POLITICAL ECONOMY OF HEALTH CARE IN INDIA

An Outline

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Medicine is not a socially independent activity. It is always articulated within a specific mode of production. Therefore, the dominant medical practice in India is bourgeois medicine and health care helps to strengthen and expand the capitalist mode of production. It also reproduces the capitalist relations of production at every level of its operation. The development of health care in India is examined in the context of the dynamics of socio-economic changes which have taken place since independence.

"My inquiry led me to the conclusion that neither legal relations nor political forms could be comprehended whether by themselves or on the basis of so-called general development of the human mind, but that on the contrary they originate in the material conditions of life, the totality of which Hegel, following the example of English and French thinkers of the eighteenth century, embraces within the term 'civil society'; that the anatomy of this 'civil society' however has to be sought in political economy."

Karl Marx
Preface to
A Contribution to the Critique of Political Economy.

Every human being, in the last analysis, after removing all covers of social existence, is natural and therefore, biological. The flesh, blood and bones comprising the human body are too materialistic for anyone to deny their existence. But this natural living individual is not a lone, isolated entity. Through centuries of social development, the individual has evolved socially, coming into interaction with nature and while transforming it, has himself/herself been transformed. In the course of this social development, human beings have entered into various types of relationships in order to produce the necessary means of subsistence and to reproduce his/her own species and so given rise to the complex organisation of, to use Hegel's term, the 'civil society'.

The 'natural' or the biological forms the fundamental basis on which, historically, the social existence of human beings has developed. In the course of this development completely new forms of objectivity have arisen and although such objectivity have no analogy in nature, they still remain socially transformed natural objectivities.

To illustrate, in primitive societies, the exchange of necessary goods was not the rule but, more the exception. Here the natural use of those goods, to satisfy hunger or other needs was the predominant consideration. But with the evolution of a more complex social organisation leading to the evolution of a social system based on commodity production such goods which were necessary and useful for life also acquired, exchange value of their own. Every commodity in the capitalist economy has therefore, two characters, the use value and the exchange value. But this exchange value cannot be located or identified in the commodity. Exchange value is then, an exclusive social category which has no analogy in nature. "The main tendency of the developmental process that arises in this way is the constant increase both quantitative and qualitative of purely or predominantly social components, the 'retreat of the natural boundary' as Marx puts it. "(Lukacs, 1978).

Health and medicine are such social categories which have reference not simply to the biological existence of the human being, but to the social nature of such existence. That is why the understanding of health has changed according to the needs of different social systems and the needs of the ruling elite of that social system..

Features of the Marxist Approach to the Critique of Political Economy of Health

Four major features of the Marxist approach to the political economy of health may be identified—

The Social Production of Illness : Medical definitions of health and illness are located in the clinical pathology of the individual. In its narrowest and most limited form this definition locates the cause of disease entirely in the human body and disease is seen as a consequence of an unwanted attack of biological entities, bacteria, or virus, on the human body. The control of disease is seen to mean the control or eradication of these bacterial or causative agents. The concept that ill health is

directly related to the socio-economic formation and to the production relations in society has been put forward by several analysts since Engels wrote the *'The Conditions of the working class in England'*. Turshen traces the origins of what is termed the 'clinical paradigm' and discusses its weakness. According to her the discipline that comes closest to explaining the notion of collectivities is medical ecology. "Medical Ecology, thus asserts a 'relationship between environment, disease and man but selects only biological and socio-cultural factors as relevant." (Turshen 1977). This too ignores the illness generating forces in society. Doyal and Pennell in their book *Political Economy of Health* have elaborated on the evolution of the clinical paradigm in modern medicine. They discuss the direct and intimate relationship between the process of commodity production and destruction of health and between economic underdevelopment and health. (Doyal & Pennel, 1981). This view does not exclude or deny the operation of the biological mechanism which cause illness. The concept that ill health can only be understood as a consequence of the dynamics of class contradictions in society, and that the occurrence of disease is intimately related to the social formation within which the biological, physical and chemical operate is one of the major marxist contributions to the critique of political economy of health.

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Health as labour power: Under capitalism health is defined as an integral component of an individual's labour power or productive capacity. Labour power being a commodity under capitalism has a specific exchange value — the quantity of social labour necessary to reproduce it.... just as any other commodity does. In other words, the exchange value of labour power is the value of consumer goods and other services necessary to keep the worker and his/her children fit enough to work at a given intensity of effort. But to maintain this level of effort, or the maximum level of productivity, a certain level of physical and mental health is vitally necessary. Below that level of health the capacity to work falls off, and with it, the amount of surplus value that will be generated. The capitalist is simply not interested in the level of health beyond this, even though the worker will be vitally interested from the point of view of the quality of life and not of productive capacity (Schatzkin, 1978).

From this point of view of health as labour power, Schatzkin argues that medical care services are designed for maintaining the requisite level of health, a kind of labour power 'repair and maintenance service'. While educational services help to maintain the knowledge and skill component of work capacity, medical services help to maintain the physical and psychological components. Since the provision of health is part of maintaining labour power, it represents to the capitalist, a part of the wages he must pay out, directly as wages or indirectly as 'social' wages in the form of medical services.

The commodification of health care: A commodity is an external object which through its qualities satisfies human needs of whatever kind and is produced for exchange in the market. Health care is one such commodity. Historically, throughout most of human history, health care was an organic part of a communal society. It has often been indistinguishable from religious or social activities, none of which were exchanged (although gifts were often presented to traditional healers). As communal societies were conquered by feudal and eventually capitalist societies, health care was taken out of the hands of traditional healers, and placed in the domain of doctors and midwives, who engaged in health care for a price i.e. as part of a money exchange. The physician was an independent producer selling the product of his or her own labour. (Roder and Stevenson, p. 19-108).

But "capitalist production is not merely the production of commodities, it is by its very essence, the production of surplus labour" (Marx *Capital*, p. 644). The capitalist can organise the production of surplus value through the provision of health care and can realise high profits in this service industry. It is immaterial whether the surplus value is realised directly through the productive activities in the clinics and hospitals owned by the capitalist or indirectly, through the provision of health care by the state to maintain or increase the productive capacity of labour.

