissions by the physician's peers, will undermine the overall quality of medical care provided to the patients. The application of CPA to medical practitioners is against the dignity of a learned and liberal profession and time will prove it to be against the interests of the patients.

The IMA urges upon all the political parties and the new government to be formed, to amend the CPA specifically to exclude medical practitioners from its purview.

This manifesto clearly shows that the main concerns of IMA are related with the demands of the doctors, whether they are of uniform wages or consumer protection acts and the social concerns are just there for the sake of facelift.

The Weaknesses of Indian Medical Association: The political weakness of the IMA is partly due to its dependence on the very government it wishes to influence. The IMA is not wealthy; it does not employ any doctors full time and depends upon the commitment of working private practitioners to do office work in the Delhi headquarters, or attend meetings and conferences during working hours. Many of its proposals (such as the involvement of the IMA in school health and family planning activities) are only viable if they are underwritten by government funds. The IMA could expand its headquarters staff and employ doctors or other professionals in an executive capacity only with government support its major sources of patronage - access to priority allocation of scare goods are provided by the government. Its prestige activities - conferences, buildings, overseas tours, also depend on government funds and permission (Jeffery, 1988).

Its political weakness also arises from internal disputes. Litigation connected with elections of the President and Vice President has in some years taken over five percent of IMA income.

A third reason for political weakness is the limited spread of doctors into rural areas. This may cause some doctors embarrassment at being unwilling to go where they are most needed. When political policy was largely the pressure of the urban intelligentsia this may not have mattered much, but the changing structure of political life, described as a "ruralisation of politics" (Rosenthal, 1970), leaves doctors less well placed than unregistered practitioners to arouse rural public support or factional followings. Political success has increasingly depended on such resources, except during the emergency of 1975-1977.

The IMA has demonstrated several features typical of professional association in post-colonial states. Johnson (1973) argues that these associations have a limited range of activities, their membership is low, and advancement and prestige within them is mostly sought by marginal practitioners. Two other criteria in his model fit the IMA less clearly - that ambitious young doctors would use an organisation such as the IMA to advance their public careers and that international networks would be of crucial significance. The first was true around independence; several men were active in the IMA and then moved onto a wider political base, most notably Dr. B.C. Roy and Dr. Jivraj Mehta. Mehta was the first secretary of health and Director General of health services in independent India before becoming an ambassador. By the 1960s such links had warned. In 1970 ten doctors MP's were invited to attend a meeting of a committee concerned with monitoring legislative proposals, but only one turned up (Jeffery, 1988).

Medical Council of India: It is a statutory body established under the Indian Medical Council Act, 1956, and is responsible for the maintenance of informal standards of medical education in the country. The Council prescribes minimum standards of medical education and also the standards of requirements of a Medical College for the award of medical degrees.

Under its functions, one can mention the following:

(a) to prescribe standards for post graduate medical education for the universities;

(b) to acquire information regarding courses of study and examinations;

(c) to make representation to the Union Government in regard to the recognition of medical qualifications;

(d) to inspect medical colleges and suggest methods of improving the efficiency of training;

(e) by an amendment in 1964, the council was given powers to prevent quackery;

(f) to maintain the Indian Medical Register.

The Council also issues "Good Standing Certificates" to the doctors who desire to seek registration with the General Medical Council of UK and other Commonwealth countries.

Besides Medical Council there are three other councils - The Indian Nursing Council (Indian Nursing Act, 1947), Dental Council of India (Dentist Act, 1948) and the Pharmacy Council of India (Pharmacy Act, 1948). These Councils have powers and functions similar to those of the Medical Council of India in their respective jurisdiction.

Indian Council of Medical Research: Till 1947, there was not much emphasis on medical research in the country. The Bhore Committee was very critical of the prevailing research facilities in medical colleges and universities. Organised medical research in the country depended mainly on researches though central and provincial laboratories and the Indian Research Fund Association (IRFA).

