

Speaking for Ourselves

Factors that influenced the development of health services in India

VIKAS BAJPAI, ANOOP SARAYA

INTRODUCTION

In an earlier paper,¹ we traced the development of healthcare services in India from colonial times till the launch of the National Rural Health Mission (NRHM). We emphasized that this development was guided by various national and international contradictions between social classes and countries. We now examine how these contradictions shaped the development of health services in India.

INFLUENCE OF CLASS CONTRADICTIONS ON HEALTH SERVICES IN INDIA

The development paradigm pursued since Independence has been structured, in our opinion, to primarily serve the interests of sections of society whose support is crucial for political parties to rule. The vast majority of the population has at best been provided minor concessions. In India, while on the one hand there is a very small but very wealthy group of people, on the other hand is the vast multitude (nearly 77% of the population) of people who struggle to seek an existence at a per capita daily consumption of up to ₹20 a day.² In between is a middle class of about 50 million people.³

The medical profession is a part of the elite section of Indian society and has fostered health policies which have led to the concentration of predominantly curative healthcare services in cities. There is pressure from within the profession as well as from the medical technology industry on the government to establish highly specialized services in urban centres. These services are expensive to set up and maintain and are available to only a small proportion of the population.⁴

To prioritize the health needs of the common people in India will potentially bring into question all national policies and privileges accrued through continuing iniquitous distribution of land, industrial resources, a dual education policy and monopolization of professional education by the rich. In a way an attempt to restructure healthcare will require restructuring of society; this premise is unlikely to be acceptable to the ruling political class and the social groups that constitute their support base.⁴

POST-INDEPENDENCE DEVELOPMENTS: THEIR IMPACT ON HEALTH SERVICES

At the time of Independence in 1947, India was a backward economy. Owing to poor technological and scientific capabilities, industrialization was limited and lop-sided. The agricultural sector

Jawaharlal Nehru University, New Delhi, India

VIKAS BAJPAI Centre for Social Medicine and Community Health

All India Institute of Medical Sciences, Ansari Nagar, New Delhi 110029, India

ANOOP SARAYA Department of Gastroenterology

Correspondence to ANOOP SARAYA; ansaraya@yahoo.com

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had features of feudal and semi-feudal institutions, resulting in low productivity. Means of transport and communication were underdeveloped, educational and health facilities were inadequate, and social security measures were virtually non-existent. Poverty and unemployment were widespread, resulting in a generally low standard of living.⁵

There were two economic models prevalent at that time which India could follow. One was of a socialist economy as in the then Soviet Union that built its economy by placing reliance on its own resources. The other was the economic model of development that had gained currency in the post-war scenario in the West.

Following an outright capitalist path of development was not feasible for a country like India. A plan for economic growth, known as the 'Bombay Plan' was proposed by seven leading Indian industrialists for the economic development of India.⁶ The plan proposed that 'in the event that the private sector could not immediately do so—establishment of critical industries as public sector enterprises while simultaneously ensuring a market for the output through planned purchases by the government.'⁷

On the other hand, the Keynesian economic model, which propagated predominantly the private sector but with a large role of government and public sector for macroeconomic stability,⁸ was gaining ground in the Anglo-American world as a way of building the war ravaged economies.⁹ Added to this was the notion that capitalism supported by the State would have a trickle-down effect and people down the social ladder would also benefit. The mixed economic model which India adopted was based on the principles of Keynes.¹⁰

Simultaneously the United Nations Monetary and Financial Conference was organized in July 1944 to regulate international monetary and financial order after the world war.¹¹ India participated in the conference as a member country.¹² The conference led to the formation of the International Monetary Fund (IMF) and International Bank for Reconstruction and Development (IBRD), later known as the World Bank to speed up post-war reconstruction and aid political stability. However, the main notion of the conference was open markets.

