Novartis Foundation

The Right to Health: A Duty for Whom

Business deliverables for the right to health: Expectations from an NGO Perspective:

Spaces and Rights

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Basel

I am so glad Novartis foundation has put these two elements, ***rights and duties*** to be discussed together and given me the space in the ***Duty for whom***? Section.

My presentation would be from the perspective of those living in poverty and within them especially women and girls. I suggest that "Things fall apart", to use Chinua Achebe's[1] most powerful three words, when we see anything, everything, - our theories, measures, policies, values and programmes, and understanding of Rights, through a poor person's -especially poor woman's - lens or perspective or deflection.

One of the most striking features of the poor is their proximity to death. Death of child, of aged and of self is a real possibility on any day. The mainstream or official figures of mortality and of life expectation do not indicate this reality. We do not have a really good base of disaggregated data by "class" or "gender" in poverty, but whatever windows we have do show dramatic variations in life and death. This closeness to death is a problematic So much can be explained by this intimacy with death – ***fearfulness*** and ***fearlessness, choices or lack of them, morals***[2]**.**

For example, in India , the Infant Mortality Rates (IMR) as given in National Health and Family Survey (NHFS), 1998-99, in the case of poorer families is about double that of their better-off counterparts and as for child mortality the poor lose three-times more children than the middle-class. [3]

[1] Chinua Achebe, *Things Fall Apart*. Heinemann Educational Publishers Oxford, 1958
[2] Devaki Jain, 'Through the Looking Glass of Poverty', paper presented in New Hall, Cambridge, 19 October 2001
[3] International Institute for Population Sciences, (2000), NFHS-2, 1985-99, Mumbai

Infant and Child Mortality by Background Characteristics[4]

Standard of Living Index*	Neonatal	Post neonatal	Infant	Childhood	Under5
Low	**48.8**	**27.3**	**76.1**	**39.1**	**112.2**
Medium	**34.6**	**16.9**	**51.5**	**17.6**	**68.2**
High	**24.1**	**8.9**	**33.0**	**6.6**	**39.4**

*Standard of Living Index is computed as an aggregate of scores allocated for various assets owned.

This proximity to death affects a family's morals too. The type of issues on which Choices have to be made are gruesome. For example who will be enabled to live or allowed to die. Girls may be sold for the family to survive; a child sent to labour instead of school. There are hard choices like who will receive the larger amount of food, who will receive health on a priority basis - a triage within the family

We have more on Inequality and Poverty from WHO[5]

The frontal issue raised by WHO in its papers 'Health: a precious asset' is startling, accurate and commands immediate attention. The point it makes is that for the poor, the only asset that they might have control over is their body – I say might as unless that body is free of disease, hunger, disability, the poor do not even have control over that body.

Another important pointer that is made is that over the course of time, not only has the percentage of poor not decreased dramatically, but the inequality between health of poor and health of rich has increased – clear evidence that unless poor are targeted for health systems, they will be left behind.

In 1960, 20% of the world's people in the richest countries had 30 times, the income of the poorest 20%. Now they command 74 times more. **The richest 20% of the world's population command 86% of the world GDP while the poorest 20% command merely 1%. More than 80 countries now have per capita incomes lower than they were a decade ago, 55 countries**, mostly in Sub –Saharan African. Eastern Europe and the common wealth of Independent States (CIS), have had declining per capita incomes.

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[4] *National Family Health Survey (NFHS-2) 1998-99.* International Institute of Population Sciences, Mumbai, India 2000 pg186 Table 6.4)

[5] Devaki Jain, *"Health As A Force For Poverty Reduction",* World Health Organisation, Panel Session on Health: A Force For Poverty Reduction WHO, Social Summit +5:Geneva 2000, 29th June, 2000

More than 800 million people lack access to health services, and 2.6 billion access to basic sanitation. Although people are living much longer lives today, **around 1.5 billion are not expected to survive to age 60**. Indeed life expectancy in some countries of Sub-Saharan African are only around forty years.

Despite population growth food production per capita increased by nearly 25% during 1990 –97. But the overall consumption of the richest fifth of the world's people is 160 times that of the poorest fifth. 840 million people are undernourished including 160 million children. Close to 340 million women are not expected to survive to age 40.

I have some more facts on inequality from a presentation by Dr Ismail Seralgadin

Inequality

The richest
225 persons
Are richer than
The poorest
2.5 billion humans
That is
2,500,000,000 persons!