Medicine as a social relation: Vicente Navarro has concretised our understanding of how medicine should be viewed within the perspective of the social system. He argues that medicine or health,

services is a social relation and reproduces the dominant relations of production. Medicine, therefore, has been different under different modes of production. He argues that since the mode of production is reproduced not only at the economic but also at the political and ideological levels, medicine contributes to the reproduction of the mode of production at the economic, political and the ideological levels and that medicine is always articulated within a specific mode of production.

These are the features of Marxist approach or methodology which we will use to examine the political economy of health care in India. But any attempt to examine the development of health care in India in the context of socio-economic development brings into focus the subject of the mode of production in Indian agriculture. We are aware that this subject has generated a lot of debate amongst Marxists in the last decade and there are divergent viewpoints. We will not here review the entire debate that has taken place nor put forward our viewpoint on the subject and substantiate it. Our focus is the political economy of health care. We will, therefore, endeavour to show that, the very efforts of the Indian State to penetrate the remotest corners of the agrarian set-up through the provision of health care facilities; is not any isolated and non-social phenomenon. But the efforts in fact strengthen and reproduce the already existing and expanding capitalist relations of production (whether in "pure" forms or intertwined with the pre-capitalist forms).

At the same time, we must admit that this analysis is our first attempt and the vastness of the exercise has made us very aware of the inadequacies in the sphere of information and data. The most evidently thin area of the outline is the lack of analysis and attention to the social roots of ill-health and disease in India. By and large, we have merely assumed that the patterns of illness are reflective of the class, caste and sexual contradictions and are influenced by the level of development, both quantitative and qualitative, of the social system. We have also assumed that changes in the patterns of illness are directly related to changes in socio-economic system, and have proceeded to focus on the changes in health care in light of the change in the mode of production. Our objective is to locate the crisis in health care and medicine within the larger political perspective for class struggle.

Health care under British imperialism

Western medicine came to India in the 17th century. The first medical men to set foot on the sub-continent were the surgeons sailing with the merchant ships of the maritime nations of the time. Throughout the century a number of Europeans found employment as surgeons and physicians in the Courts of the kings and nawabs. By the end of the 18th Century all the factories of the East Indian Company had at least one surgeon in their employ and the Indian Medical Service had been founded (Crawford, 1914).

At that point of time the medicine practised by the company doctor was hardly different from local systems. The doctor of the day had a limited range of therapeutics and curative procedures : . . . herbal medicines, a very few disease-specific chemical preparations, the new 'exotic' drug the Peruvian cortex (cinchona) for intermittent fevers, blood letting, venesection and other such procedures which had been in vogue since the time of Galen. The birth of modern scientific medicine was yet to be. In the following century however, there were enormous developments in the content, theory and practice of medicine in Europe. Not only had the knowledge base of medicine expanded but it was being structured to meet the needs of the dominant class. For instance, the two major disease casuality theories that were competing for acceptance, the coptagion theory and an environment theory were more than medical theories and theirincorporation into contemporary medical thought was dependent on how they affected the operations of the dominant class of the time. During the first half of the 19th century the contagion theory which suggested quarantine measurs as a means of controlling disease, was the best accepted. But with the increased movement of goods and of people towards the middle of the 19th

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century, quarantine measures proved ruinous to the new entrepreneurs and merchants. One important reason for the acceptance of the miasma theory which located the cause of disease in unsanitary conditions was the potentially disastrous effects the acceptance of the contagion hypothesis would have caused (Tesh, 1982).

By the end of the 19th century, the sanitary reform movement in Britain had resulted in limited state intervention in the form of legislations and in the creation of institutions for administering them. But these reforms were actually self-limiting. Although they affected a section of the capitalists whose profits came from housing, water supply and sewerage dealerships, they served the needs of capital by decreasing the cost of disease. At the same time public health work and preventive medicine could never gain the status nor weild the same influence as clinical medicine. Public health work highlighted the shortcoming of capitalism and it would mainly benefit a class which was incapable of conferring status. (Turshen, 1977). On the other hand, clinical medicine with its focus on the individual rather than the social conditions underlying disease states offered a means of diverting public attention from the ills of capitalism.

"One of the aims of the planning was to aid the capital accumulation in the private sector."

The origins of the sanitary reforms in India are rooted in a different set of circumstances. After 1857, and the take over by the Crown, the number of troops on Indian soil increased and the health of the army became a subject of discussion. Moreover, cholera which had been confined to India so far broke out in a devastating epidemic in Europe. The British colonial government was pressurised into initiating sanitary measures in the Presidency areas. But these measures did not give rise to a public health system and the government chose instead, to encourage the setting up of medical research facilities for the assault on tropical diseases, an assault master minded in England. (Ramasubban, 1982).

Outside the government framework, a number of missionary groups and individuals had also begun to set up hospitals and medical institutions. For instance, a number of maternity hospitals and training centres were set up to teach midwives the 'modern' methods of childbirth. The funding for these came from wealthy Indians who wished to set up hospitals as memorials. (Billington, 1973).

Medical Colleges were set up to train assistants and a large number of Indians were taking avantage of the opportunity. The upper castes were specially encouraged to enter these colleges. Right from the beginning allopathic medicine in India acquired an upper caste elite base. (Banerji, 1974). Women too were given special concessions, so that the new maternity homes could be well-staffed.

The development of 'scientific' clinical medicine which embodied bourgeois ideology and relations of production was far more important than the creation of a public health system which might expose the true nature of British imperialism.

The health care network under the British comprised desultorily implemented sanitary measures and a fair number of hospitals and dispensaries with a growing number of medical research facilities undertaking work on tropical diseases under the tutelage of European doctors and researchers.

The path of development consciously adopted by the Indian ruling classes at the time of Independence.

The increasing popularity of modern allopathic medicine amongst the Indian elite strata was not an accidental phenomenon. It was rather a part of the process of emergence of Indian bourgeoisie as an economically powerful and politically shrewd class under British imperialism. As we will show later in this section, the choice of modern allopathic ("scientific") medicine as a basis of development of health-care system in India was deliberate (despite the fact that other choices and concrete proposals existed), and was in consonance with the path of socio-economic development adopted by the Indian ruling classes. To substantiate this statement, we will examine the situation at the time of independence under three headings : a) the strength of Indian bourgeoisie at the time of independence, b) the political and economic strategy adopted by the Indian bourgeoisie for strengthening its class rule, and c) the health care strategy adopted as a part of development perspective.