The Indian Council of Medical Research came into existence in 1950 as the Central Medical Research Organisation recommended by the Bhore Committee, by taking the place of the IRFA. The objectives of the Council are to prosecute, co-ordinate and assist research in communicable diseases, to finance enquiries and research projects, to exchange information with other institutions similarly engaged and interested, to prepare and publish reports of research work, papers and periodicals, to grant fellowships. The Council maintains, besides a number of semi-permanent units, 18 permanent research institutes and centres. The Council Governing Body is presided over by the Minister for Health and Family Welfare. It has a Scientific Advisory Board under the chairmanship of the Director General of Health Services and

other members representing experts in scientific fields, directors of research institutes etc.

The objectives of the ICMR are as follows:

(a) The prosecution and assistance of research, propagation of knowledge and experimental measures generally in connection with the causation, mode of spread and prevention of diseases.

(b) To intimate, aid, develop and co-ordinate medical, scientific research in India and to promote and assist institutions for the study of diseases, their prevention, causation and remedy.

(c) To finance enquiries and researches.

(d) To exchange information with other institutions, associations and scientists interested in the same project.

(e) To prepare, print and publish any paper or periodical in furtherance of the objects of the Council and to contribute to any such periodical.

(f) To grant fellowships, scholarships, etc. for training research workers and to offer prizes in order to encourage research pursuits.

(g) To serve as an apex body for the planning, organisation, implementation and co-ordination of medical research in the country. In the past, foreign support for bio-medical research has been forthcoming from WHO, Ford Foundation, Swedish Foundation, PL-480 etc. The practice of foreign agencies directly contacting Indian scientists and formulating and supporting research programmes led to undesirable consequences as it resulted in duplication of efforts and neglect of priority areas. The Ministry of Health has decided that all proposals for foreign support must be supported through the ICMR.

(h) The ICMR has been following two broad directions in the field of research: (i) applied research for solution of outstanding current problems in the field of medicine, public health and allied subjects; and (ii) fundamental research in these areas.

Other Medical Associations: Associations of specialists have not actively attempted to affect medical policies except for relatively technical issues, such as conditions for the import of medical equipment. They also depend on the government for financial support. They are generally dominated by doctors in the public sector, with official posts usually held by professors from senior medical colleges, and factional disputes rarely erupt into public or legal arenas. The associations of employees, such as those in state governments, and the diploma - granting bodies have a wider significance. The employees associations tend, not surprisingly, to be concerned mainly with the terms and conditions of employment. In the Employees State Insurance Scheme the main debate has been over its basic form of organisation. Initially especially in Maharashtra, there was a panel system where private practitioners could apply to be included. Panel members were paid according to the numbers of insured people registered with them. But this fell out of favour with the Employees' State Insurance Corporation, which increasingly offered care provided by salaried doctors, often seconded from the state health services. The Association of Employees State Insurance Scheme doctors still favours the panel system, but it has had to acquiesce in a scheme where panel doctors are a small minority and capitation allowances have not kept pace with inflation (Jeffery, 1988).

Professional associations of employed doctors have acted essentially like other Indian Trade unions. The associations, prove grounds for budding politicians, protect the interests of their members only insofar as this is compatible with the wider political interests of the leadership. Nonetheless, their strikes for higher pay for improved status for junior hospital doctors, for reinstatement of sacked or suspended colleagues, and for protection of rights to private practice have sometimes brought medical politics into the forefront

of general politics. In the late 1960s and early 1970s they often collaborated with the IMA in actions resisting the "legalising of quackery"; and some issues (such as the right to private practice) are potentially very significant for medical policy. Nonetheless, most such associations have generally had an episodic life and have not shown as sustained ability to raise the status or the conditions of their membership. Doctors in employment still complain about their subordination to administrative staff, their failure to be awarded class-one-status (or senior class-one), and discrimination among doctors on administrative grounds (such as the distinction between those allowed to prescribe a full range of drugs and those restricted to a basic list).

Non Governmental Organisations and policy framing: The political changes of the past few years have opened up the system, and in some countries there is a great deal of growing activity among civil organisations, resident's associations and trade unions. There are also many examples of existing active groups: the Consumers Association of Penang in Malaysia has been an important interest group both at national and international levels. The Bombay based Association for Consumer Action on Safety and Health (ACASH) has, together with other organisations such as the Medico Friends Circle, drafted a Bill of Patients Rights to protect patients against the relatively unregulated medical profession. ACASH hopes the issue will be widely discussed through different media and ultimately introduced as a Bill to Parliament (Sharma, 1993).

