Health Care, Health Policy and Underdevelopment in India

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SINCE independence health policy making and the design of health programmes (like all other development programmes) have been guided by programmes of imperialism. As a result the Indian peripheral population has been denied state-sponsored health care services (that exist theoretically) and have instead had to depend on the vagaries of the market forces in which operates the overwhelming private health sector that has virtual monopoly of curative health services, being supported to the hilt by the multinational pharmaceutical industry. Privatisation, high technology, population control, low-cost models, aid and the consequent dependency are the means imperialism uses to shape our health policy and programmes.

THE underdevelopment of health is not an original state, but an active process generated by imperialist exploitation. Thus the nature of the third world health problems and the obstacles to their solution are to be found primarily in the structure of the economic relations historically created between the capitalist powers and their satellites. This is reinforced by the economic and social relationships created by imperialism within particular underdeveloped countries. [L Doyal and I Pennel. *EPW* August 1977]

The links of underdevelopment with imperialism are today. well established. The world systems approach [Baran, 1975; Frank, 1967, Amin, 1974; Wallerstein, 1976] that critiques the developmentalist paradigm of liberal political economy has also looked at the health sector, then it moves on to discuss the underdevelopment of the health sector in India establishing the linkages with imperialism based on an analysis of health and population control policy.

Modern medicine got established in the developed world only in the last quarter of the nineteenth century. And now for over a century it has prospered under capitalism and has spread globally under imperialism expropriating the health of the people. In developed countries sanitary reforms and other public health measures had provided the foundation on which modern clinical medicine could grow and flourish. This did not happen in what are today's underdeveloped countries because the latter were colonies of imperial powers. In underdeveloped (colonial) countries modern medicine developed as an enclave sector and therfore, though early in introduction, modern medicine catered to a very small proportion of the population.

The phenomenal growth of modern medicine under capitalism in the last one hundred years and its expansion under imperialism had no doubt revolutionised medicine. But in its rushed growth to find a pill for every ill the medical-industrial complex, under the auspices of monopoly capital and imperialism has not only become an expropriator of health but also global expropriator of surplus through a network of large multinational corporations. Good health is not only a question of availability and accessibility of modern medical care but is also related to the basic question of the right and access to a comfortable, human standard of life.

Today the difference we see between the developed countries of the west and the undeveloped countries of Asia, Africa and Latin America is the gap that imperialism has created. The question is not one of lack of resources in the peripheral (underdeveloped) countries but that of expropriation of their resources by the centre (developed) countries. The world product today (far below level as which human beings can produce with the present level of productive forces) works out to over US $ 3500 per capita per annum. If equitably distributed this is sufficient to support a comfortable life-style for the entire global population. However in the present world the underdeveloped countries, which have over 3/4ths of the world's population, get only 1/5th of the share of the world's product [World Bank, 1984]. The situation in 1800, for instance was a little different. The same population of underdeveloped countries had 44 percent of the share of world output. Since 1800 the gap has widened because of the expropriation of surplus of the underdeveloped countries by developed ones, earlier through colonisation and now through imperialism. And this gap today is widening further because of the stepped up process of privatisation all over the world. Thus under capitalism and imperialism development alone is not possible-development is necessarily constructed on the foundation of underdevelopment. The growing of such a development (increasingly for fewer people) also means a growth of underdevelopment (increasingly for more people). [see Navarro, 1976]
health sector.

A futher point to be noted with regard to the health sector is that it has historically belonged to the category referred to in western economics as the welfare or social sector. The argument is that a healthy population is essential for higher productivity. But under capitalism the production sector is unwilling to bear the burden of maintaining the health of the population, therefore this function is transferred to the state. The state collects taxes and makes provision for health care services either through its own delivery system or through subsidies or support of the private health sector. But with the strengthening of monopoly capital, contradictions of capitalism become completely bare and it seeks the support of the

state, the latter tripping into a fiscal crisis. The direct consequence is a demand by capitalism for a cut in social expenditures (health, education, welfare etc). However, at the same time monopoly capital is well prepared to take on social expenditures because new techonological developments have rendered this sector profitable. It is not that there were no profits in the health sector earlier-the pharmaceutical industry, private pracitioners, medical equipment manufacturers etc were grossing large surpluses. Only now, because of the new medical technology, large scale corporatisation of health services has become possible.

This development in the health sector is not restricted to the developed world. It has diffused very rapidly in the underdeveloped world further advancing (sic) the underdevelopment of health in these countries. The developed and the peripheral mass has less and less of basic health care. On the contrary, imperialism pushes 'new' low-cost, self-care models for the periphery. "In the health sector, we find substantial cuts in government health expenditures with privatisation and commodification of medical services, accompanied by the ever-present ideology of self-sufficiency and self-care brought to those peripheral countries by transmission belts of dominant core ideologies, such as the international agencies of aid". [Navarro, 1984].