(a) The strength of the Indian bourgeoisie at the time of independence : On the eve of independence, although, India's total economy was overwhelmingly agricultural, substantial industrialisation had taken place. In fact, India was much

better placed than most other colonial or semi-colonial countries of that time.

India's domestic capital, at the time of independence nearly occupied an equal place with foreign capital in Indian economy.(Bettelheim, 1968). According to the same source, foreign capital's sphere of influence was particularly in the principal foreign currency earning industries (tea, jute and cotton) and in those which were the main sources of power in India (petroleum, coal, electricity).

In assessing the political strength of the Indian bourgeoisie at the time of independence, two points should be understood. Firstly, Indian capital had to develop under the tight control of British imperialism. In its confrontation with foreign capital and imperial policies, it was but natural that a tendency developed towards developing stronger economic and political organisations of its own. Moreover, Indian Capital did not develop through "free competition." Due to several intrinsic factors specific to India, and due to the fact that World Capital was already at the monopolistic stage, there was naturally a tendency for Indian industral capital to take monopolistic forms. This situation helped it to organise its various groups with much more ease and also made it more shrewd and alert in extending right political patronage.

Secondly, the Indian bourgeoisie was politically shrewd enough to understand the importance of Gandhi's ideology of harmony between capital and labour. During the 1918 textile workers' strike in Ahmedabad the newly formed Bombay Mill-owners' Association utilised this opportunity to establish contacts with Gandhi. Subsequently in 1921, with the launching of the Swadeshi movements they found in Gandhi a representative leader and in the Congress their representative Party. It is important to note that from this point onwards, the bourgeoisie never lost its political leadership of the nationalist movement. Thus, at the time of independence, the party of the Indian bourgeoisie, the Indian National Congress maintained its leadership of the nationalist movement and very meticulously implemented the strategy of the Indian bourgeoisie for the post independence growth of capitalism in India.

b) The political and economic strategy adopted by the Indian bourgeoisie for strengthening its class rule: The Indian independence was not a social revolution in which, one class through violent means seizes political and socio-economic power from another. In fact, independence was just transfer of political power from British imperialism into the hands of Indian bourgeoisie, keeping the socio-economic structure of the society more-or-less intact. Moreover, under the Mountbatten plan this transfer was affected through negotiation and bargain. Therefore, after taking over the reins of State power, the Indian bourgeoisie did not adopt radical measures attempting to do away with India's pre-capitalist forces. In so far as those forces did not seriously obstruct its plan of gradual transformation of Indian agriculture through state intervention it adopted a policy of compromise and accommodation.

At the same time, in the turbulent 1940s the Indian bourgeoisie feared the militancy of the working masses. It should be noted that from the later half of 1930s, the mass unrest had attained serious proportion. On the industrial front, the number of strikes in 1937 reached 379, the highest since 1921. Between 1942 and 45, the cost of living went up by 200 percent. The year 1940 saw another strike wave, in which workers of cotton textile, jute, oil, coal, iron, and steel and many other industries participated. The number of trade unions went up from

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188 in 1938 to 515 in 1944 with the membership rising from 3,65,450 to 5,09,084 (Dutt, 1983).

At the same time, the All India Kisan Sabha, which took a leading role in fighting against government repression and had helped organise self-help movements for food and funds, quadrupled its membership between 1942 and '45. (Dutt, 1983, p. 279). The end of the war saw two significant peasant movements - the Tebhaga movement between '46 and '47 in what is now Bangladesh and the Telangana struggle in '46 and '51 in Andhra. These were the most outstanding indicators of peasant ferment brewing all over the country.

The political ferment also spread to the armed forces in '46. The RIN mutiny and the support it gained in Bombay from the working class and middle classes shook the Indian bourgeoisie. Thus although, the Indian left, because of many reasons into which we cannot go in in this article, could not destabilise the bourgeoisie nor have a perspective

to take control of the national movement, the latter was forced to recognise the explosive potential for militancy among the labouring masses. The realisation that the mass pressure the bourgeoisie had so far used to their advantage could get out of hand, forced them into granting concessions in the overall plan of development at independence.

In the context of the above, the bourgeois strategy that developed after independence was twofold. Parliamentary democracy was accepted because it would widen the mass base of the regime, to give room to the contending socio-economic forces in the governmental block and to provide a safety valve for mass discontent. This method of bourgeois rule granted universal franchise, formal political democracy, equality before the law and so on all at one stroke. In the Constitution, it gave the State Power a clear bourgeois impress by making the right to private property a fundamental right. The right to work, the right to receive free health care, education and so on were not included in the list of fundamental rights but were relegated to being directive principles. Also, for the future socio-economic development of India, planning with the active intervention of the State in the economy was adopted as the best way for industrial development and for the transformation of backward agriculture.

"The expansion of capitalism is dependent on a politically stable and healthy labour force."

Briefly, the aims of planning with the active State intervention in the economy were the following: (i) To develop an infrastructure of the heavy industry, transport, communication, and energy, so vitally necessary to overcome the most glaring weaknesses of industry or the under-developed capital intensive industries. This development required huge investment and a long gestational period for invested capital, the private sector was not yet ready for this. (ii) To aid the process of capital accumulation in the private sector. This was to be done providing private capital with easy access to the infrastructure, by employing private contractors in the operation of public sector, by enriching individuals or groups of individual bureaucrats and so on, and (iii) To carry out limited agrarian reforms, to provide facilities for agricultural development and strengthen and expand existing bourgeoise forces leading ultimately to the modernisation of agriculture on a capitalistic basis.

c) The health care strategy adopted as a part of the development perspective : At the time of independence, three major reports concerning the health system in the new nation saw the light of the day. In 1939 the national planning committee had set up a subcommittee to prepare a plan for health. In 1940, the Chopra Committee was constituted at the first health minister's conference. And the Bhore committee began work in 1943, and was charged with the task of conducting a survey of the entire field of public health and medical relief on which to base plans for post-war development in the health field. (Bhore, 1946). It advocated a doctor-centered system of health care and urged the creation of a vast health infrastructure. Its main inspiration were the Flexner report (which consolidated the establishment of 'scientific' medicine in the US) and the Goodenough Committee (which had been a more recent report restructuring medical education in U.K.). Briefly, the Bhore committee recommended (i) the main focus of all health measures should be to enable people to enjoy life to the fullest extent and to help the individual reach his maximum level of productive capacity; (ii) the future health care system should be a doctor-based, hospital-centered system with a proliferation of health institutions; (iii) a salaried service should be preferred over private practice although "any apprehension that private practitioner will be seriously affected to their detriment by our proposals for a state health service is unfounded." (Bhore, 1949 p. 16); (iv) occupational and industrial health was an important aspect of health services; (v) maternal and child health was to be given a high priority; and (vi) consequent on the development of a health infrastructure, the pharmaceuticals and the surgical goods industries would have to be encouraged to expand.