4

Rising Inequities

- **Assets of world's 3 richest people exceed combined GDP of poorest 48 countries**
- **World's 15 richest people have assets that exceed total GDP of Sub-Saharan Africa**

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In this presentation, **I would argue:**

1. **that the rights framework is both enabling and disabling** when seen from this perspective, namely the perspective of those living in extreme poverty in a developing country.
2. that since setting up the framework to access rights is not only not easy, but requires extraordinary machinery , as well as funding guarantees , **perhaps sometimes just straight forward provisioning of basic health sevices,** a floor of basic amenities as the duty of the State , guaranteed by the Constitution **would reduce the horrors of poverty and deprivation**
3. that **for the poor to be able to exercise any right**, be it for health, or livelihood, for any of the freedoms[6] that Amartya Sen talks about, and which is spelt out in the HDR of 2000 (*Human rights and human development)* **there is need to provide them the spaces for exercising these rights.**
4. that the spaces are many and at different levels, but **my main point would be that it is the duty of business to enable the less privileged to exercise their rights., which in turn means that they ensure that spaces are available** , and **expanded** , **and capabilities built amongst the poor to claim these rights .**

My illustrations to bolster these arguments would be drawn primarily from India.

What do I mean by saying **Duty of Business** to protect and expand spaces for poor and excluded to claim rights?

FIRST: **Support democratic processes and structures**. Often business finds it easier to work in totalitarian and authoritarian states, as decisions are quicker being in the hands of one person. The USAID and the World Bank often used to compare the speed of Pakistan to sanction and implement projects in comparison to India, when Pakistan was under the strong grip of President Ayub Khan. These and many other such agencies continue to compare, the speed of Reform as liberalization privatization globalisation, [***lpg*** as it is nicknamed in India and by organizations like the Forum for the Global South,] is euphemistically called, in China with the "slow progress " in India. The difference in the backdrop of political culture between these two countries is not part of the consideration in the judgement on speed with which the contracts are signed, land and other requirements provided. In India these processes are slow, as it is debated in parliament, it is criticized in the press, travels through the lobbies of left and right, of labour vs business and so on. These are called delays in the language of the business community. But it is

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[6] Human rights and human development – for freedom and solidarity (HDR 2000)

- Freedom from discrimination – by gender, race, ethnicity, national origin or religion.
- Freedom from want – to enjoy a decent standard of living.
- Freedom to develop and realize one's human potential.
- Freedom from fear – of threats to personal security, from torture, arbitrary arrest and other violent acts.
- Freedom from injustice and violations of the rule of law.
- Freedom of thought and speech and to participate in decision-making and form associations.
- Freedom for decent work-without exploitation

these “delays” that protect the interests of those who might be affected. But the long term interest of business would be in a democratic state as it also protects business and its interests with the same structure of the rule of law, of rights and so on. There are rights and there is accountability to elected and transparent governance. The right to information is one of the most powerful people s movements in India to day. **Thus business needs to support the democratic culture, as that is the foremost condition for the poor to access rights**

It is also the argument of the women’s movement today that the best safeguard for the exercise of rights by any subordinate or disadvantaged group is the existing of the larger framework of democracy. Of all the subordinate or disadvantaged groups, it is my submission that women most acutely need space to protest, deviate, affirm their “agency”, their “autonomy”, as part of building their capability to access rights. I say this because whatever other types of enabling environment is provided since much of women’s subordination is located within the households and often within religious and other such traditional structures of power, the good old freedoms, of expression, freedom of association and freedom to resist, with access to independent judicial structures is crucial.

SECOND do not encroach upon the spaces that the poor need for asserting their rights. For example, **do not encourage privatization of public goods, even if the State or the World Bank requests you TO.** Back off on grounds that it inhibits the poor from accessing these basic services, in turn to exercise their rights.

Why should provisioning of basic amenities be the duty of the State? **Business cannot be held as accountable as elected government so when business takes over public amenities it inhibits exercise of right,** right to access the service, to demand an affordable price. Business has to be driven by profit, other wise it is not business

Here is a conversation with the millionaire and IT Icon, from India called Narayana Murthy and his colleague Nandan Nilekani. When we asked them if they would like to fund the development of local self government, they said:

We have to work for profit that is our character that determines our competitiveness and our acumen. So do not ask us to be non-profit, but we will engage in public service as philanthropy, not as business.