But even in those situations where interest group activity has been relatively limited, the same cannot be said for non-government organisations (NGOs). There are hundreds of indigenous and international NGOs, which have been working in developing countries for many years, and at least some of these groups have been influential in changing public policy.

Non-governmental Organisations as interests groups: Most scholars, whether from the development field or political science, argue that civil society in most of the Third World is weak, and that there is very little influence on

public policy making from outside government. Government is portrayed as isolated from its citizens and, on the whole, non-accountable to them.

Although this picture is probably true - especially in Africa - it does not acknowledge sufficiently the existence of the myriad NGOs, which do exists, or the informal way in which much policy is diffused.

In many parts of the Third World there is a growing number of groups - commonly referred to as non-governmental organisations - which are not recognised as interest groups, and yet which may, among other things, have a clear aim of influencing public policy. This may not be their formal, primary goal but through their activities they seek to change or reform the way the state operates in particular areas, and to force the state to be publicly accountable. Like interest groups everywhere, they do not want to overthrow or replace state structures or even become part of them. They include consumer councils, human right groups, women's groups, AIDS networks; trade unions and professional groups such as nursing associations or public services associations, the national union of journalists or students; residents associations or co-operative organisations. Such groups may through informal or formal contact with each other and with policy makers - bureaucrats and politicians - have significant parts to play in forming and changing attitudes to particulars policies (Walt, 1994). They are a growing force. Sometimes they are self-help groups, which have inauspicious beginnings. Edge (1993) describes a group of Palestinian doctors driving around the West Bank to identify local needs: the medical relief committees which have become a mass movement crucial for the provision of health care and decisions about health policy. By the 1990s the Palestinian NGOs were attracting over US $ 30 million from overseas donors. Such groups are likely to have a major influence on the shape of health policy in the lead up to, and after, Palestinian independence.

Moving from "doing" to "influencing": Historically, non-governmental organisations in the health sector were apolitical providers of welfare and

relief to the poor. They were largely service deliverers, and often provided an essential service in rural areas under-served by government. They were predominantly from the developed world, staffed and run by expatriates. That picture has changed. Many NGOs have moved from a "doing" role to an "influencing" role (Clark, 1991) taking up causes of injustice and oppression, and challenging governments, as well as delivering services. Clark (1991) gives an example of an NGO in the state of Gujarat, called DISHA, which has begun to force acceptance of legislation concerning minimum wages and bonded labour which was being ignored by employers. DISHA has challenged the landlords but has also taken action on behalf of labourers in the High Court, in the state parliament and through the media.

NGOs working with government: Many NGOs work with governments in small projects, providing some resources in terms of personnel or funding. Where there is a receptive environment, NGOs may be able to introduce innovatory ideas, or change attitudes, which may over a period lead to others following suit, and may effect an eventual change in policy.

Introducing Innovative Approaches: Because of their smallness, their ability to respond quickly to community demands, their relative lack of bureaucracy and their grassroots or fields experience, NGOs are often willing to support or try out innovative ideas. Where these work and their achievements become known, they can provide models for other communities, or even the public sector, with more appropriate approaches becoming policy.

A Direct Advisory Role: NGOs have to become trusted and accepted partners of government, but may also face hostility from those who feel threatened by change in existing legislation, or who feel that by external NGOs funding such processes are exercising undue influence in national policy making.

Building Networks: One of the weaknesses of NGOs (although it is also a strength) is that most are fiercely independent, and preserve their autonomy energetically. Even where they have similar functions, their work may be motivated by very different ideas, and where some NGOs may be happy to work with government, other will be cautious about being seen to be co-opted by government. For all its strengths, however independence brings its own weaknesses. Many NGOs collect information, are in touch with grassroots feelings and reactions, and their own experience gives them expertise in many areas. In getting together NGOs can exchange information which may be useful to their own constituencies, as well as give a broader picture than is possible for a small NGOs limited to working in a confined area. As a result NGOs have begun to form networks, building on the legitimacy gained through their grassroots work and experience, in order to have a greater impact at the national level.