The Chopra committee (the committee on Indigenous System of Medicine) report was published in 1948 and made recommendations which, had they been implemented at that time, would have resulted in a drastically different system of medicine. It saw an urgent necessity for evolving one unified system. It pointed out that the Bhore Committee had been rather silent on the question of indigenous systems in their grand plan for the development of health services in India. The Chopra Committee, in fact, had drawn up a plan for health services where the primary levels would mostly use indigenous system and the taluk hospital and beyond would practise 'synthesised' medicine. Almost all the recommendations were rejected. It

was decided that a full course in modern scientific medicine was to be the basis on which other systems were to be engrafted.

The Indian bourgeoisie opted for a model of health care service in which health care could be transformed into a commodity. Even in adopting the recommendations of the Bhore committee, it selectively incorporated those recommendations which contributed to the growth of the health infrastructure and the consolidation of bourgeoisie and its concomitant organisation. The development and consolidation of allopathic 'scientific' medicine was also a deliberate choice which offered several advantages which we will elaborate in a later section. For the moment, it is sufficient to state the supposed resolve of the Indian bourgeoisie to develop indigenous systems did not get translated into any meaningful programmes and India was well set on the way to enlarging the world base for the practice of 'scientific medicine'.

First fifteen years of Planning

(a) Growth of industries hastening captial accumulation : The public expenditure on development in the first three five years plan period was as shown in Appendix 1.

From the second plan, Industry and mining started receiving the attention of the planners and in the third plan it got the first priority. The major investment in this branch was in heavy industry. By 1965, substantial changes took place in the industrial structure. The gross value of output of light industry increased from Rs. 17,100 million in 1951 to 35,900 million in 1965, i. e. it more than doubled in 15 years. In this period, the output value increased by 8.5 times in the heavy industry. The share of heavy industry in the total output of manufacturing industries went up from 22 to 52 percent. The investment in heavy industry went up from 43.4 percent of the total investments in the manufacturing industries in 1951 to 79.8 percent in 1965. (Shirokov, 1980).

Thus, at the end of third plan period, the public sector had set up productive plants mainly in the sphere of heavy industry. It could do this by receiving soft-term loans from the Soviet and other 'Socialist' countries.

Even while developing the industrial infrastructure, in this period a slow but steady transformation of the Indian agrarian sector, was also begun.

(b) The Transformation of Indian agriculture The progress in the agricultural sector in the first fifteen years can at best be termed modest. The production of food grains recorded a much smaller growth than that of cash/industrial crops. The rise in grain production did not outstrip or even equal the rise in population. The sectoral allocations in the first plan gave first priority to agriculture, community development and irrigation which together accounted for 35.8 percent of the outlay. After that, the percentage share of the outlay in these areas consistently decreased.

Throughout this period agrarian legislation strengthened the position of the rural upper classes. The richer peasantry were able to gain greater freedom from their landlords and were able to increase their holdings. The big landlords were being transformed into capitalist farmers. The conditions of the poorer peasantary considerably worsened during these years. On the whole there was a slow development of rural capitalism. (Betteleheim, 1968).

Agrarian reforms were in this period directed not so much at transforming the modes of production in agriculture, as adapting the colonial agrarian structure to fit the pattern of growth envisaged by

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the bourgeoisie. They were directed at eliminating the intermediaries and middle men and reducing the effect of feudal and semi-feudal relations. Agricultural policies and programmes favoured those landlords who had undertaken cultivation on their own, rather than rentier landlords (Joshi, 1969). The non-implementation or failure of those portions or land reforms or the 'failure of land reforms' was not surprising, considering as Davey remarks aptly, that the state assemblies were dominated by landlords and kulaks. Likewise, land ceiling legislation was easily circumvented. The Failure to ensure security of tenure has resulted in evictions. In the Punjab alone, the number of tenancies fell from 583,400 in 1955 to 80,520 in 1960 (Davy, 1975).

The Community Development Programme, launched with US aid in the first plan further strengthened the economically and politically dominant classes. Later evaluations showed that 70 percent of the benefits from agricultural extension went to

the elite groups, the more affluent and influential agriculturists" (Dubey, 1969). The CD projects worked through existing village institutions which were more often than not, dominated by landowning groups. The 'Shramdan' drive which was supposed to encourage people's participation, in terms of free labour on road construction and repair, was usually contributed by the poor who had nothing to gain from roads; while those who benefitted from the roads, the large landholders who needed to transport goods out, got away by merely supervising. The CD programmes not only strengthened the rural elite but also created bureacratic institutions which acted as a link between the rural-elite and the government.

After 1960, agrarian policies and programmes became openly favourable to rich peasants. The Ford Foundation sponsored Intensive Areas Development Programmes with its packages of credit, modern inputs, marketing facilities and technical advice was one such. This meant also the increasing use of high yielding varieties and fertilisers. Between 1960 and 1966 the consumption of fertilisers more than doubled (Davey, 1975). The two disastrous droughts in '65 and '67 upset bourgeois plans of strengthening and developing rural captitalism.

"Bourgeois radicalism either in the form of reports or legislations or programmes can best be viewed as concessions gained by working class militancy."