There existed an understanding in the world as well as in developing countries that they need not go through the tedious process of sociopolitical and economic development through which the countries in the West had gone, to ensure their development. All that they needed was to copy the model as established in developed countries. India thus embarked on a path which has been described as 'State-led capitalism'¹³ along the economic pattern being adopted in the West. The State became the entrepreneur and considerable physical infrastructure, heavy industries and knowledge institutions were created. However, there was little effort towards developing agriculture and the vast majority of people dependent on agriculture for sustenance continued to remain impoverished. Continued economic backwardness resulted in the lack of empowerment of vast sections

of the population and thus they lacked an effective say in policy matters, including the development of health services. Drawing its lineage from an international policy framework dominated by the West, the development process chosen provided a stable base for continued domination of western interests in our social, economic and political development—this process has been described as neo-imperialism.¹⁴

This development paradigm influenced the development of healthcare services in independent India. As Banerji has said: 'Each pattern of approach to healthcare emerges as a logical outcome of a given political, social and economic system. These forces generate an unwritten policy frame which influences the health of a population.'¹⁵ These influences are acknowledged in the deliberations of the Bhole Committee.

A mixed economy saw the public sector lead health service development along with growth of the private sector. Urban areas got over three-fourths of the healthcare resources whereas rural areas received 'special attention' under the community development programme (CDP).¹⁶ The vertical disease control programmes launched immediately after Independence with the financial assistance and technical guidance of western agencies subscribed to the belief that diseases could be controlled by taking care of germs through modern technological interventions. This ignored the social determinants of disease—inadequate nutrition, clothing, housing and the lack of sanitary conditions.

The National Malaria Eradication Programme (NMEP) was started in 1953 with aid from the Technical Cooperation Mission of the USA and technical advice of the WHO. The initial tuberculosis control programme put emphasis on BCG vaccination. These programmes depended on international agencies such as the UNICEF, WHO and Rockefeller Foundation for supplies of necessary pesticides and vaccines. Experts of various international agencies decided the policy framework, programme design, financial commitments, etc.¹⁶

However, these programmes and policies did not have the desired effect. The continuing lack of access to quality healthcare by the majority, more than two decades after Independence led to introspection on the choices made at the time of Independence. A number of committees concluded this to be the result of 'urban-oriented, curative, technology-centred evolution of health services alienated from the masses'.¹⁷ The fact that policy planners were time and again compelled to at least talk of reorienting this development is evidence of the need to change the then prevalent orientation of healthcare services.

PRIMARY HEALTHCARE: THE 1970s AND 1980s

Multiple events in the mid-20th century such as the oil embargo by Arab countries and the 1973–74 stock market crash,¹⁸ led to stagnation of major western economies, having high inflation due to industrial slowdown, shortage of production and high prices of goods.^{19–21} The defeat of the USA in the Vietnam war in 1975²² and the People's Republic of China joining the United Nations (and subsequently WHO) in 1971²³ led to changes in the global economic scenario.

The economic disparities between the 'haves' and the 'have-nots' persisted even in the western world.^{24,25} This led to major movements of people all over the world to force concessions for the impoverished, including a more pro-people healthcare. The entry of China into WHO compelled the world to take note of the impressive gains made by China in improving the health of its people through the model of 'barefoot' doctors and the innovative experiments in low-cost healthcare during the cultural revolution.²⁶

In this scenario, the goal of 'Health for all by 2000 AD' was adopted by the 30th World Health Assembly in 1977.²⁷ The Alma Ata conference in 1978 committed countries all over the world to achieve this ambitious social and political goal. Health was not merely a technical question but was placed in the centre of the entire social and economic planning of countries. It was recognized that providing 'Health for all' was a political goal. Health became a right of the people wherein achieving the highest possible level of health was considered necessary for the development of people. From the realm of theory, the goal of 'Health for all' was sought to be put into practice and 'primary healthcare' was the new 'bottom-up' strategy to achieve it as opposed to the earlier 'top-down' approach of the top heavy 'curative model' of healthcare. Health was no more to be the concern of individuals, but the prime concern of society.²⁸

However, most governments reneged on implementing 'primary healthcare' almost as soon as they committed themselves to it. Yet, that is not the failure of the idea. The idea continues to resonate in the hearts and minds of those who stand for the noblest of human values.