NGO Movement in Health in India: The 1980s saw a consolidation of the NGO strengths, with their representatives getting place in government policy making bodies and effectively asserting their position, both in government bodies and through public platforms. The health section in the Sixth Plan document was heavily influenced by NGO methodology and the rural infrastructure prescribed was founded on recommendations, based on NGO experience, as stated in the ICSSR - ICMR Report (1982), "Health for All: An Alternative Strategy": For the first time the government declaration of the National Health Policy acknowledged the importance of NGOs. The Seventh Plan asserted the increasing reliance on the NGO sector to achieve Health for All (Jesani, 1986). The policy statement in the Chapter for Rural Development contained details of the role, criteria for identification and programmes and areas where voluntary agencies may be involved. The National Development Council approved the role the voluntary agencies could play in planning and implementation of their own schemes since they had developed expertise to do so, particularly in the health sector. The active participation of rural agencies had been encouraged in a number of areas like improvement of primary health care, control of communicable diseases, MCH services,

sanitation, rehabilitation of handicapped, reduction of infant mortality and Family Welfare. The Prime Minister's Technology Missions on drinking water, literacy and immunisation envisaged a more effective role for voluntary agencies. A Mission Director (Voluntary Agencies) on Technology Missions had been appointed by the office of the Advisor to the Prime Minister, on Technology Missions, for better co-ordination and effective implementation (Antia, 1993).

The government has thus been increasingly acknowledging the expertise and the innovative nature of NGO intervention, and shown keenness to replicate innovative schemes already tried and tested in the field as well as readiness to reformulate old schemes, just as the NGO sector has sought to influence government policies on the basis of its experiences. The meeting of these two efforts however has not always been too happy. Whenever the government has tried to incorporate NGO initiatives within its rigid policies and infrastructure, the original innovation has been largely co-opted, only to become part of the traditional government machinery (Antia, 1993). Thus, village health workers, the very basis of NGO rural health projects, were reduced to the undervalued lowest rung in the health hierarchy of the rural public health system. The original Community Health Centre, which was to be the centre of comprehensive health for 100,000 population, was reduced to yet another curative hospital rather than the centre for comprehensive health activities at 100,000 level. The government was accused of following the NGO experiments twisted out of context.

As an illustration of working of an NGO, Voluntary Health Association of India can be looked at. The VHAI came into being in 1974 as the result of a decision by leaders of voluntary hospitals and health associations to promote community health in order to balance the overemphasis on expensive hospital oriented health services. Today VHAI is a federation of more than 3000 health organisations throughout India, working to promote social justice in the provision and distribution of health care. Its work spans a wide range of

activities that include shaping public policy for health, providing training, involvement in public affairs and communication.

The advocacy activities of VHAI are directed at the parliament and the press. The concerns of thousands of voluntary organisations working in the health field go unnoticed by policy makers so VHAI realised it was in a position to bring these concerns to their notice and offer recommendations to decision-makers and policy makers in government ministries, the planning commission and parliament. VHAI interacts with the main political parties to impress upon them the health realities of the nation, highlighting areas needing immediate attention. Some of VHAI's ideas and recommendations are now reflected in the manifestos of these political parties.

VHAI's persistent efforts led to assurances from the Minister of Health that there would soon be a comprehensive law on smoking with strict sanctions for offenders, a review of drug policy and agricultural policy and increased importance given to primary health care.

The Association has also initiated work in the area of health and the environment, and the problem of adolescent girls. A feature film and a booklet have been produced with UNICEF support, an Independent Commission on Health in India was constituted and it gave its report. In its advocacy efforts, VHAI has always been careful to maintain close contact with the media.

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CHAPTER 5

CONCLUSION

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

Union Ministry of Health and Family Welfare has two departments - Department of Health and Department of Family Welfare. The Health Department is headed by Secretary and it has one attached office, Director General of Health Services. The DGHS is the principal advisor to the Union Government in both medical and public health matters. The DGHS is dominated by doctors and thus through their advises doctors tend to have an influence on health policy.

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

Thirdly, doctors form professional associations to exert pressure on government from outside. The activities of Indian Medical Association of doctors shows the power and influence enjoyed by these associations. IMA members attend a wide range of committees, around 18, the IMA President is

usually invited to attend the meeting of Central Councils of Health and Family Welfare, though not as a full member.