Underdevelopment of Health in India

In India the growth of the health sector has followed the enclave pattern of development. Public health in India was completely ignored. Unlike Europe, India and most of the third world missed the opportunity of implementing sanitary reforms because they were colonised [for details see Ramasubban, 1985]. Even until today, because of the nature of capitalist medicine and imperialism, this simple and basic change has not been possible in underdeveloped countries—the entire focus of modern medicine is centred around the clinic and the only beneficiaries of this are the providers and monopoly capital. The recent cholera and gastro deaths in Delhi and other parts of India shows how underdeveloped public health in India is and it also proves the enclave sector pattern of development.

The genesis of an institutionalised health care delivery system in India began with the consolidation of British colonial rule. The motive of the imperial government for providing such modern and sophisticated medical care was not to improve health care of the general Indian community but as a concern for the health of its own armed forces and civilian administration. This very enclave sector introduction of modern medicine in India became the basis of its growth in the country. This pattern continues even today. Upto the end of the war modern medicine in India was not introduced to the periphery at all. It was only available to the rich Indians and civil servants, besides the Britishers and the Indian Army. With the advent of provincial government after the Government of India Act 1919, some semblance of a medical care network evolved. By 1941 India had 7441 hospitals and dispensaries (2150 hospitals). For rural areas there was one unit (hospital and / or dispensary) per 45,966 population and for the urban areas one unit per 16,913 population. (only 7.6 per cent of all these units were in the private sector) [Government of India, 1946]. Anyway, these facilities were too meagre to be of any significance, especially considering the fact that they largely catered to a select population.

Compared to any significant health care delivery system in the developed world the facilities and investment in India were miniscule and of little consequence for the health of its population. For instance, before the start of the second world war India had a bed/population ratio of 0.24 beds for 1000 population with a state expenditure of about 16 annas per capital only (5 per cent of Government expenditure), compared to Britain and USA which had bed/population ratios of 7.14 and 10.48 beds per 1000 population and a state health expenditure of Rs.54-8 annas 12 pies and Rs.51 -6-0 per capita (20.4 per cent and 13.8 of government expenditure), respectively [Government of India, 1946]. The fact is that Britain's and USA's state health expenditure was equivalent to India's national income and their health care even worse today. In 1984 health expenditure in the USA was $ 15.80 per capita out of which state expenditure accounted for 41 per cent (Levit et al,1985). By comparison in the same year health expenditure in India was only Rs.50 per capita. State private expenditure in 1984 is estimated at Rs.47 per capita by the CSO [GOI, 1988] but is more likely around Rs. 190 per capita [Duggal, 1986]. Even taking the latter estimate of private health expenditure in India, the USA spends 66 times more on health than India. Futher, the US health expenditure alone in 1984 was eight times that of India's national income (state health expenditure alone of the USA was 3 $^{1}/_{2}$ times India's GNP).

In India the Bhore Committee Report had provided the first insight into dimensions needed for a comprehensive health care system in India. It was a plan that was almost equivalent to Britains own national health service but having features closer to the Russian model because of Dr. Sigerist's and Prof.Ogenov's influence [GOI, 1946]. The committee stressed that suitable housing, sanitation and safe drinking water were primary conditions for good health was not to be equated with health services or illness care. The beneficiary was identified clearly as the tiller of the soil and the committee drew pointed attention to his plight. Specific groups such as women and children and industrial workers, were also paid special attention." [Giridhar et.al.,1985].

However, after independence the Bhore Committee Report remained unimplemented. The main reason for this, as also for the poor performance of other social

sectors, was the role of the Bombay plan (also known as Tata-Birla Plan) in shaping India's economic policy. Briefly, the Bombay Plan directed the nation's economic policy to serve the needs of private capital by making the state invest in heavy economic infrastructure, under the cover that such participation by the state in economic production would evolve a socialist society. That was as far as Nehru's socialism went and the private sector got state subsidised capital goods and services sector (steel, minerals, transportation, communmication, finance capital etc.) from which to reap benefits. It is clear that state investment has historically dominated in areas which helps the growth of private capital.

In the health sector the government let private practice of medicine flourish. For instance the government subsidised significantly the growth of private medical practice by training medical personnel from tax-payer funds and by providing bulk drugs at very low prices to private formulation units. However, the government took the entire responsibility of public health largely preventive and promotive programmes with curative services (the primary need of the population in terms of demand) taking a back-seat.

Investment in Health Sector

As mentioned earlier, at independence the investment in the health sector was marginal. Hospitals, dispensaries, health centres, health personnel and pharmaceutical production were abysmally low to have any impact on the health of the population, especially the poor masses. Between independence and today the growth of the state health sector has not kept pace with the needs of its population and quality.