(c) Health Care in a Planned economy: The evaluation of health services and the growth of medicine in India can only be analysed in the background of the development strategies employed by the Indian bourgeoisie. As we have seen the primary aim of Indian capitalism at independence was the consolidation and expansion of capitalist relations and the transformation and integration of pre-capitalist mode of production. Accordingly, the health strategies that were chosen directly or indirectly supported and strengthened the drive for capital accumulation.

There were four factors, one may call them constraints, which limited the bourgeoisie's options in the health sector. Firstly, they functioned in an economy linked to and subservient to World capitalism. Secondly, they were committed to planned development. Thirdly, they had to function within the garb of a 'welfare State' and fourthly, in the beginning at least, they had to counterpoise and diffuse working class demands and tensions. What were the health plans and programmes of the period and how did they advance bourgeois aims and ideology?

In 1951, the population of India was 361 million. Nearly 38% of the working population were wage-earners (Bettelheim, 1968). The economic growth envisaged required a healthy and productive labour. However, the recent series of famines and droughts, increased exploitation of war, further deterioration of the abysmal public health and sanitary services, the post partition exodus had resulted in a labour which obviously could not contribute its best in terms of productivity. The situation also favoured political instability. The expansion of capitalism is dependent on a politically stable and healthy labour force and these called for measures to reduce mortality and morbidity in the Country. Moreover, the unhampered bourgeois hegemony of the national movement had been paid for by making promises to the working class and its leaders as well as the progressive educated elite. In response to the growing mass discontent the bourgeoisie had to make visible gestures which could demonstrate their concern and their intention of fulfilling promises. The creation of large health institutions, and building of medical colleges and research establishments was a most appropriate strategy.

At the same time it was recognised that the reinforcing of capitalist ideology and reproduction of bourgeois class relations was necessary to the growth and development of capitalism. 'Scientific' medicine' which had evolved and matured under capitalism was obviously the most appropriate choice. In this sense, the adoption of modern medicine as the dominant system of medicine and the creation of hospital infrastructures where it could be practised was an ideological as well as political necessity.

1) Reduction in Morbidity and Mortality: At the time of independence 50 percent of all deaths were estimated to be from epidemic diseases. The expectation of life at birth was 32.45 years for males and 31.66 for females (Health Statistics, 1982). Cholera, Malaria, tuberculosis and smallpox were major killers. In 1950 malaria killed 75 million and

it was estimated that 156 million work days were lost causing a loss of Rs. 75 million. PAC Report-1983-84). Moreover, "aggregation of labour in irrigation, hydroelectric and industrial projects is attended with severe outbreaks of malaria". (First F. Y. Plan, 1952, p. 500-501). Tuberculsois was the other major killer which claimed fives lakhs lives annually and rendered 25 lakh people ill. It was estimated that 900 to 1000 million mandays were lost because of the disease. (First F. Y. plan 1952).

The Malaria control programme co-ordinated all Malaria control activities and consisted of DDT spraying, treatment with antimalarial drugs and providing malaria engineering services wherever there were developmental irrigation and hydroelectric projects.

The Tuberculosis Control Programme included vaccination with BCG, clinics and domiciliary services, and aftercare. The emphasis was on prevention with BCG. Both these programmes depended on international agencies like the UNICEF and WHO for supplies of necessary chemicals and vaccines.

Both these programmes, especially Malaria Control Programme, achieved spectacular results in the beginning, after which their success levelled off. By 1956 the mortality due to malaria had declined to 19.3 million and in the first year of the programme the number of workdays saved was estimated to be 116 million.

These programmes, especially the malaria programme conducted like a military campaign were conceived in such a manner that they were bound to fail. Cleaver (1976) points out that programmes like malaria control must be seen as death control programmes preceding the birth control programmes of a later period. Together they constitute "the means for obtaining control over populatian growth and thus over the supply of labour". These have been the strategies sought by business whenever they have sought to invest — in US, South, SW Asia or China.

These programmes have also been used to divert attention from the real causes of ill-health by equating disease eradication to 'technical' measures such as DDT spraying in the case of malaria or BCG vaccination in the case of TB. Both eradication and immunisation programmes constitute the 'medicalisation' of socially and economically determined problems of health.' By introducing disease control and later eradication programmes, the Indian bourgeoisie was ensuring control over labour supply. Its early spectacular results also aided the legitimation of the 'welfare state'.

By the '60s increasing urbanisation with a 40 percent increase of urban population, inadequate housing and living conditions, low availability of food and impoverishment and unemployment had pushed up disease incidence rates. The health impact of new industrial processes that were being introduced went unrecorded. In industry, intensification of labour coupled with chronic malnutrition accounted for a rise in industrial injuries which rose by 30 percent between 1961 and 1966 while work force rose only by 16 percent (Ajit Roy, 1973)

2) Institution Building : Both the Bhore committee and the First Plan took serious and anxious note of the lack of medical facilities. Low health status was seen as being primarily because of lack of medical facilities. The major emphasis in the first fifteen years was an increase of hospitals, beds and dispensaries and the numbers of doctors, nurses and other health personnel. (Appendix 2).

"The faithful implementation of recommendations is contradictory to the interests of capital and can be brought about only by continued struggle."

The first plan envisaged an increase of 24 percent in the number of hospitals, a similar increase in the number of urban dispensaries, a 11 percent increase in the number of rural dispensaries and a 10 percent increase in hospital beds. The number of maternity and child health centres both in urban and rural areas was also to be increased. More than fifty percent of the budget for medical schemes was allocated to the establishment of hospitals and dispensaries.

Public health expenditure went into the provision of water supply and health sanitation, the major share going to Madras and Bombay. Since training of personnel of all kinds was so important, institutions and facilities for training were given high priority. The establishment of the All Indian Institute for standardising and co-ordinating post-graduate medical education was also initiated (First

F. Y. Plan). This venture, as well as others, such as the setting up of the Virus Research Centre in Pune, and the expansion of the All Indian Institute of Hygiene and Public Health was assisted by the Rockfeller Foundation. This trend for increasing the medical infrastructure continued throughout the fifties and the early sixties.

The Mudliar committee which published its report in 1961, recommended a strengthening of the district hospitals as against any expansion of primary health centres. In its opinion, the resources in regard to personnel, finance were not available sufficiently for any further expansion of PHCs.