The professional associations usually do not adopt the methods of protest and demonstration but if need be than they take part in these also. On the question of National health Scheme of 1972 doctors took to streets, they felt that their professional status was at stake. The Indian Medical Association opposed the scheme by saying that, it was totally against the continuance of practice of medicine by the unqualified quacks who are neither educated nor trained, nor qualified. Their backdoor recognition is bad, their involvement in rural medical relief is worse. The result of this protest was that the scheme was dropped and the health minister D.P. Chattopadhyay also resigned.

Thus Western educated medical professionals had always very successfully opposed the inclusion of indigenous practitioners like vaids and hakims in the ambit of scientifically trained medical profession.

The other organisations like Medical Council of India have failed to play any major role. Its functions have been restricted to prescribing minimum standards of medical education. Indian Council of Medical Research has also been involved just with research work and its impact on the policy field has been limited. Other medical associations like those of dentists are not properly documented and at the time of crisis just act alongwith Indian Medical Association.

Researchers are also technocrats. Research results may also be used in policy-making, it can be done in two ways, firstly researcher gives results on the basis of which policies are framed or secondly, policy makers say that they are waiting for results on the basis of which policy will be decided. A very important thing in this regard is the political factor, policy makers may highlight those research results, which favour their interests and sideline those, which goes against their interests. The donor agencies also have an

important role in this, because they finance researches and may want results, which favour their point of view.

NGO's have given an alternative way of looking at health problems and they have also started to try to influence health policy. The Government has also been increasingly acknowledging the expertise and the innovative nature of NGO intervention, and shown keenness to replicate innovative schemes already tried and tested in the field as well as readiness to reformulate old schemes, just as NGO sector has sought to influence government policies on the basis of its experiences. But because of limited reach and penetration in rural areas their role is limited. Thus it is the state which holds the key to solving health problems by formulating correct policies and implementing them.

The role of Parliament in health policy framing has been very limited, this has been due to the lack of informed debate on the issue. The only point at which parliamentarians take little interest is at the time of passage of budget for health.

Although medical personnel have been dominant in policy proposals within the health ministry, they have been less successful in negotiations with more powerful economists and administrators in the Planning Commission.

Bureaucrats (in the Planning Commission or in health ministries) frame policy partly in response to their own perceived interests as bureaucrats, or as members of particular social classes, and also in response to clients, politicians, and organised pressure groups. These pressures generally reinforce the preference of those within health ministries, in other words they share a doctor oriented curative services view. However, conflicts do occur, particularly over medical education and over the role of people practising western medicine without a western medical qualification. Conflicts between supporters of unregistered practitioners and those who regard them, as "quacks" have been strenuous and remains basically unresolved.

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

Medical profession as an interest group in India has certain definite features. It is basically represented by the elites in the profession, placed in responsible position of authority in government organisations or running lucrative private practice. These members are linked by bonds of concern and advantage related to their professional practice. Such a group is organised to include continuing role performance by majority members. Its tactics and goals are mostly recognised as legitimate in our society. Control over vital information by the medical profession in a semi-literate society strengthens its hands, and the decision-makers perception of the consequences of the rejection of demands is essentially helpful to the interests of the profession.

A greater involvement in their own professional matters and relatively little involvement in community related issues lead the medical profession towards forming its own professional mansion and fight for its glory and grandeur in maximising its utility. The doctor in India is a co-heir of "medicalisation" process that has been going on in the Western societies on a larger scale. The low key level of local participation is one of the latent indications of such a process of politicisation of medical profession in pressurising the legislative authorities for desired changes in the medical system, without really bothering about the needs of the community.

The question that arises in conclusion is that why do technocrats give the kind of advice as they do? Why do pressure groups apply force on certain issues

and not others? The Western medicine is basically individualistic in character. The term "western educated practitioners" itself makes the fact clear that the education has a western orientation. Even Dr. Bhola Nath, President of IMA in his Presidential address in 1967 recognised the wrong social orientation of the profession acquired through a western style education. Thus the ethics and morals that are imbibed through the western education are also rooted in their culture, and here the orientation goes wrong.