Between the beginning of the first plan and 1986 the number of hospitals have increased from 1,694 (1,17,000 beds) to 7,474 (5,35,735 beds) but in terms of availability to the population the situation has not very siginificantly improved. Thus in 1951 one hospital served 1,34,001 population (3,085 population per bed) and in 1986, 1,003,48 population (1,400 population per bed). The situation gets worse when we look at the rural - urban differentials. For the earlier years this figure is not available but even in 1986 only 21 per cent of the hospitals (and 12 per cent of the beds) were located in rural areas, one rural hospital serving 3,49,394 rural population, and one rural bed serving 8,135 rural population. In comparison to this in the same year one urban hospital served 34,281 urban population and one urban bed served 432 persons in the urban areas. In 1956, 24 per cent of all beds were in rural areas but in 1986 this figure had declined to 12 per cent (GOI-CBHI, respective years). Further when we consider access factors like morbidity rates, sanitary conditions, malnourisment etc, the rural health sector investment appears to be only a marginalised investment. (See Table 1).

It also appears that compared to the growth of the private health sector the growth of the state health sector is very slow. For instance in 1974, 16 per cent of all hospitals were in the private sector (16.2 per cent beds) but within a decade in 1984 private hospitals had grown to 42.3 per cent of all hospitals (26.7 per cent) (Ibid). This means that availability of health care for the poor classes, who constitute more than 3/4th of the population, is becoming more and more expensive as they have to increasingly rely on market forces.

The urban population, besides having the cream of the state and private health services also have access to relatively good and well organised local-body sponsored health services, and the organised sector working class in addition has the benefit of having either health insurance [ESIS, CGHS] or reimburesement of costs (by employer) or even special health care facilities by railways, mines, defence, public sector undertakings, corporate health facilities).

To check this imbalance a network of primary health centres have been established to cater to the needs of the rural population. Between 1956 and 1986 the ratio of population served by one PHC has changed from 5,51,724 to 88276 but no siginificant impact on the health of the population is perceptible. The problem with this is that PHCs are different from hospitals and dispensaries. People's need and demand is for curative services (i.e. hospitals and dispensaries), rather than public health and family welfare. On an average only 1/5th of PHC funds and time of the staff are spent on curative services when over 90 per cent of those who visit the PHC seek curative care. When curative care supply in such institutions increases, such as in case of upgraded PHCs, its utilisation by the population also increases. Similarly a good PHC doctor (in terms of providing curative care) increases the patient-load of the PHC substantially.

Drug production is one area (the other being the production of doctors) in which considerable success has been achieved and the targets surpassed. The reason is simple that profitability is high and an effecient (even though largely irrational) pharmaceutical industry is the lifeline of private practice of medicine and vice versa. Pharmaceutical formulation production (including net of import/export) has increased from Rs.51 crore in 1956 to Rs.1993 crore in 1983 [FRCH, 1987]. In terms of population served, this means drug availability of Rs. 1.30 per capita in 1956 and Rs.27.68 per capita in 1983.

But the most important segment of the health sector in India is the private medical practitioner. Today there are over 700,000 medical practitioners (including institutionally and non-institutionally qualified and non-qualified from all systems of medicines); out of these 36-percent (250,000) are allopaths. Besides this there are about 800,000 paramedics, pharamacists, nurses, various medical teachnicians etc. Of all qualified allopathic

practitioners only 28 per cent are located in rural areas and out of these 40 per cent work in the government's rural health institutions. Of all non-allopathic (qualified as well as others) practitioners. 56 per cent work in rural areas; and from among these only 2 per cent work in the state health sector 6 per cent of qualified non-allopaths) and of course, most of them practise allopathy. So here again we see that rural-urban differentials are very marked. And finally what is the proportion of medical professionals working as private practitioners? Of the qualified allopaths about 172,000 (or 69 per cent) are in private practice. And of all the non-allopathic (qualified and not qualified) practitioners 90 per cent of 400,000 work as private practitioners. This means that about 5,72,000 practitioners (one per 1300 population) of all sorts constitute the largest chunk of the health sector, [extrapolated from Census -1984; GOI, 1986].

This overview of health infrastructure development and investment in India clearly shows that the pattern of growth of the health sector in India has only contributed to its underdevelopment. The three high growth areas of medical education, pharmaceuticals and private practice have only helped imperialism and monopoly capital. Development of health care service has been concentrated in the enclave sector benefitting largely the urban-enterpreneurial economy. Health care services, like all other sectors of the economy, in the periphery are backward and what little exists is both poor quality and of difficult access.

There are various issues health and non-health, involved in this debate.In this article the discussion is limited to the nexus between imperialism and the health and population control policy in India and how they perpetuate underdevelopment.