Privatisation of health and of basics like water have been a blow to poor, because of pricing ...But now it is also shown by the Empress, namely the World Bank that privatization does not necessarily mean greater efficiency either on the criteria of cost or of delivery. In a paper the World Bank[7] (August 2003), reveals that privatization of civic amenities “public goods” namely water, power, etc. - has been a failure on both counts – profit and recovery of investment (key to Bank and Private sector); and efficiency of

[7] Madelaine Drohan, *“Now They Tell Us: Privatization Is No Panacea”*, Globe & Mail / Canada, 6 August 2003

delivery. The report says I quote "that private ownership did not solve problems in government-run enterprises." It adds, "consumers can threaten not to re-elect a government that fails to provide adequate services. They have a harder time holding private companies to account…. A Latinbarometer poll that covered 17 countries in 2001 found that 63 per cent of respondents felt they had not benefited from privatization. The most difficult enterprises to privatise successfully are traditional monopolies that sell essential services to consumers, such as water and electricity - does not solve the essential problem – which is how to pay for such systems in the first place"[8]

THIRD Another duty that I can perceive is that business must actually **build the capability of poor to access those rights.**

How do I translate this?

To illustrate: For women to have reproductive choice, it is not enough to offer only a choice of contraceptives. Women's fertility is not a function of only her body but the power of men. Gender relations determine freedom of choice; and these relations have also to undergo change for choice to be exercised.[9] For this shift in gender hierarchies to take place it has been seen that women's participation in cooperative movements and organisations outside their home, like SEWA, enables them to challenge with greater confidence and certainty and to assert with authority their rights vis-à-vis the men. When women have effective availability and access to support structures such as a proximate women's organisations, proximate women's awareness programmes or sustained interaction with training orientation programmes they are able to assert their voices whether it is a voice for an issue or for woman kind.[10]

Further, It is my submission that effective expression of **reproductive rights** is dependent on a broader acceptance of the language of rights, in a broader set of areas such as – the right to natural resources, the right to protest, the right to leadership and the right to information. **Such a view affirms the importance of a political platform, a framework of rights, in the quest for highlighting health as a crucial aspect of poverty. (SLIDE) The poor are discriminated against by society, economic policy and political processes. Hence responses** to this phenomena "thing called poverty" **have to react to discrimination and** therefore **need to be built around affirmative action, positive discrimination, an affirmation or rights, a political approach even more than an economic approach**. [11] **It is the argument of people like me that women cannot exercise reproductive rights without having proximate accountable government and being an organized voice.**

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[8] Clive Harris, "*Private Participation in Infrastructure in Developing Countries, Trends, Impacts and Policy Lesson*," _(Washington D.C, The International Bank for Reconstruction and Development/The World Bank, April 2003)

[9] Devaki Jain, "A historical narrative and update" at the Millennium Conference on Population, Development, and Environment Nexus", February 14-16, 2000

[10] Mahila Samakhya, SEARCH, ISST.

[11] Jain, Devaki. Social Summit + 5: Geneva 2000, World Health Organisation, Panel session on Health: A Force for Poverty Reduction WHO, "Health As a Force For Poverty", June 29, 2000

India's model of local self-government. The PRI's (Panchayati Raj Institutions)

There are more than one million elected women representatives amongst the 3.5 million local political persons in India who have come into governance due to the 73rd and 74th Amendments to the Constitution, which mandates a 33 % reservation of seats for women in the local self government bodies .. "This exposure to politics, of fighting elections even if set up as a dummy, this sitting in councils even if hand and mind twisted by the men, is politicising women in formal politics and the scent of power, like the scent of honey is not easily shed. Women are flexing their muscles and revealing their influence on local institutions." [12]

Here is an opportunity to build capacity – Business should support projects which help to build the capabilities of the poor to exercise rights, which usually means to help them to organize themselves into various forms of collective voice, be it economic or social or political. (SLIDE) **Business houses can undertake to strengthen these local institutions, especially the women committees within them with funds and skills to engage in health delivery and its monitoring , including accountability.** India has a fund to be given exclusively to the local government bodies for achievement of health goals, and one of the suggestions we have made is that they put this money entirely in the hands of associations of elected women politicians to design and implement health services . [13]

Withdraw from sale of "evil" goods: a moral responsibility

The latest Indian Census, 2001 shows through the child sex ratios, female elimination, with the worst case in the Punjab which has the highest per capita income. We know that this son preference culture is across class i.e. not specially related to poverty. But 2001 census has mapped the change in child sex ratio across districts in India, over the last decade 1991-2001.