UNDOING OF ALMA ATA AND THEREAFTER

The interests of the medical industry (pharmaceutical, medical appliances, medical insurance and private for-profit healthcare) and politicians were threatened by the idea of primary healthcare. It was anticipated that 'proper application of primary healthcare will have far-reaching consequences, not only throughout the health sector but also for other social and economic sectors at the community level. Moreover, it would greatly influence community organization in general. Resistance to such change is only to be expected ...'²⁹

Health ministries in developing countries, prompted by international funding agencies and consultants, began to launch national programmes based on primary healthcare. However, in practice the same 'top-down' approach continued. To maintain this new image, the progressive language of Alma Ata was adopted in official communications including expressions such as 'people's participation', 'decision-making by the people' and 'empowerment'.³⁰

'Central control, however, remained intact. While community participation was encouraged, it was generally the participation of weak compliance, rather than strong participation of decision-making control. Community health workers (CHWs) were trained, but rather than being the most important members of the health team, they were relegated to the lowest, most subservient position in the existing health hierarchy.'³⁰ This sounds like the familiar story of trial and errors by health policy-makers in India.

SELECTIVE PRIMARY HEALTHCARE

Concerned about the identification of the most cost-effective health strategies, Rockefeller Foundation in 1979 sponsored a small conference titled 'Health and population in development'. The goal of the meeting was to examine the status and inter-relations of health and population programmes as the organizers felt there were 'disturbing signs of declining interest in population issues'.³¹ Important global agencies participated in the meeting—the World Bank, the Canadian International Development and Research Center, the Ford Foundation and the US Agency for International Development, among others.³² So the large players of the international policy establishment were all represented.

The conference was based on a published paper titled 'Selective primary healthcare, an interim strategy for disease control in

developing countries'.³³ The paper sought specific causes of death, and paid special attention to the most common diseases of infants in developing countries such as diarrhoea and diseases caused by the lack of immunization. The authors did not openly criticize the Alma-Ata declaration. They presented an 'interim' strategy or entry points through which basic health services could be developed. They also emphasized 'attainable goals' and 'cost-effective' planning. Selective primary healthcare was introduced as a new perspective at the meeting. The catch phrases were 'attainable goals' and 'cost-effectiveness'. In our opinion these implied being practical and not sentimental about people's health, hinting at primary healthcare being good but not quite feasible. Primary healthcare was thus supplanted by selective primary healthcare. The opportunity for the development of self-reliant health systems in developing countries offered by the 'primary healthcare' approach was thus lost to 'selective primary healthcare'.

REAGANOMICS AND THATCHERITE CONSERVATISM

A nearly decade long recession and inflation in major economies in the Anglo-American world led to disillusionment with Keynesian economics. The counter-revolution was led by free market economist Milton Friedman of the 'Chicago School' fame, whereby 'altruistic pretensions' of the State came under increasing attack.¹⁰ In the realm of politics, it led to the resurgence of the right. In England Margaret Thatcher of the Conservative Party came to power in 1979 and helped 'topple the welfare state and make the world safer for capitalism'.³⁴ In the USA, Reaganomics displaced Keynesianism in 1981. The displacement of Keynesianism was a gradual process—it began with implementation of monetary policies to control the rising inflation, transforming into a 'silent revolution' displacing development economics with free market influences by the mid-1980s.³⁵ In South America, efforts at displacing development economics were more upfront such as the 1973 coup in Chile and other military dictatorships, which brought in governments strongly favouring free market economies.³⁶ In developing countries of Africa and Asia the commitment to development economics largely faded away and by the mid-1980s the free market agenda was broadly accepted.³⁷ Even in erstwhile socialist China, the leadership launched pro-market reforms under the garb of 'Socialism with Chinese characteristics' in 1978.³⁸ These developments set the tone for gradual jettisoning of the 'socialist rhetoric' in India, which had hitherto served as an effective cloak for an otherwise private capital-friendly orientation of the economy.