Health Policy and Imperialism

In the colonial period health policy was unabashedly in favour of the enclave sector. The periphery existed only for expropriation, not deserving even lip sympathy. However, a few years prior to Independence both the Government of India and the Indian National Congress decided that the health of the periphery needed attention. The now famous Bhore Committee and the National Planning Committee's reports on the health situation in India and what could be done about it appeared on the eve of independence. Both these reports clearly favoured the establishment of a broad based integrated national health system that would be equally accessible to the entire population, irrespective of their ability to pay.

The Bhore Committee report used the Flexner Report of the USA as its basis in chalking out the plan for health care services for India but the influence of both the British National Health Services that was then emerging and the Russian model are clearly perceptible. However, it is evident that the Bhore Committee Report was clearly designed within the framework of welfare economics. It is a different matter that most of the recommendations of the report were rejected by the Indian state because the shrewd Indian bourgeoisie preferred a system of health care services where health care and medicine would be commodities (for instance the then prevailing Indian Medical Service that could have become the foundation of a national health service, was truncated and finally dissolved). The state was given the responsibility of public health and health care services for the periphery. The state was also made to provide the infrastructure medical education and research, bulk drugs, tax rebates and subsidies. Private medical practice developed as the core of the health sector in India initially strengthening the enclave sector, then gradually spreading into the periphery as opportunities for expropriation of surplus by providing health care increased due to the expansion of the socioeconomic infrastructure. It must be noted that this pattern of development of the health sector was in keeping with the general economic policy of capitalism. And Indian capitalism had clear links with imperialism. Thus the health policy of India cannot be seen as divorced from the economic and industrial policy of the country. In India until recently there was no formal health policy statement. The policy part and parcel of the planning process (and various committees appointed from time to time) which provided most of the inputs for the formulation of health programme designs. However what programmes were to receive priority was decided by imperialism.

In the early years after independence the Indian state was engrossed in helping and supporting the process of accumulation of capital in the private sector through large scale investments in capital goods industry, infrastructure and financial services. Social sectors like health and education were low priority areas. Industrial growth was the keyword. But by the end of the fifties imperialism had convinced the Indian state and the bourgeoisie that if the periphery was left out of the development process then not only surplus expropriation but the existence of capitalism itself would be threatened. Imperialism did not want another Cuba or China. Earlier the US patented CDP had failed. Thus the Green Revolution and subsequently other rural development programmes came to India through assistance from the US Technical Mission and Ford and Rockefeller Foundations. Along with this came support for health programmes also. The aid that came to India was not only financial and technical but also political and ideological. The entire policy framework, programme designs and foci, financial commitments etc. were decided by the imperialist agencies. For instance, during the fifties malaria, which constituted, an international threat, was the main focus of our health care delivery system an overwhelming majority of the health budget going into spraying out the mosquito menace. This priority was dictated largely by US imperialism - 78 per

cent of the US (health) technical assistance and 68 per cent of PL 480 grants went to malaria control and eradication [USIAD, 1976]. Similarly in later years small-pox eradication assumed importance. This time 57 per cent of all WHO assistance to India between 1973-76 went to small-pox eradication [WHO, respective years].

In the fifties and sixties the entire focus of the health sector in India was to manage epidemics. The health infrastructure remained grossly inadequate, catering largely to the enclave sector (see Appendix 1).

Another area of imperialist influence has been medical education and research. The entire curriculum of medical schools in India is oriented to serve western capitalism. Trained medical graduates, who have studied in public financed medical schools have migrated to western capitalist countries en masse, the latter gaining cheaply (for them) trained medical manpower. Imperialism directly perpetuates this form of medical education and migration centres of medical excellence in India (AIIMS, PGIMR etc.) have been funded by imperialist agencies. For instance between 1950 and 1974, 98.7 per cent of all health sector assistance by the Rockefeller Foundation to India went to medical education and research [Rockefeller Foundation, respective years].

In the early sixties, alongwith the great push given to the Green Revolution imperialism was preparing the ground for a fundamental change in India's health policy. The epidemics that were being controlled were bringing down the death rate rapidly. The consequence was a sudden spurt in population growth. India already had an official population programme but in the Mahalanobis scheme of things population growth was not a priority factor in planning. For imperialism the high growth of population (compared to their own declining growth) in India and rest of the underdeveloped world was a major threat. The initial beginnings in guiding this policy change in underdeveloped countries was routed through private foundations of American capitalism [for details see Mass, 1976]. In India, for instance 84 per cent of all Ford Foundation health sector aid between 1955 and 1979 went to population programmes and reproductive biology [Ford Foundation, respective years].

In the first two plan periods the family planning programme was mostly run through voluntary organisations under the aegis of FPAI which received funds mainly from IPPF, Population Council and the FPA of Britain. It was only during the third plan that government agencies began to actively participate in pushing population control. It was at the end of the third plan that Family Planning became an independent department in the Ministry of Health (meaning its status for financial commitments etc. would be increased substantially) and the camp approach was tried out for the first time under the advice of the Ford Foundation. The budget Sky-rocketed from a mere Rs. 2.2 crore to Rs. 25.0 crore (an increase of 1036 percent as compared to only a 128 percent increase for the entire health sector) [Government of India 1982].