Map 1 indicates Districts with below 850 Child Sex ratio (the Punjab) and Map 2 of Districts showing decrease of Fifty and above points in Child Sex Ratio (in Age Group 0-6)

What is startling and shaming in these figures is that this red mark is appearing in geographical and cultural areas where it did not exist 15 years ago.

If one visualise the red colouring used in Maps released by the Registrar General, emerging out of Census 2000-01, where the colour red is used to highlight those parts of India, where the infantile sex ratio has dropped by about 50 points between 1990-01 and 2000-01 then it appears as if blood is dripping down, moving from Punjab/Haryana, all the way down through Gujarat and Andhra into Karnataka. Female foetuses being killed is the explanation for this drop and the dripping down of this red is the new phenomenon.

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[12] Devaki Jain,– Globalism and Localism "Negotiating Feminist Space", 20-22 May 2002 in Italy

[13] VS Elizabeth and Devaki Jain, Enabling Population Stabilisation Through Women's Leadership In Local Self Government: A Proposal for the department's new scheme" for Department of Family Welfare Ministry of Health and Family Welfare, Government of India, 17-18 February 2003, New Delhi

This kind of killing fields of the female before birth was usually limited to Punjab-Haryana and the district of Salem in Tamil Nadu, before 1991. I call it “the blood stained fingers of Mother India”.

MAP 1 to be inserted here

One of the ways in which the elimination of the female foetus takes place is through the use of the Ultra sound equipment, usually used to recognize tumours and so on . India has made laws banning the use of these machines by private practitioners , and for such purposes as sex determination tests of pregnancies . But the spread of this machine and its use is uncontrollable , even if underground , naturally driven by the demand **. It is only if the business houses which produce this machine, would take the stand that they would not sell these machines except to authorized hospitals that one can put a stop to this cruelty or discrimination.**

MAP 2 to be inserted here

FIVE Another space encroachment comes from donors and corporates who do what is called single line, or vertical funding. It is the duty of these financiers to change, withdraw from such pernicious practices. **Do not engage in vertical or single line funding**

Why is this pernicious?

If it is argued that primary health care is one of the most basic needs of the poor , then the goal of strengthening 'primary health care' requires effective and affordable comprehensive primary level health care services becoming accessible and user-friendly for all sections and in all regions of the country, with back-up referral to equally appropriate and user-friendly secondary and tertiary level public hospitals. **Two approaches exist for the primary level**. **One focuses on 'vertical' single disease control programmes** (for TB, malaria, leprosy, filariasis, AIDS) **and the RCH/ family planning programme. The second focuses on the general health services that deal with all health problems comprehensively**. Past experience reveals the dilemmas here.

Why more than rights – a ground hugging health service is crucial for poor:

Overall, in India ,there has been a neglect of the general health services that cater to the immediate 'felt needs' of people at primary level. The financial resource at its disposal has been less than one-fourth of the 15 per cent budgetary allocation envisaged in the blueprint adopted at the beginning of planned health service development in independent India (Bhore Committee Report 1948). There has also been a top-down development alienated from the common people and their realities; the very anti-thesis of the vision of primary health care. This has increased since the mid-1990s. **The 'vertical' programmes are becoming almost synonymous with primary health care, while the general health services are allowed to deteriorate. The reason is that agencies like eg USAID or the World Bank want targeted outcomes especially related to population reduction. Hence they would like to see outcomes related to their funding, hence for example we find that in India, the family planning wing of the Health Ministry , receives larger funding and prompting than basic accessible quality health care – or even water sanitation and other requirements for health**

We see this approach reappearing again in the latest Indian effort to serve the poor, called the Common Minimum Needs Programme- where I have a quote from a leading Health NGO, The Foundation for Research in Community Health appealing to the Government not to repeat a population control programme when it is possible with the same funds to deliver health services through community participation . **see below**

An NGO – writes to the Government of India

"The Mission Approach: It is proposed to launch a Rural Healthcare Mission (RHM) in the 17 states of Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan, Orissa, Uttaranchal,

Chattisgarh, Jharkand, Sikkim, Jammu & Kashmir, Assam, Meghalaya, Mizoram, Tripura, Nagaland, Manipur & Arunachal Pradesh, to improve access of poor people, in rural areas and urban slums, to integrated health care services.