IMPACT OF THESE DEVELOPMENTS ON HEALTH SERVICES

We have traced through the article how the policy orientation of the Indian health establishment had dovetailed that of their role models in the West. The national and international developments were no exception to this phenomenon. The withdrawal of the State almost all over the world from the realm of social welfare was epitomized in Reagan's presidential inaugural speech by the words 'government is not the solution to our problem, government is the problem'.³⁹ Ronald Reagan's views against 'socialized medicine' had been known since 1961 when he 'criticized social security for supplanting private savings and warned that subsidized medicine would curtail Americans' freedom' and that 'pretty soon your son won't decide when he's in school, where he will go or what he will do for a living. He will wait for the government to tell him'.⁴⁰

In the UK, Thatcher made an attempt to dismantle the National Health Service of Britain.⁴¹ The cynicism of the Thatcher era is reflected in her statement: 'There is no such thing as society.

There are individual men and women, and there are families. And no government can do anything except through people, and people must look after themselves first. It is our duty to look after ourselves and then to look after our neighbour.'⁴²

These developments were mirrored in the health policy in India. The involvement of the Indian State in caring for the health of its people, which at no point was comprehensive, started becoming even more subdued. By the 1980s, private healthcare in India had started acquiring a dominant role. Data in the 1980s from small as well as national level studies by the National Sample Survey and the National Council of Applied Economic Research (NCAER) provided evidence of the overwhelming dominance of the private health sector in India.⁴³ Additionally, the 'World Bank' came to have an increasing say in our health policies, as well as those of other developing countries.

THE 1980s BALANCE OF PAYMENT CRISIS AND ITS IMPACT ON HEALTH

The debt crisis in developing countries, which reached a peak in 1982, had its genesis in the mid-1970s. The oil crises of 1973, as a result of the Arab-Israeli war, and that of 1979, meant a windfall in terms of increased income for petroleum-producing countries resulting in massive build-up of surplus capital by OPEC (Organization of Petroleum Exporting Countries) countries in banks in western countries. The OECD (Organization for Economic Cooperation and Development) countries encouraged the use of this capital for loans to developing countries on very liberal terms, and often without careful credit analysis.⁴⁴

In the face of ongoing stagnation, inflation and political reasons, aid from western countries to developing countries dried up, thus creating an imperative for increased borrowing from western banks flush with cash. This borrowing spree in most cases led to the purchase of consumer items, obsolete equipment and machinery in keeping with the premise of aping the West to develop yourselves, or for projects that never took off or later became 'white elephants'.⁴⁴

There was a gradual build-up in the external debt of Third World countries from the 1970s until it reached unmanageable proportions in the early 1980s. Simultaneously, there was a drop in international prices of primary commodities (cash crops such as cotton and mineral ores) which were the primary exports of Third World countries; this further worsened the debt crisis.⁴⁴

Corruption, political instability in many developing countries and lack of governmental management expertise were some other factors which compounded the situation. The balance of payment crisis reached a point where countries were obliged to take further loans from multilateral agencies for servicing the interest on loans. These loans came with strings attached, having wide-ranging consequences for the sovereignty of the countries and welfare of the people.

BRETEN WOODS CONDITIONALITIES AND CONSEQUENCES FOR HEALTH

It is now widely acknowledged that the structural adjustment programme implemented as a part of the 'New economic policies' in various Third World countries came as a necessary condition for the loans given by the World Bank and IMF to these countries, especially since 1980. Some of us have lived and experienced the current phase of 'structural adjustment' in healthcare in India since 1991 with the unleashing of globalization. We now discuss the essence of these policies which have led to the growth of market-oriented healthcare services.

The structural reforms began much earlier than what is commonly believed. India had embarked upon substantive reforms in economic policies in the early 1980s when it decided to approach the IMF for a loan of more than US\$ 5 billion (the largest loan given by the IMF till that time) by accepting conditions which were widely believed to have compromised India's sovereignty.⁴⁵ Fiscal prudence in the form of a structural adjustment programme was initiated with gusto.