During the same time US imperialism had made inroads into the United Nations policy with regard to population control [Mass, 1976]. Following this in 1966 a UN advisory mission visiting India strongly recommended that population growth must be curtailed immediately and for this the resources of the health sector were to be used. "The directorate (Health and Family Welfare) should be relieved from other responsibilities such as maternal and child health and nutrition. It is undoubtedly important for Family Planning to be integrated (it had been integrated with MCH in 1963) with MCH in the field, particularly in view of the 'loop' programme, but until the family planning campaign has picked up momentum and made real progress in the states, the Director General concerned should be responsible for family planning only. This recommendation is reinforced by the fear that the programme may be otherwise used in some states to expand the much needed and neglected maternal and Child Welfare Services" [UN Advisory Mission, 1966].

Taking the cue the Indian government for the first time evolved a traget-oriented approach for sterlisation and the IUD programme. Resources were considerably enhanced and in the first year of its implementation the 'loop' programme netted a phenomenal 8.13 lakh acceptors (much more than sterillisations which had started 10 years before it). And with regard to sterillisations the number of female acceptors also increased substantially.

The above was made possible by redirecting the efforts and inputs of the Third Five Year Plan's ANM-subcentre health scheme, which was mainly designed to reach out health care to women and children, the most vulnerable section of the population. Before this massive investment of the third plan could reach its target, population with the various health programmes — child immunisation, ANC, PNC, domicilary curative services, preventive and promotive health programmes — the imperialist agencies had reoriented the policy to attacking the 'population menance'. Thus the entire basic health care services which were designed for the periphery were reduced to a population control programme at the behest of imperialism. This distortion of an already underdeveloped health sector continues even today.

The population control strategy was based on the imperialist hypothesis that imporved health care necessarily accelerates population growth. [World Bank, 1980; Mass, 1976]. Therefore to check population growth health intervention was to be kept at a minimal level, a level that would generate adequate surplus labour to perpetuate exploitative relations. This was to be realised through heavy financial assistance and export of the ideology of the 'population bomb' by the imperialist powers. The pattern of financial assistance and population growth in

underdeveloped countries is given in Table 2. It shows that the initial lead was taken by private organisations (mostly foundations of the corporate sector) and gradually transferred to bilateral and multilateral agencies through their influence.

(It is also evident that two decades of vast financial commitments did not dampen population growth in underdeveloped countries. Their hypothesis was proved incorrect but this did not decrease their interest in population control. Their own studies in the seventies showed that in underdeveloped countries there were strong economic reasons for high fertility. The nature of the subsistence economy makes it expedient for a household to have a large family so that exploitation of fluctuating opportunities of source of income can be maximised, especially so when most of these opportunities coincide in a particular season — monsoon in India [Chaudhary, 1982]. Also under such conditions children are highly cost-effective. The cost of their raising far outweighs the benifits that arise due to their plenitude children contribute substantially to households through their labour (not necessarily wage-labour) in the fields, outdoor activities (fetching water, firewood etc) and household maintenance (babysitting, cleaning etc.) [Caldwell, 1977; Epstein et. al., 1975; Hull, 1977; Nag, 1978]. Further, these studies also indicated that an important determining reason for high fertility was high infant mortality. The World Bank selectively picked up this latter point [World Bank 1980] and advocated the "child survival hypothesis" to replace the older one mentioned earlier. That is, significant effort needs to be invested in assuring the survival of children so that parents can visibly perceive lower infant and child mortality rates. Thus, instead of direct support to population control activities support to universal immunisation of infants, children and pregnant women becomes the key for achieving lower levels of fertility. Related to the child survival hypothesis is the corollary of 'safe-motherhood'. This corollary is essential because of high maternal mortality and neonatal mortality rates. It is unfortunate that these important issues of survival are being-dealt from the perspective of lowering fertility. In India the current mission approach (Sam Pitroda variety) to immunisation is a case in point. It may be further noted that the issues related to the subsistence economy of underdeveloped countries referred to above have been completely ignored because the underdeveloped countries can overcome their subsistence nature only with the destruction of imperialism.

The Indian state and bourgeoisie have found this imperialist ideology beneficial for their own survival. All problems (especially economic and health) are linked by them to overpopulation. For capitalism and imperialism it is important to regulate fertility because surplus labour beyond a certain level can pose a threat. (The World Bank calls it the spectre of communism). Further, modern capital intensive technology makes generation of surplus labour under capitalism even easier, thus making the need for population control even more urgent.

Population control policy is one area of imperialist intervention in the health sector of underdeveloped countries which has kept health care services underdeveloped in these countries. The other area is promotion of low-cost primary health care for the periphery of these countries.