"The proposed Framework for Action: Village Level: It is proposed to strengthen village health delivery by providing an additional worker at the Anganwadi level, who would be an Accredited Social Health Activist (ASHA)"[14]

It is unfortunate that the above concept note which will determine Rural Health Care of our people over the 10th and 11th Five Year Plans which is being pursued in haste needs for more deliberation before its implementation. There is an inherent risk for this to become yet another population control programme with all the attendant problems and sequelae as in the past. Obviously it has caused deep concern to the large number of people-based organizations involved for decades in training and functioning of female village health functionaries who provide overall community health and medical care – a bottom-up approach to a function that predominantly involves the community with its own self interest, rather than the traditional top-down approach which has failed over the past 50 years to deliver the goods…..

…..The ICSSR/ICMR Report also stated that up to 80% of all health care can be best undertaken by suitable training of the village's own female health worker and that 95% of all health as well as medical care can be achieved by the Panchayat at Rs. 80/- per capital per annum (which is equivalent to Rs. 200/- per capita per annum at current rates) with a small but effective community's own hospital and training centre. This cannot be achieved by merely adding a village-based helper (ASHA) at the bottom of the existing rural health care system. Such a people's own functionary if properly trained and utilized within the village and under the gram sabha control, cam not only provide health-as well as Family-Planning-care to her own people but will also be an important functionary for the Panchayati Raj at the grassroot level.

It is hence important that the larger number of community-based organizations/institutions that have experience and expertise in training and utilization of such female village health functionaries be involved and play an important role in such a Mission".[15]

Financing Health – choosing priorities:

Even 2-3 per cent of India's GDP is not enough for the public sector to provide comprehensive health services to all its citizens.

A recent report by World Bank on India's capacity to reach the MDG on health has this to say "India needs to spend more on healthcare to reach the Millennium Development Goals. "An additional 2.5% growth in government health spending as a share of the

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[14] Concept Note on the National Rural Healthcare Mission, (Draft), Consultation on the proposed RHM, on November 2004 at New Delhi, Government of India

[15] *Dr. N H Antia, Comments on The Concept Note on national Rural Health Care Mission, sent to Dr. Manmohan Singh, Prime Minister of India, New Delhi, October 29, 2004*

Gross Domestic Product would enable Indian and South Asian states, to reach their Millenium Development Goals (MDG) by 2015, a World Bank study *Rising to the Challenges*". **[Health is wealth, *The Financial Express*, Bangalore, November 21, 2004, pg 4]**

The public share of expenditure on health in the India among the lowest in the world (0.9 per cent of GDP). Countries with much lower per cent of GDP spent on health but a greater share of it through the public sector have achieved much better health indices, such as Sri Lanka and China. However, the much lower levels of poverty in Sri Lanka and China, i e, 6.6 per cent and 18.8 per cent of population living below $1per day compared to India's 44.2 per cent, could be responsible for their better health indices. The relative importance of levels of poverty and public expenditure as determinants of health status is debated, but that both need urgent attention for improving health status is well accepted.

An equally serious consideration is the nature of expenditure of public funds for health. For instance, the US has the highest GDP, spends the maximum on health through both public and private sectors, has the most hi-tech medical care and generates the maximum state-of-the-art medical technology. Paradoxically, it has lower health indices than Japan and Sweden. It also has extremely high levels of iatrogenic ill health, i e, disease and death due to medical treatment.[16] This highlights the importance of defining the optimal standards of health care for ourselves.