The essence of this programme was conversion of erstwhile 'market economies' to 'market societies'. In the words of John Gray, Oxford professor of political science and a staunch Thatcherite, the difference between the two is that, while in market economies, 'markets are embedded within the broader social relations and, in part, constrained by them'; in market societies, 'society is made to run as if it is more or less an adjunct to the market'.⁴⁶ The implication of this is that while in market economy it might still be possible that the private health sector shares social concerns for the health of the people apart from the profit motive; in a market society the unabashed use of healthcare for pursuit of profits becomes an exalted virtue. Even public sector healthcare does not remain untouched by this. Market principles such as revenue generation, and monetary incentives for doctors and paramedical staff have become accepted norms in public sector healthcare. Worse still, it is projected that people would work only under two conditions—either for incentives or for fear of losing them. It seems none would work because to work for creating a better society is an essential human trait—an idea that is problematic. There apparently is little desire to alter the system that neither provides the conditions where one's work becomes the overriding virtue, nor acknowledges the work of the selfless millions in India.

The results of such an orientation are available for us to observe and reflect upon. A qualitative study in the 'Subaltern healthcare consumption under neoliberalism' in India, undertaken in a large city (Kanpur), gives us a glimpse of the present scenario. It was found that the biggest state-owned hospital in the city, which was traditionally an important source of healthcare for the subaltern groups, despite having an excellent infrastructure, was dogged by the apathy of physicians and support staff towards servicing the needs of the subaltern consumers. Patients repeatedly complained that physicians and paramedical staff did not provide proper care to the subaltern groups because of their enfeebled socioeconomic position.⁴⁷

COURSE CORRECTION

The disaster of 'globalization' and 'structural reforms' in terms of human development became too obtrusive to be ignored, either nationally or internationally. Slowly but steadily, the virtues of the 'welfare State' are being reinvented to give globalization a human face. Paul Krugman (the American economist awarded the Nobel Prize for economics in the year 2008) cites Gregory Mankiw to say this of Keynes in the backdrop of the current economic meltdown: 'If you were going to turn to only one economist to understand the problems facing the economy, there is little doubt that the economist would be John Maynard Keynes. Although Keynes died more than a half-century ago, his diagnosis of recessions and depressions remains the foundation of modern macroeconomics. His insights go a long way towards explaining the challenges we now confront.'⁴⁸

Krugman is not the only one to remember Keynes. Joseph Stiglitz (Nobel Prize laureate and former chief economist of the World Bank) and Professor Amartya Sen have also written about the role of the State in safeguarding public good. No doubt, having

rocked a gaping hole at the bottom of the world economy, the world's biggest bankers wanted State bailouts to save them. The system needs to be bailed out, hence the need to eulogize Keynesianism.

Alerted by the bombed 'Shining India' campaign of the National Democratic Alliance government, the United Progressive Alliance (UPA) I government led by the Congress came up with programmes such as the NRHM, the Mahatma Gandhi National Rural Employment Guarantee Scheme (NREGA) and now the Food Security Act. One government committee after another declared that the levels of poverty in India were much higher than what the Planning Commission would otherwise have us believe. The health and human development indicators of India have dipped even below those of some sub-Saharan countries. Hence, the virtues of 'primary healthcare' are sought to be reinvented in the NRHM. However, these steps do not betray any desire on the part of the rulers to bring any paradigm shift. NRHM is in its second phase of implementation and the report of the Sixth Joint Review Mission showed that we were far from achieving the targets set before the mission.⁴⁹

From the Bretten Woods Conference to the economic meltdown of 2008, the world has indeed, come a full circle. The point, however, is: do we wish to just keep moving in circles? We have detailed how the interests of the national and international expropriating class thwarted aspirations of the labouring masses of India to build a humane and just health system. The need is to defeat the conspiracy; break the circle.

CONCLUSION

The evolution of the healthcare system cannot but be understood as a dialectical process that impacts almost every sphere of human activity. Hence, the solutions to the problems and challenges facing the development of a humane and just healthcare system can only evolve through an understanding of this dialectics. This is either not considered necessary by health professionals or dealt with casually as something that can be learnt any day. Rarely, if at all, do we see the functional utility of this understanding. This approach needs to change.

Healthcare is an inherently political issue. To address the problems facing healthcare in India, there is a need for a change of the socioeconomic and political conditions. Those of us, who stand for a healthcare system free from the pervasive control of the market, need to take a stand and work for systemic change.

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