In India the Narangwal experiment in Punjab in the sixties set the framework for the 'low-cost' 'self-care' approach [Johns Hopkins 1976]. Following this similar experiments and projects were undertaken in Maharashtra and other states by various non-government organisations (Jesani, et.al. 1986). The consequence of this was the questioning of the medical model (especially the Bhore Committee) and promotion of a "community" health care approach. This proliferation of NGO experiments and models became the basis for an important change in the health policy framework of the state. The population control obsession of the health policy of the decade between 1966 and 1976 suffered as set back, albeit temporary, after it had reached its peak during the emergency.

It is interesting to note that the liberal western economies offered full support to the coercive population control activities during the emergency by stepping up their financial assistance for the family planning programme. When in 1976-77 the state's expenditure in family planning increased by 114.6 per cent over 1975-76 (and sterilisation by 204 per cent, assistance by imperialist agencies (bilateral and multilateral) increased by 50.8 per cent in the subsequent year. But when the Janata government came to power in 1977 and government expenditure declined by 46 percent (and sterilisation declined by 88 per cent) the cut in international aid for the subsequent year was 43.4 per cent. And to prove that this was not a mere coincidence the coming back to power of Congress (I) in 1980 increased population control aid by 111.7 per cent [Government of India, 1982].

In the mid-seventies a global change in the health strategy in underdeveloped countries was being worked out by the international agencies. It emerged in the form of Alma Ata declaration of 1978. India had anticipated this earlier with the influence of NGO models which were mostly funded by international agencies [Jesani et.al.1986].

India had officially started with the Community Health Worker Scheme (now called Community Health Guides) in 1977 with the idea of decentralising further the PHC and subcentre model which had failed to work, except in meeting Family Planning targets. There was no guarantee that the CHW scheme would not end up pushing family and planning traget precisely the same thing happened.

Before the introduction of the CHW efforts had been made to integrate the paramedical workers of the vertical health-programmes (malaria workers, vaccinators, ANMs etc.) through the multipurpose worker scheme as suggested by the Kartar Singh Committee. This integra-

tion idea had again emerged from the Narangwal experiment. "The committee unanimously agreed that the concept of multi-purpose workers at the periphery was both the operational research experience of Narangwal, Gandhigram, conclusion" [Giridhar et.al.,1985]. But the integration did not help in anyway in even starting the process of deceleration of the underdevelopment of health in the periphery. On the contrary all the health workers (alongwith many non-health workers, supposedly to justify the promise of interdepartmental cooperation and integration) were laden with carrying the burden of population control targets.

The consequence of this, over the years has been that the state's health care services in the periphery are today viewed by the people as family planning clinics. People in general have developed a distrust for the state's health care delivery system. Thus, thanks (sic) to imperialism primary health care, health services integration and Universal Immunisation Programme 'child survival') have become 'new' flag-carriers of the population bogey.

In the midst of all this for the first time in 1983 an official National Health policy (NHP) was announced. It was largely based on the ICMR-ICSSR Committee Report [ICMR/ICSSR, 1981]. The policy states: India is committed to attaining the goal Health for All by the year 2000 A.D. through the universal provision of comprehensive primary health care services. The attainment of this goal requires a thorough overhaul of the existing approaches to the education and training of medical and health personnel and the reorganisation of the health services infrastructure. Furthermore, considering the large variety of inputs into health, it is necessary to secure the complete integration of all plans for health and human development with the overall national socio-economic development process, specially in the more closely health related sectors, e.g. drugs and pharamaceuticals, agriculture and food production, rural development, education and social welfare, housing, water supply and sanitation, prevention of food adulteration, maintenance of the prescribed standards in the manufacture and sale of drugs and the conservation of the environment. In sum, the contours of the National Health Policy have to be evolved within a fully integrated planning framework which seeks to provide universal, comprehensive primary health care services, relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of the various health programmes is through the organised involvement and participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the health sector [Government of India, 1983: point 5, pgs. 3-4;]

Very progressive and comprehensive indeed! but all this gets pushed into the background with the paragraph that follows the above: Irrespective of the changes, no matter how fundamental, that may be brought about in the overall approach to health care and the restructuring of the health services, not much headway is likely to be achieved in improving the health status of the people unless success is achieved in securing the small family norm, through voluntary efforts, and moving towards the goal of population stabilisation. In view of the vital importance of securing the balanced growth of the population, it is necessary to enunciate separately, a National Population Policy [Ibid: Point 6, pg.4]

There is ample evidence in implementation of this policy to prove that the population control programmes emphasised in the NHP has been accorded an overriding focus in the "comprehensive primary health care programme" and rest all (specified in the first quote from NHP) is just for the record!