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But India has a public plus private out-of-pocket expenditure on health of 5.1 per cent of GDP, higher than most 'developing' countries including China and several Latin American countries which spend 3.5-4.5 per cent and close to Japan and the west European countries that spend 5.5-8 per cent.[17]

Therefore **the imperative for private services will remain. The issue is what kind of private services should the government promote – the 'informal' providers** that the poor access most easily, **OR formally trained generalist private practitioners** who are a varied group and cater to different classes, **OR the corporate sector that does not cater to the poor even when it avails of government subsidies.** 'Informal' providers often lack sufficient training, and even the 'qualified' medical practitioners indulge in irrational overuse of diagnostic tests, drugs and procedures. Services provided by these

[16] K Steel, P M Gartman, C Crescenzi and J Anderson, 'Iatrogenic Illness on a General Medical Service at a University Hospital', New England Journal of Medicine, 304, 1981, 638-642
[17] Human Development Report – 2002 – Deepening Decmocracy in a Fragmented World, United Nations Development Programme, Oxford University Press, New York, 2002

formal and informal private general practitioners accessed by the poor need to be strengthened by upgrading their knowledge and skills for rational management. [18]

I would argue for a greater role of the state in funding but more broad based than purely primary health care. Such an attitude that it is sustainable development with all its elements water sanitation, livelihood, education and health that can be the package which is needed or not single thrust programmes is clear from past experience.

The exercise of looking at a set of duties for business deliverables as a part of a right to health agenda indicate that it would be perhaps more immediately useful in implementing the MDG goals if health services become part of the grant fund programmes of the government

SLIDE

Amartya Sen, in a lecture given in Tokyo, at the Inter- Academy Panel on 15th May 2000 called Sustainability and Freedom on International Issues, has another important and original perspective

> **"we need a vision of mankind not as patients whose interests have to be looked after, but as agents who can do effective things – both individually and jointly. We also have to go beyond the role of human beings specifically as "consumers" or as "people with needs", and consider, more broadly, their general role as agents of change who can – given the opportunity – think, assess, evaluate, resolve, inspire, agitate, and through these means, reshape the world.**
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> There are, some important grounds for favoring a freedom-oriented view – focusing on the enhancement of human capability – rather than seeing human beings only in their more elementary "animal" form of having needs which demand fulfillment.

Annexure

The hard choices:

The new Prime Minister of India, Dr Manmohan Singh has spoken of making India 'world class' in health. What do we mean by 'world class in health' and how do we attain it? Do we mean that health services should achieve international standards in terms of state-of-the-art medical technology, specialists, and corporate hospitals with five-star

[18] Ritu Priya, Alpana Sagar, Rajib Dasgupta, Sanghamitra Acharya, "*CMP on Health, Making India World Class,*" EPW, July 03, 2004

comfort? Or do we mean appropriate, trustworthy health care through user-friendly primary level health services accessible to all, with equally trustworthy secondary and tertiary level public hospitals? Or that the Indian people attain the highest international indices for health status, e g, life expectancy reaches the 80 years of Japan, infant mortality and maternal mortality decrease to the 3 per 1,000 and 5 per 1,00,000 live births respectively of Sweden.[19]

One could well ask– are these mutually exclusive, can we not strive for all three together? If the first is the goal it will provide world class medical care for those who can afford it (or who get it as employees in the organised sector institutions). It will also set 'high' standards for all health services and bring the country financial resources and foreign currency through medical tourism. The second goal will provide the common people with affordable, comprehensive, preventive and curative health services. The third is, of course, the final outcome of all developmental activities. The writings of health policy analysts deal with these as very different visions of public health. The National Health Policy-2002 speaks of all three, but has been criticised for favouring the first and distorting the second. In the practical world divergent visions have often to be put together, especially within a democratic polity. When they cohere into a shared national vision they will lead to more coherent policy choices and a synergy of actions.[20]

What is required are improved livelihoods[21] through economic growth with distributive justice; a healthy environment through a sanitary and ecologically friendly development; healthy lifestyles that overcome under-nutrition without increasing over-nutrition; and good quality health care services accessible to all – in that order of priority. Nutritional and environmental conditions determine communicable disease prevalence and mortality, which despite a marginal improvement still constitutes 54 per cent of causes of death. Even today 48 per cent rural children under five years of age are moderately and severely malnourished and only 9 per cent are normally nourished. Well over one-third of adults suffer a chronic insufficiency of basic calorie intake. Additionally, over the last two decades unnatural causes (suicide, homicide and injuries) have increased manifold among the most productive age of 15-49 years of rural Indians (computed from Survey of Causes of Death, Registrar General of India). Deaths under conditions of destitution (due to excessive heat, cold and natural calamities) as well as those due to cardiovascular disease have doubled. Prevention of these causes of death requires amelioration of conditions of poverty and over-consumption, situations of social violence and mental stress. Some of this suffering and premature mortality can be averted by preventive services and timely medical care. Access and quality of health services become relevant here.