The term development as we understand should be culture specific but it has meant more of Westernisation rather than overall development. Thus when we try to juxtapose the western model of development on our society which has entirely different characteristics than things go wrong. Thus for the western educated doctors the patient is just a case. And when the same set of doctors sit in various committees or hold important positions in Director General of Health Services, than, they tend to give the kind of advice which will protect and enhance their selfish interests. Hence the major emphasis of the advice has always been on expensive hospital based, urban, curative services in both the private as well as public sector for the convenience and monetary gain of the medical profession at the cost of basic services for the rural population. The pressure applied by professional organisations of doctors on policy making has also always been of the same characteristic i.e. enhancing their own interests. Whenever they have talked about broader societal interests than it has been just for the sake of facelift and no seriousness has been attached to it. The demands which they have raised for their own interests have been very specific, like as related to consumer protection act, but when it concerns the larger masses, than they will vague in character like controlling the population or providing clean drinking water, and in this, they themselves would have very little role to play and the onus will shift on state.

Thus medical profession due to its western orientation has failed to take the interests of larger masses alongwith them and has remained individualistic in character.

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BIBLIOGRAPHY

ARTICLES AND REPORTS:

Ali, Sofi 1992. Public Policy making in India, **Indian Journal of Public Administration** (Apr-June).

Anita, N.H. 1990. Comprehensive Health care, **Seminar** (September).

Archibald, K.A. 1970. Three views of the Experts role in policy-making, **Policy Sciences**, Vol.I.

Baer, William C. 1977. Urban Planners: Doctors or Midwives, **Public Administration Review** (Nov-Dec).

Bakthavathsalam, Dr. G. 1999. Heralding a robust Health Policy for the millennium, **The Hindu** (Sept 10).

Banerjee, Madhulika 2000. Whether Indigenous Medicine, **Seminar** (May).

Banerji, D. 1989. Achieving Health for All, Paper presented to the **International and Social Policy**, held at the University of Washington, Seattle, U.S.A. (September).

Banerji, D. 1992. Health Policy and Programmers in India in the Eighties, **Economic and Political Weekly** (March 21).

Borkar, G 1961. Health in Independent India, New Delhi, Ministry of Health, **Government of India**.

Government of India 1946. Report of the Health Survey and Development Committee (Chair, Sir J. Bhore), New Delhi, Superintendent of Government Printing.

Government of India 1961. Report of the Health Survey and Planning Committee (Chair A.L. Mudaliar), New Delhi, Ministry of Health.

Hunter, D and C. Pollitt 1992. Developments in Health Services research: perspectives from Britain and the United States, **Journal of Public Health Medicine**.

Indian Medical Association, Election Manifesto 1998. **Lokayana Bulletin** (January-February).

Jain, R.B. 1997. Managing Public Policy in India: The Implementation Gap, **Indian Journal of Public Administration**, Vol.43.

Jeffery, Roger 1979. Recognising India's Doctors: The Establishment of Medical Dependency, 1918-39, **Modern Asian Studies**.

Jesani Amar and Shilpi Ganguli 1993. Some Issues in community Participation in Health Care Services, **Review Paper for ICMR-ICSSR Joint Study on Health**, Bombay, FRCH.

Journal of Indian Medical Association 1960. Vol.35, No.I (1 September).

Journal of Indian Medical Association 1961. Vol.37, No.12 (16 July).

Journal of Indian Medical Association 1963. Vol.40, No.3 (1 February).

Journal of Indian Medical Association 1967. Vol.48, No.7 (1 Apr).

Journal of Indian Medical Association 1971. Vol.56, No.6 (16 March).

Journal of Indian Medical Association 1973. Supplement, Vol.60, No.2 (16 January).

Journal of Indian Medical Association 1973. Vol.60, No.9 (1 May).

Jungalwalla N. 1967. Committee on Integration of Health Services, New Delhi, Ministry of Health and Family Planning, **Government of India**.

Kochanek, Stanley A. 1970. Interest Groups and Interest Aggregation, **Economic and Political Weekly** (July).

Lindblom, Charles E 1959. The Science of Muddling through **Public Administration Review** (Spring).

Lindblom, C 1979. Still muddling, not yet through, **Public Administration Review.**

Maheshwari, S.R. 1987. Public Policy-making in India, **Indian Journal of Political Science** (July-September).