It must be pointed out that most of the expansion in facilities took place in urban areas and a majority of the medical graduates set up practice in cities. Together with this, the pharmaceutical industry which had made small beginnings after the first world war had expanded a little during second world war. By the beginning of the '50s, India was self-sufficient in all the galenical preparations, most of the vaccines and alkaloids. But medicines like Pencillin, Streptomycin and sulphas were largely imported. After 1956, many foreign subsidiaries which had begun as trading operations went into the production of formulations, and public enterprises such as Hindustan Antibiotics and Hindustan Organic Chemicals were started in the late '50s mainly with the help of Soviet aid and technical know-how. But the major expansion of production was of the foreign subsidiaries. By '68-'69 the average profits for pharmaceuticals was 20.3 percent (Rangarao, 1977.)

"The rationale of the Indian bourgeoisie in adopting massive family planning drive was a means of controlling labour."

In short, the health care system being developed was a doctor oriented, hospital centered, curative system largely dependent on modern pharmaceutics with its locus in urban areas. For the Indian bourgeoisie, such a health system created a large base for consumer durables which were manufactured in the private sector. It also motivated the growth of the pharmaceutical and chemical industry. Increase in the number of hospitals and medical institutions also meant many more 'converts' to both 'scientific' medicine and the growing array of drugs and associated products. Also, these institutions were an emphatic and 'visible' assertion of the State's concern in fulfilling its 'Welfare' goals and in keeping with the 'leap frogging' approach to catch up with developed countries that was being advocated.

This is not to deny that the increase in the numbers of health personnel and institutions was not necessary or useful. That would be patently untrue. But arguments which place blame for the current crisis on the non-implementation of 'radical' recommendations of the Bhore committee are inadequate. Given the path of development chosen by the bourgeoisie, the alternative offered in, say the Bhore report or the Community Development Programme could never have been implemented. Bourgeois radicalism either in the form of reports or legislations or programmes can best be viewed as concessions gained by working class militancy. The faithful implementation of recommendations is contradictory to the interests of capital and can be brought about only by continued struggle.

3) Reproduction of bourgeois social relations and social control : The bourgeoisie always adopts policies and strategies which will reproduce and reinforce bourgeois social relations.

(i) The adoption of allopathic medicine as the dominant medical system : From the outset, it was clear that the western allopathic system was to be the medicine of choice. In the period between 1948 and 1960 four committees Chopra, Pandit, Dave and Udupa) were constituted to plan for the development of indigenous systems of medicine in the country. By and large the only recommendations which were implemented were those which helped to suppress or discourage the growth of indigenous systems. We have already noted what happened to the Chopra Committee report. Later reports increasingly emphasised the need to examine indigenous medicine 'scientifically'. Further, it was generally agreed that the only area where indigenous medicine could play a role in the health system was in area of drugs and remedies.

Why was the adoption of allopathic system as the dominant system of medicine so important to the bourgeoisie? Firstly, the class and sex biased, positivist individualist ideology of modern medicine reflected bourgeois ideology. The hospital system reproduces the social structures of bourgeois society and by doing so reinforces and authenticates it. Modern medicine with its dependence on mysterious sounding drugs and its array of task specific

functionaries and unfamiliar language facilitated the monopolisation of knowledge and skills. From this comes the power and influence to those who have access to this knowledge viz; the doctor and to a lesser extent other health professionals. These professionals, mainly doctors, who shared the same class background as the bourgeoisie were necessary for the legitimation, strengthening and maintenance of the capitalist order. In recognising and locating 'scientific' medicine as the dominant system, the bourgeoisie were also acknowledging and encouraging the role of the educated elite.

(ii) The development of maternal and child health services : Concern for the health of women, as mothers, has a long history in India. At the time of independence, the sex ratio (women to 1000 women) had already started declining. But none of the health plans nor policy statements were ever concerned with this. However, investment in the health of the child (and incidentally its mother) were seen as an investment "for building a sound and healthy nation" (First F. Y. Plan). These facilities were seen as facilities through which women could fulfil their socially determined primary role as mothers. In consequence, women's health needs became subordinate to the needs of the family. The deterioration of women's health and women's status through the '60s is to a large extent the result of the policies and programmes that have been adopted by the Indian bourgeoisie.

The provision of MCH service,however relevant, in the absence of primary care accessible to women indirectly perpetuates 'the myth of motherood' and the social location of women under capitalism mainly as 'reproducers of labour.'

(iii) Health Education. One of the most important component of 'preventive' services was and has been health education, which mainly reinforces the victim-blaming ideology of modern medicine. It also helps to mask the social roots of illness and disease. The emphasis on changing life styles rather than on changing the socio-political environment which endanger such lifestyles protects the existing power structures in society and the exploitative mechanisms of capitalism.

Changes in Health Policy after 1965

In the health sector the trends which were discernible in the first decade after independence continued to be prominent until about the '70s. In this section, we will analyse the seemingly drastic change in health policy and programmes in the mid '70s in the context of socio-political and economic developments.

The two consecutive droughts in the mid-sixties had brought impoverishment and ruin to the rural landless and agricultural labourers. The proportion of rural population below poverty line reached a new hight of 57.9 percent (Shah). The nett per capita daily availability of food-grains was around 402 grams the lowest since 1952. It was in this situation that the Green revolution was launched. The concept itself, according to Davey was a part of America's post war strategies and was an extension of the agricultural research of the Rockfeller and Ford Foundations. The Green revolution also coincided with the glut in the world fertilizer market.

In the arease where the green revolution took root the crop yields shot up and also altered the agrarian structure. There was an increase in the numbers of agricultural labourers and despite mechanisation, the demand for labour also went up. In time the landless labour gained in strengh and emerged as a distinct class (Bhalla, 1983). Most of these also belonged to the deprived sections — the scheduled castes and scheduled tribes. At the same time the introduction of new technology and easier credit facilities had strengthened the small and marginal farmers and increased their staying power. Rich farmers were unable to buy them out. However there were no basic contradictions between the large and marginal/small farmers. These holdings constituted two-thirds of the cultivating households. In such a situation agrarian struggle was inevitable. Agitations for better wages were also, in reality struggles against caste oppression.