Some reflections on Poverty and Gandhis ideas.

[19] Human Development Report – 2002 – Deepening Decmocracy in a Fragmented World, United Nations Development Programme, Oxford University Press, New York, 2002
[20] Ritu Priya, Alpana Sagar, Rajib Dasgupta, Sanghamitra Acharya, 'CMP on Health – Making India World Class', Economic and Political Weekly, 3 July 2004
[21] Devaki Jain, 'Enabling Reduction of Poverty and Inequality in South Asia', Population and Poverty – Achieving Equity, Equality and Sustainability, Population Development Strategies, No. 8, (UNFPA, New York, 2003) pg 79-100

This "thing" called poverty: Poverty is the outcome of the tolerance of inequality by all of us and if there is a moral element in the amalgam it needs to be an ethic of intolerance of inequality of a certain kind – namely the existence of acute human deprivation in the midst of plenty. Such situations must be seen by us as an abomination – a rebuttal of humanness and personally redressed. Poverty is a reflection of inequality, and inequality is one of the causes of poverty

The existence of poor people is due to discrimination in all policies, political social and economic, a discrimination which sustains disparities and, the existence of women at the bottom of the poverty pile is an endorsement of discrimination.

Hence responses to this phenomena or "thing" called poverty have to react to discrimination and therefore need to be built around affirmative action, positive discrimination, an affirmation of rights, a political approach even more than an economic approach.

In my opinion one person who actually prepared and practiced the magical amalgam of morals, politics and economics which I suggest is necessary for removing this blot on our existence is Mahatma Gandhi, and at the risk of inviting ridicule I want to venture into a view of him.

It is my view that every era needs an Idealogue, a kind of pole around which the good people can mobilise and for this era it could be Gandhi. He was a strategic economist. His ideas linked to his political symbolism – his mass mobilisation – was brilliant. I suggest we bring him back into critical analysis in the discourse on political economy in discussions of development – not isolate him only in peace and conflict resolution debates.

He was not a saint or a spiritual figure as he is often projected. His clothing looks like that of some of the Hindu sadhus or hermits, but actually it was a loin cloth like an agricultural labourer would wear in India: Much of his life style choices were symbolic, a language of symbols to communicate with the Indian masses. Of course he had his eccentricities as we all have. I often interpret his dietary rules about eating uncooked food, sprouts and nuts as linked to his message to men that their wives should not be cooking elaborate meals for them. If people ate these kinds of foods, as indeed now they are eating pre-cooked foods, then household drudgery for women would be removed. This issue of total identification with the poor, getting under their skin, and beginning the journey of transformation from their location; this moral embarrassment with injustice, and embodying that injustice in one self, seems to me sound political economy, and at least less distant from the reality of the poor.[22]

Gandhi offers a discriminating tool, or norm that he calls his "talisman" and I have called the **"bubbling up theory of growth"**.[23] According to this line of reasoning, the criterion by which any political choice for economic changes is made, is whether it improves the

[22] Jean Johnson, *Gandhi Speaks Through Clothing*. New York University, 1997

[23] Devaki Jain, 'Enabling Reduction of Poverty and Inequality in South Asia', Population and Poverty – Achieving Equity, Equality and Sustainability, Population Development Strategies, No. 8, (UNFPA, New York, 2003) pg 79-100

condition of **poorest** person. If we deal with removal of poverty first, then the rest of the economic policies follow.

To quote Gandhi and his talisman, 'Whenever you are in doubt, or when the self becomes too much with you, apply the following test: Recall the face of the poorest and the weakest man/woman whom you may have seen and ask yourself if the step you contemplate is going to be of any use to him......". My friend Mahbub Ul Haq has also given the talisman pride of place in his South Asia Human Development report.1999.

Imagine if in the last 50 years of Independence, every Indian administrator, politician, businessmen, educated person, every citizen had used the talisman? Our entire goals of growth and progress would have been totally different. The poor and poverty eradication would have provided the best engine of growth. For, as they push themselves out of poverty, they would have generated incomes and purchasing power, a demand led growth path. **a Keynesian solution. And the struggle to develop a programme for health for the poor would not have been a separate agenda. Gandhi like those who support sustainable livelihoods believed that it is livelihoods that provide the base for removing poverty.**

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