Mathew Thomas 1991. Perspectives on India's Health Policy, **Yojana** (July 31).

Mathur, Kuldeep 1991. Bureaucracy in India: Development and Pursuit of Self-interest, **Indian Journal of Public Administration** (Oct-Dec).

Mathur, M.P. 1989. Local Government and Public health, **Yojana** (December 16-31).

Milio, Nancy 1987. Making healthy public policy: developing the science by learning the art, **Health promotion**.

Mosher, Frederick C. and Richard Stillman 1977. The Professions in Government, **Public Administration Review** (Nov-Dec).

Nair, Dr. M.D. 2000. Needed Multi pronged strategy National Health Policy, **The Hindu** (April 25).

Report of the Sub-committee on Public Health, Bombay, **National Planning Committee of the Congress party**.

Ramalingaswami, V 1981. Health for All: an alternative strategy, **Report of the Indian Council of Social Science Research and Indian Council of Medical Research Joint Study**, Pune, Indian Institute of Education.

Rosenthal, D.B. 1970. Deurbanisation, Elite Displacement and Political change in India, **Comparative Politics**.

Sharma, K 1993. Controlling the hand that cures, **The Hindu** (30 June).

Shrivastava, J.B. 1975. Report of the Group on Medical Education and Support Manpower. Mimeographed, New Delhi, Ministry of Health and Family Planning, **Government of India**.

Vidya, Rao 1994. Social Policy: The Means and Ends Question, **The Indian Journal of Public Administration** (January-March).

BOOKS:

Anderson, James E. 1975. **Public Policy Making**, New York, Praeger.

Antia, N.H. and Kavita Bhatia 1993. **Peoples Health in Peoples Hands**, Bombay. The Foundation for Research in Community Health.

Bhat, V.N. 1990. **Public Health in India**, Delhi, Amar Prakashan.

Bie Nio Ong. 1996. **Rapid Appraisal and Health Policy**, London, Chapman & Hall.

Bjorkman, James W. 1995. The Mechanics of Professional Dominance in the Health Sector: Critical clues from comparative perspective, in Benno Galjart and Patricio Silva (eds), **Dynamics of Development**, Research School, CNWS, Leiden, The Netherlands.

Brass, Paul 1972. The Politics of Ayurvedic Education, in L.H. and S.I. Rudolph, (eds) **Education and Politics in India**, New Delhi, Oxford University Press.

Brass, Paul 1992. **The Politics of India since Independence**, New Delhi, Cambridge University Press.

Chatterjee, Meera 1988. **Implementing Health Policy in India**, New Delhi, Manohar Publications.

Chatterjee, Partha 1998. **State and Politics in India**, New Delhi, Oxford University Press.

Clark, J. 1991. **Democratising Development**, London, Earthscan.

Commission on Health Research for Development 1990. **Health Research**, Oxford, Oxford University Press.

Dayal, I et al 1975. **Dynamics of Formulating Policy in Government of India - Machinery for Policy Development**, New Delhi, Concept.

Dayal, I. 1977. **Change in work organisations**, New Delhi, Concept.

Dayal, I., Kuldeep Mathur, Abhijit Dutta and Utpal K. Banerjee 1975. **Dynamics of Formulating Policy in Government of India - Machinery for Policy Development**, New Delhi, Concept.

Dayal, Ishwar 1996. Organisation for Policy Formulation in Kuldeep Mathur (ed) **Development Policy and Administration**, New Delhi, Sage Publications.

Dror, Yehzekel 1968. **Public Policy Re-examined**, New York, Chandler.

Frankel, Francine R. et al. 2000. **Transforming India: Social and Political Dynamics of Democracy**, New Delhi, Oxford University Press.

Friedrich, Carl J. 1966. **Constitutional Government and Democracy**, Calcutta, Oxford and IBH.

Galjart, Benno and Patricio Silva 1995. "Knowledge, Expertise and Political Power: Intellectuals and Technocrats in Developing Countries in Benno Galjart and Patricio Silva (eds) **Designers of Development**, Research School, CNWS, Leiden, The Netherlands.

Giddens, Anthony 1973. **The Class Structure of the Advanced Societies**, London, Hutchinson.

Goel, S.L. 1984. **Public Health Administration**, New Delhi, Sterling Publishers.