In areas outside the green revolution area, such as M.P., Rajasthan, Gujarat, parts of Bihar and

> *"Reduction of state inputs in health care and a great involvement of the private sector were the outstanding features of the national health policy and is in keeping with the objectives of the new bourgeois strategy for health care."*

Orissa and West Bengal, it was the small and middle farmers who gained most by the introduction of new technology. They soon began to challenge the economic and political power of the landlords, most of whom were absentee landlords. The interests of these new rich small and marginal farmers were contradictory to both that of the landless as well as that of the politically influential landlord. Having gained economically this section of the peasantry, the middle farmers who were usually from the middle castes, began to develop political clout both on the regional and the national scene. They also began to demand development inputs which would enable them to gain a qualitatively better standard of living... electrification, consumer goods and health services.

By the beginning of the '70s, industrial production had stagnated, the rise in national income being only 4 percent in 1971-72. The population went on rising, hence the labour force had continued to expand. The total work force was 184 million, 8 percent or 15 million were unemployed. While wages had remained stagnant the average product per worker had increased. So, the employing class had benefitted, thus polarising income (Davey- 1975).

The Fourth Plan's emphasis was on rural and agrarian programmes and the enormous emphasis on family planning. This was an attempt to postpone and forestall the crisis and also a recognition of the new and growing political influence of the middle peasantry. In the health sector almost half of the allocation went to family planning.

There have been a number of analyses of why there was an emphasis on family planning. The most obvious explanation is of course, the enormous spurt in numbers in the previous decade, which was mainly because of decrease in death rates. Eventhough epidemic diseases had not been eliminated there was a decrease in the number of death in each of these epidemics. Another less obvious reason was that given the high rates of unemployment and impoverishment, the sheer numbers presented a threat to the stability of the system. That there was imperialist pressure, through the use of conditional international loans and such, cannot of course be denied. But the rationale of the Indian bourgeoisie in adopting a massive family planning drive was a means of controlling labour supply to suit the expansion of more capital intensive modern industries.

Throughout the first half of the '70s there was a marked increase in the number of industrial conflicts, strikes, peasant agitations, tribal movements, student and mass movements most of which were directly or indirectly concerned with economic grievances. The Gujrat and the JP movement were against price rise initially but later made political demands. The Naxalite movement and the revolt of the tribals in Srikakulam, were more broad based and directly challenged class oppression. That brutal repressive measure were used to break and suppress them was an indication of the insecurity of the Indian bourgeoisie. The world economic situation had also changed by the mid '70s. Many advanced capitalist countries were on the brink of a third technological revolution. The national bourgeoisie realised that if they were to forge a new relationship with the world capitalist economy they had to re-structure the industrial sector by reducing state intervention and increasing opportunities for foreign investment. This also meant disciplining and controlling labour and stabilising the political climate.

Inputs into rural development therefore served two purposes — firstly, they facilitated the further penetration of capital and secondly, 'visible' efforts such as provision of health care, educational facilities, electricity, low capital intensive 'appropriate' technologies would not only nullify the growing discontent and political influence of the new rich 'middle' peasants and capitalist farmers but also strengthen them as a class who would associate with the industrial bourgeoisie in opposing and suppressing working class struggles. Moreover, these efforts would also mean an expanded market for the new technological consumer products.

The Fifth Plans' Minimum Needs Programme is just one such strategy. In the health sectors it was being realised that a hospital based health system supported by vertical programmes such as Malaria Eradication and Family Planning no longer performed either this ideological role or achieved their socio-politcal objectives. There had not been any large scale improvements in health indicators in the past years. Their role as advertisements for the bourgeoisie's concern for 'welfare' had long outlived its usefulness. Moreover, it was no longer a good economic option. The amount spent for welfare of the working class comes out of the surplus value being created. If this no longer achieves the purpose of either maintaining and reproducing labour or of strengthening class relations by reproducing and legitimating the capitalist order, the loss in surplus value cannot be justified. The only answer was a change in strategy. 'Scientific' medicine gave way to a 'community'

conscious science-based medicine which was accommodating enough to allow the operation of other systems under its hegemony.

Through the '70s a number of voluntary agencies funded by industrial houses, Christian missions or foreign development agencies, and individual professionals frustrated and disgruntled with the existing system began to 'experiment' with alternative health strategies following essentially the 'health-by-the people' approach. The rising cost of health care, of medicines and equipment provided a further impetus to many. Naturally enough this approach had an instant appeal to a mass of socially-conscious urban and rural youth, plagued by the threat of unemployment and sensitive to the increasing deprivation of the masses. Many of these projects achieved initial success in-improving health indicators such as infant mortality or maternal deaths, epidemic deaths and achieving high immunisation rates.

In 1975, the Srivastava Committee was the first official document which put forward a proposal for health care which created a new health functionary.. the community health worker. Based on the premises that most of the commonest health problems are of the easily preventable kind and may be easily looked after at the village level, the committee proposed the training of selected villagers as the first contact in the new rural health care structure. It suggested a well organised and graded structure of dispensaries, hospitals and referal services.

The alacrity and the speed with which these proposals were accepted and implemented by the government is a measure of how appropriate and urgent they were to those in power. By then, in 1977 the Janata Party, a configuration albeit temporary, of the commercial bourgeoisie and capitalist farmers had dislodged the Congress, which then represented mostly the industrial bourgeoisie. The Janata Party saw the provision of rural health care as a means of fulfilling election promises. Moreover, they were the representatives of just those sections who would be benefitted most... the rural rich and middle peasantry. Democratic selection processes notwithstanding, the community health workers were certainly not to come from among the poor.

Around this time several countries, met under UN auspices at Alma Ata and signed the Declaration which proposed just such a strategy. The international move conferred on the programme a high status which would play a part in persuading reluctant and antagonistic professional bodies to co-operate.

In 1980, the new strategy for rural health was formalised and integrated into overall bourgeois strategy in the form of a national health plan, proposed by the ICMR-ICSSR committee. This report, a good indicator of the bourgeois radicalism, in the '80s, proposed a pyramid model of health care, based on a diffused primary health care programme relying on limited, cheap, labour-intensive techniques and technology and a smaller, capital-intensive, mainly curative, referral and specialist service using sophisticated, modern, high tech resources, and the hospital system. Both the terminology and the spirit of the report was greatly influenced by Illich. It saw the organising of primary health care on a community basis as an essentially 'political experience' which would enable people to fight other battles and this in turn would set in motion a 'process to strengthen a decentralised, democratic and participatory social order'. (HFA, 1981). The major recommendations of the HFA were incorporated into the Sixth Plan.