The consequence of this health policy making in India and the resultant programmes with the assistance, guidance and ideological inputs of imperialism has kept the health sector underdeveloped. Even today in India 80 per cent of all health resources and medical manpower are located among the 25 per cent urban population when 75 per cent of the country's population resides in rural areas: even in urban areas 80 per cent of the health resources are accessible only to the top 20 per cent of the socio-economic strata. This shows that the enclave sector structure of health care services continues even today.

Inspite of this apalling situation the government is talking of privatisation of health services : The policy (NHP of 1983) envisages a very constructive and supportive relationship between the public and the private sectors in the area of health, by providing a corrective to re-establish the position of the private health sector.... with a view to reducing governmental expenditure and fully utilising untapped resources, planned programmes may be devised. related to local requirements and potentials, to encourage the establishment of practice by private medical professionals, increased investment by non-government agencies in establishing curvative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the health field [Government of India, 1983].

This process of privatisation is not confined to India or to underdeveloped countries but has also been going on in western developed countries which have state supported health programmes. Further privatisation is not limited to the health sector but extends to all sectors of the economy. Privatisation is a response of imperialism both to firm its control of the international economy so that any process of socialisation of production and services is truncated and reversed, and a response to tiding over the fiscal crisis of the state.

This process has begun in India too in a big way. But this is in contradiction to the policy of promotion of low-cost self-care health models. However, this contradiction does not appear sharp because of the enclave structure of our

economy. The high technology and corporate health services are for the few who already have more than adequate health services accessible to them, and the low-cost models are for the periphery.

The low-cost model strategy is a deliberate attempt to keep health care out of the reach of the periphery because without the latter's underdevelopment the over-development of the centre cannot exist. This takes us back to the Bhore Committee model which talked of a level of development of the health sector for India which was on par with developed countries during that time. That level of development is the minimum required if health care services must be adequately available to all. The Bhore Committee also re-commended that health services should be available free of cost to everyone. The rejection of the Bhore Committee report as a policy statement and instead shaping our health services over the years on the whims and fancies of imperialism is one of the important causes in underdevelopment of the health sector in India. Of course the Bhore Committee could only have been implemented if our economic policy had also been radically different.

[Conclusions]

To sum up the discussion one can conclude that the underdevelopment of health care services in India (and similarly in the rest of the underdeveloped world) is part of the process of underdevelopement which is the consequence of monopoly — capital and imperialism. Imperialism controls, monitors and manipulates every aspect of the social structure to the extent that it also expropriates the culture and mind of the population in under-developed countries. Our policy makers, planners are brainwashed and bought over so that our underdevelopment is perpetuated for the development of imperialism. Thus for a small investment in brainwashing and a paltry financial assistance imperialism is able to sell underdevelopment to underdeveloped countries.

Since independence health policy making and the design of health programmes (like all other development programmes) have been guided by programmes of imperialism. The core of the entire health policy and programming of the Indian state has been population control. This has been largely due to imperialism's successful propagation of the 'population bomb' phenomena. As a result the Indian peripheral population has been denied state sponsored health care services (that exist theoretically) and have instead had to depend on the vagaries of the market forces in which operates the overwhelming private health sector that has virtual monopoly of curative health services, being supported to the hilt by the multinational pharmaceutical industry. Today the policy of privatisation is making the scenario for the periphery even worse.

Privatisation, high techonology, population control, low-cost models, aid and the consequent dependency are the means of imperialism to shape our health policy and programmes. Imperialism exploits, expropriates, creates dependency and generates underdevelopment, both within and outside the health sector. And to prevent underdevelopment from getting out of its control imperialism keeps throwing up new tricks (or old tricks in new garbs) each time the contradications of its existence threaten to knock it down. In India too these new tricks have surfaced time and again and have helped underdevelopment survive, even though breathless.

Table 1 : Growth of Health Infrastructure and Investment in Population ('000s) Served Per Rupees Per Capita

	POPULATION (000s) SERVED PER					RUPEES PER CAPITA		
YEAR	HOSPITAL	DISPENSARY	PHC (RURAL)	HOSPITAL BED PERCENT	MEDICAL COLLEGE	QUALIFIED ALLOPATH DOCTOR	DRUG PRODUCTION	STATE HEALTH EXPENDITURE
1951	130(NA)	55.4	-	3.2 (NA)	12890	5.8	0.96	0.9
1956	120(NA)	56.3	550	2.5(25%)	8230	5.5	1.30	1.60
1961	140(NA)	46.7	140	1.9 (NA)	7310	5.4	2.27	2.67
1966	120(NA)	48.3	80	1.6 (NA)	5410	4.2	3.90	4.13
1971	140(NA)	50.3	80	1.7 (NA)	5770	3.6	6.11	6.86
1974	150(16%)	60.3	80	1.7(13.2%)	5530	2.9	7.55	11.71
1982	100(44%)	41.7	90	1.4(13.4%)	6600	2.5	27.87	36.26
1986	100(45%)	27.9	90	1.4(12.5%)	7070	2.5	NA	53.94

Compiled from : *Handbook of Health Statistics*, CBHI, respective years; *Combined Finance and Revenue Accounts*, CAG, respective years; Commerce (supplement) *Pharamaceutical Industry - A Growth Perspective November* 12, 1977. *Health Status of the Indian People*, Sonya Gill (ed,), FRCH, 1987.