Gouldner, A.W. 1979. **The Future of Intellectuals and Rise of the New Class**, London, Mac Millan.

Grindle Merilee S. and John W. Thomas 1991. **Public choices and Policy change: The Political Economy of Reform in Developing Countries**. Baltimore and London: The John Hopkins University Press.

Hall, P., H. Land, R. Parker and A. Webb 1975. **Change choice and Conflict in Social Policy**, London, Heinemann.

Harrop, M (ed) 1992. **Power and Policy in Liberal Democracies**, Cambridge, Cambridge University Press.

Jeffery, Roger 1987. Doctors and Congress: The Role of Medical Men and Medical Politics in Indian Nationalism, in M. Shepperdson and C. Simmons (eds). **The Indian National Congress and the Political Economy of India, 1885-1985**, London: Gower.

Jeffery, Roger 1988. **The Politics of Health in India**, Berkeley and Los Angles, California, University of California Press.

Johnson, T.J. and M. Caygill 1973. **Community in the Making**, London, Institute of Commonwealth Studies.

Jordan, A. and J. Richardson 1987. **British Politics and Policy Process**, London, Unwin Hyman.

Khilnani, Sunil 1999. **The Idea of India**, New Delhi, Penguin Publications.

Lasswell, Harold 1956. **The Decision Process**, College Port, Md. University of Maryland, Bureau of Government Research.

Maru, Rushikesh M. 1985. Policy Formulation as Political Process - A case study of Health Manpower: 1949-75 in R.S. Ganapathy et al. **Public Policy and Analysis in India**, New Delhi, Sage Publications.

Mathur, Kuldeep and J.W. Bjorkman 1995. **India's Top Policy Makers: Cabinet Ministers and their Civil Service Advisers**, New Delhi, Concept.

Meynaud, J 1968. **Technocracy**, London, Faber and Faber.

Mukhopadhyay, Alok 1997. **Report of the Independent Commission of Health in India**, New Delhi, Voluntary Health Association of India.

Myrdal, G. 1968. **Asian Drama, An Inquiry into the Poverty of Nations**, Pantheon, New York.

Naik, J.P. 1977. **An Alternative System of Health Care Service in India: Some Proposals**, New Delhi, Allied Publishers.

Panandiker, V.A., Pai 1989. Policy-making in India in N.R. Inamdar (ed.) **Profiles of Indian Government and Politics**, Poona, Vishwanil Publications.

Rose, Richard 1976, Models of change in Richard Rose (ed) **The Dynamics of Public Policy: A comparative Analysis,** London, Sage Publication.

Roy, B.C. 1964. **Towards a Prosperous India**, Calcutta, Pulia Bihari Sen.

Rudolph, Lloyd I. and Susane H. Rudolph 1987. **In Pursuit of Lakshmi: The Political Economy of the Indian State**, Chicago, University of Chicago Press.

Saigal, K. 1982. The Possibility of Optimal Policy Making in India in K.D. Madan et al (eds). **Policy Making in Government**, New Delhi, Publications Division.

Sen, A. and J. Dreze 1995. India: **Economic Development and Social Opportunity**, New Delhi, Oxford University Press.

Silva Patricio 1995. Intellectuals and Technocrats in Third World Politics towards a Convergence? In Benno Galjart and Patricio Silva (eds) **Designers of Development**, Research School, CNWS, Leiden, The Netherlands.

Smith, B. 1977. **Policy Making in British Government**, London, Martin Robertson.

Walker, J.L. 1981. The diffusion of knowledge, policy communities and agenda setting: The relationship of knowledge and power in J. Tropman, M.J. Dathy and R. Lind (ed) **New Strategic perspectives on social policy**, New York, Pergamon Press.

Walt, Gill 1994. **Health Policy: An Introduction to Process and Power**, London and New Jersey, Zed Books.

Weiner, Myron 1963. **Politics of Scarcity**, Bombay, Asia Publishing House.

Weiss, C 1991. Policy research: data, ideas or arguments?, in Wagner et al, **Social Sciences and Modern States**, Cambridge, Cambridge University Press.

Wright Mills, C. 1956. **The Power Elite**, Oxford, Oxford University Press.

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