In 1982, the government of India published a Statement on National Health Policy. It enunciated an integrated, comprehensive approach toward the future development of medical education, research and health services. Broadly it followed and repeated the recommendations of the HFA. But in doing it re-emphasised certain trends which had been barely discernible in the HFA and the Sixth Plan. For instance, it focussed greater attention on reducing governmental expenditure and utilising untapped resources to encourage the establishment by private practice professionals . . . . and financial and technical support to voluntary agencies (NHP 1982-). More importantly, it focussed on the need to establish a referral system which could provide speciality and super speciality services. Again, to reduce governmental expenditure private investment in such fields was to be encouraged. In providing water supply and sanitation too, appropriate technologies were to be used 'to reduce expenditures'. The 'involvement of community' in the implementation was also seen as a means of reducing costs. Thus, reduction state of inputs in health care and a great involvement of the private sector are the outstanding features of the national health policy and are in keeping with objectives of the new bourgeois strategy for health care.

We will examine briefly how the alternative strategy fits into the overall strategies adopted by the bourgeoisie since last quarter of 1970.

(1) The growing mass of rural poor has little access to any kind of health care. Diseases which could be easily prevented were still claiming lives. Maternal and infant mortality rates were still pretty high. Community health workers, however inefficient orinappropriately selected would ameliorate sickness conditions to some extent. The credit for this in turn, would accrue to the party in power.

(2) More importantly the new alternative is demystifying medicine just sufficiently for people to learn to use and to become dependent on modern drugs. If until now injections had a 'magic' value, soon metronidazole or B-Complex which the CHVs use will become familiar enough for people to ask for and demand them. This expands the base of operation for pharmaceutical companies.

(3) As we have noted earlier, the medicine practised by the community health worker was no different from the medicine practised by a hospital-located health functionary. Its content was the same but its garb was different. Therefore, the dominant/dominated relations that it embodied are strengthened and reproduced. Since the outreach of these rural health alternatives is so much larger, bourgeois ideology is being strengthened.. It is possible that these programmes are hastening the degeneration of indigenous practices and local healers.

As the main disseminators of health education messages, the village health workers are also spreading the ideology of 'victim blaming' shifting attention from socio-political roots of illness and masking class contradictions. In locating the main focus of health care in the family, programmes determine and lend support to the oppressive institutions which are so necessary to the maintenance of capitalist order.

Moreover, the village health workers have generally been from among the rich and middle peasants and middle castes. The acquisition of new techniques and knowledge has led to a different level of monopolisation strengthening the power base of this class. The existing selection process does not cut across existing power relations in society, including that of man and woman, and so reinforces them.

(4) This separation of primary and referrel facilitated the modernisation and development of productive forces of modern medicine on the one hand, while at the same time appearing to cater to the needs of the masses. The new strategy attempted to resolve the growing contradictions between the relations of production and production forces in modern medicine. The introduction of CAT scans, linear accelerators, laproscopy and so on in the last few years must be viewed in this context. The new 'medical leasing' companies which have started to function will facilitate the introduction of new technology and instruments in health institutions.

Conclusion

Medicine is not a socially independent activity. The evolution of medicine and the development of health care can only be understood within the larger perspective of the overall development of the Indian economy and the changes in the relation of production that came about.

The choice of 'scientific' medicine and a hospital-centred structure through which it can be practised was a deliberate choice on the part of the Indian bourgeoisie and was a necessary component in achieving the objective of a capitalistic transformation of India. This also had a profound impact on the traditional practices in India, not simply in terms of making their techniques less effective, but more so by changing the social relationship that such practices of those techinques embodied. Such transformation has further strengthened the domination of bourgeois medicine.

The community health approach so lauded since the late '70s initially gave an illusion that radical changes were being brought about in health care. We have argued here that this approach was never intended to bring about any radical changes but on the contrary, it was very much a part of a strategy to expand the hosptial-centred health care structure at the primary and secondary level in the rural areas. Not only. The strategy also involves inviting private investment and collaboration in the health care system with state gradually reducing its inputs in health. The community health approach also helps the pharmaceutical and surgical goods industry (which is largely in the domain of the private sector) to expand their domestic market.

Lastly India with her vast area and dense population divided into class, caste, sex, cultural, ethnic and a host of other differences is probably the most complex of socio-economic formations rendering attempts to properly comprehend it a most difficult task for the social scientists. There is always the danger of making sweeping generalisations and over-simplifications in providing an analytical outline of the development of health care in the context of the dynamics of socio-economic changes in India. We have not taken into consideration in

this analysis the regional differences and the unevenness of socio-economic development. But we have identified the dominant trend of development at the general level and analysed how the development of health care services is integrated with it. We are also aware that we have not included in our analysis the relative strength and political influence of medical organisations like the Medical Council of India nor their relationship with the pharmaceutical and surgical goods industry.

Given the vastness of the subject it was only natural that all aspects could not be covered. But the article, we hope, will generate enough interest in this subject so that the analysis can be deepened and broadened.

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Appendix 1

	First Plan*		Second Plan		Third Plan	
	Rs. in thousand million.	in per cent.	Rs. in thousand million	in per cent	Rs. in thousand million	in per cent
Agriculture and community Development	2.9	14.4	5.7	11.8	10.68	14
Irrigation and Major projects	4.3	21.4	5.3	11.1	6.5	9
Electricity	1.5	7.4	3.8	7.9	10.12	13
Industry and Mining.	—	—	8.9	18.6	17.74	24
Other Industries	1.0	5.0	—	—	—	—
Transport and Communication.	5.3	26.4	13.8	28.9	14.86	20
Social and other services.	5.1	25.4	10.5	21.7	13.0	17
Stocks	—	—	—	—	2.0	3
Total	20.1	100	48.0	100	75.00	100

*Actual result.

(Compiled from, Bettelheim, 1968, p. 157, 161 and 163)

(Appendix 2 contd. on page 48)