International Assistance for Population Control 1960-1980.
Assistance by Selected Major Donors (000's US$)

Year	Western Government	Multi-Lateral Agencies	Private Organisations	Population Change in Underdeveloped Countries Over Last Decade (Percent)
1960 *	91	..	3107	22.4
1970 *	87187	18750	56012	25.6
1980 **	369800	287900	16000	31.6

Source : * Quoted in World Bank Staff Report : *Population Policies and Economic Development*, John Hopkins Press 1979.

** Compiled from *Population Reporters* January-February 1983, Population Information Programme, John-Hopkins 1983.

*** World Bank, *World Development Report*, 1983.

References

Amin, Samir: *Accumulation on a World Scale*, Monthly Review Press, NY, 1957.

Baran, Paul: *The Political Economy of Growth*, Monthly Review Press, NY, 1957.

Caldwell, John: The Economic Rationality of High Fertility, *Population Studies* 31 (1), 1977.

Census - 1981 : *Five Percent Sample Report, Census of India* Registrar-General, Government of India, 1984.

Chaudhary, Rafique : Social Aspects of Fertility, Vikas Publishers, New Delhi, 1982.

Duggal, Ravi: Health Expenditure in India, *FRCH News-letter* vol.1 no. 1, November-December 1986.

Epstein, Scarlet et.al. (eds): *The Paradox of Poverty*, Macmillan, New Delhi, 1975.

Ford Foundation: *Annual Reports 1955-1979*, respective years.

Frank, Andre Gunder: *Capitalism and Underdevelopment in Latin America*, Monthly Review Press, NY, 1967.

FRCH: *Health Status of the Indian People*, Sonya Gill (ed); Foundation for Research in Community Health, 1987.

Giridhar G.Satia J.K. and Subramania Ashok : *Policy Studies in Health and Population -A Review in public Policy Analysis in India* by R.S. Ganapathy et.al. (eds.) Sage Publications, New Delhi, 1985.

Government of India: *Health Survey and Development Committee Report* (Bhore Committee), Government of India, 1946.

Government of India: *National Accounts Statistics* - New Series, Central Statistical Organisation, 1988.

Government of India : *National Health Policy*, Ministry of Health, 1983.

Government of India: *Year Book of Family Welfare 1981-82*, Ministry of Health and Family Welfare, 1982.

GOI - CBHI : *Handbook of Health Statistics 1951, 1956, 1974, 1986*, Government of India, respective year.

Hull, Valerie : 'Social and Economic Support for High Fertility in Peasant Communities', in the *Economic and Social Supports of High Fertility* LT Ruzica (ed.) ANU, Canberra, 1977.

ICMR/ICSSR : *Health for All : An Alternative Strategy*, Indian Institute of Education, 1981.

Jesani Amar, Gupte Manisha and Duggal Ravi : *NGOs in Rural Health Care*, Volume One FRCH, 1986.

Johns Hopkins : *The Functional Analysis of Health Needs and Services*, Departments of International Health, Johns Hopkins University, Asia Publishing House, Bombay, 1976.

Levit, K.R., Lazenby H., Waldo D.R., Davidoff L.M.: National Health Expenditure, 1984, *Health Care Finance Review*, 7 (1), 1985.

Mass, Bonnie, Population Target *The Political Economy of Population Control in Latin America*, Charters Publishing Co.; Canada, 1976.

Nag, Moni: *Economic Value and Costs of Children in Relation to Human Fertility*, Population Council Working Paper 36,NY, 1978.

Navarro, Vicente: 'The Crisis of the International Capitalist Order and its Implications on the Welfare State,'in John McKinlay (ed.) *Issues in the Political Economy of Health Care*, Tavistock, 1984.

Navarro Vicente : *Medicine Under Capitalism*, Prodist, NY, 1976.

Ramasubban, Radhika: The colonial Legacy and the Public *Health System in India, in Socialist Health Review, vol. II* No. 1, June 1985.

Rockefeller Foundation : *Annual Reports*, respective years.

United Nations Advisory Mission: *Report of the Family Planning Programme in India*, United Nation NY,1966.

USAID : *Technical Assistance : Completed Projects and Activities*, Office of Controller, USAID, 1976.

Wallersein, Immanuel: *The Modern World-System* Academic Press, NY, 1976.

World Bank: Staff Working Paper no. 412; *Health Problem and Policy in Developing Countries*, world Bank 1980.

WHO : *Financial reports 1973, 1974, 1975, 1976, 1977*, WHO, Geneva, respective years.