expected, from the start, to sink or sail with it. If it is has failed to live up to expected levels of efficiency, it is because of the socio-political and operational problems that beleaguer the public health services; namely, irrational and inadequate funding, misplaced programme priorities and the undermining influence of an unregulated private sector. The last factor is crucial and explains why an identical control programme works in an underdeveloped district but fails in a developed district.

The imposition of DOT is set at a time when health care is no longer viewed as a right but as a priviledge that a certain section will be entitled to. Cutbacks in public spending along with privatisation and cost recovery schemes are resulting in curbs on the expansion of infrastructural facilities and making health care only more inaccessible and beyond the reach of a large section of the population. In the absence of universal coverage, even the most well laid out strategy runs the risk of failing.

DOT is partly concerned with the standardisation and rationalisation of treatment regimens. This is an honourable enough objective. However, the new regimen being proposed is expensive and its inclusion is indefensible unless the added costs can be absorbed entirely by the state and not passed on to patients through the imposition of user charges.

Equally, the emphasis on supervision of treatment poses a number of operational, social and ethical problems. While a concern about the patients' adherence to treatment regimes is natural from a clinical and public health point of view, the objective goes a step further and is founded on the premise that patients cannot be trusted to take their medicines unless they are monitored by an external agency. At one end of the spectrum are the hapless patients who now become targets in much the same fashion as 'eligible couples' do under the family planning programme. However, there is a qualitative difference here as the state does not restrict itself to the role of a persuader but becomes an enforcing agency. The visible presence of a health worker during the consumption of every dose during the intensive phase of treatment militates against the principle of confidentiality between patients and the medical profession. Considering the fact that tuberculosis is known to create or aggravate the social disadvantages that certain sections of the population (such as women, disabled persons, non-wage earners) face in families and in communities, the repercussions of this loss of privacy for patients are tremendous. And at the other end of the spectrum are the supervising agents, the community level health workers (health post workers, multipurpose health workers, etc.) who are already laden with the task of meeting unrealistic family planning and health programme targets under adverse working conditions. Under the circumstances, the necessity of supervising treatment will not only be additionally burdensome but will engender an atomised understanding of health that will only alienate them from the community.

—Aditi Iyer

Beyond Economics

The debate on structural adjustment programmes has so far sidelined a most significant factor: India's political system which by its very nature ensures that the vast masses remain disenfranchised.

IN India the structural adjustment and economic stabilisation programmes were set in motion in 1991. It may be argued, therefore, that it is too soon to assess the Indian experience. However, for a large part of the develooing world the 1980s was a decade of adjustment. And there are enough pointers available from the experience of other countries. What stands out is that the performance of structural adjustment programmes (SAP) in terms of their own objectives — rectifying fiscal and balance of payments imbalances and raising the rate of growth — cruelly affects the social consequences of these programmes.

Among the countries following SAP the experience has been mixed; Indonesia has combined SAP with rising investment and growth; on the other hand, in Argentina and Zambia there has been a decline in per capita incomes and investment. Despite the variations, the balance of experience in Latin America and Sub-Saharan Africa, two major areas implementing SAP, has been negative. Each region taken as a whole exhibited declining per capita incomes and investment and accelerated inflation in the 1980s. Among countries implementing SAP in Sub-Saharan Africa, three-fourths had declinig per capita income and half, declining investment and accelerating inflation. In Latin America and the Carribbean, more tha 4/5ths of countries had negative performance in terms of per capita investment and incomes.

How SAP affects the condition of the mass of the people is determined by three principal factors: (a)through incomes, which are affected by changes in employment, wages and income from self-employment; (b) through prices of basic goods, especially food; and through the availability of essential services normally provided by the state notably health and education. In Latin America the GDP per capita fell in 18 countries and rose or remained the same in five. In Africa the GNP fell in 26 countries and rose or remained unchanged in 12. The overall experience has been that SAP tended to depress real wages as control over money wages is combined with devaluation and price decontrol. Evidence for Latin America shows that average real wages declined in the majority of the countries. In Africa real wages declined in 16 out of 18 countries.

Stabilisation and adjustment policies lead to reduced employment and fall in real wages in the short run; but the hope is that new, more productive employment opportunities will come up over time. However, evidence shows that employment growth slowed down in most countries in Latin America and Africa in the 1980s. For Latin America as a whole it has been

estimated that in the 80s four million fewer jobs were created than if pre-SAP trends had continued. In both Latin America and Africa, in response to the slow growth of employment in the formal sectors, the proportion of the labour force engaged in the informal sector rose significantly in the 80s. This led to depressed average wage and income levels.

Coming to government expenditure on social services, the evidence shows that aggregate per capita government expenditure declined in both Latin America and Africa. Within this there was a decline in the proportion of expenditure on health and education. As many as 60 per cent of the countries experienced cuts in per capita expenditure on health and education.

On the basis of all this evidence, which incidentally is from evaluations of SAP by organisations such as the World Bank and the UNICEF, do we then take a stand against the implementing of SAP in India ? But take a look at India's own record after four decades of economic planning and state regulation, a large public sector and an economic policy with social justice and equity as conscious objectives.

In terms of the UNDP's human development index India ranked 123rd among 160 countries in 1990. Other facts are well known and hardly need to be reported here. The employment growth has barely kept pace with the growth of the population, and over long periods it has fallen short of it, such as in the period since the mid-1980s. In 1991, only one half of the population were literate with two-thirds of women illiterate. The average number of years of schooling is 2.4 compared to 8.8 in South Korea and 5.3 in Malaysia. The infant mortality is 79 per thousand. There are vast variations in these indices over the country, with the situation being much worse in some of the biggest states such as Uttar Pradesh, Bihar and Madhya Pradesh. There has been a slowing down of employment growth to 1.8 per cent in the second half of the 1980s from 2.1 per cent earlier.

These statements are not intended to be comprehensive, but to drive home the point that if the performance of SAP has been dismal, our own performance has been nothing much to write home about. How can we explain that the share of primary education in total government expenditure in eduation has dropped from 58 per cent in the First Five Year Plan to 29 per cent or in health, the comparable neglect of preventive and social medicine ?

The current debate on economic development has tended to focus on issues — planning versus free market, open economy versus import controls, export-led growth versus import substitution or public sector versus private sector — which largely leave untouched the abysmal performance of the Indian state. There are yawning gaps created and perpetrated by the Indian political system. A system geared to constituting the political authority at the national and state level, nothing below that, with many of the states as large as countries. The result is that despite universal adult franchise the vast majority of the people are effectively disenfranchised. But no party is seriously concerned with this; no fuss is being made over the fact that in many states local elections as required in the 73rd and 74th Constitutional amendments have not been held. This then is the central issue in Indian political economy, and it is time we grappled with it.

Through a Bhopal Prism

The experience of the victims of Bhopal is being mirrored everywhere: the powerless continue to be victims of disasters—chemical, natural, economic and social.

OVER the last decade literature on the critique of health has accumulated at a rapid pace. This has led to a qualitative change in the outlook of the social sciences towards health care and medicine. While many factors have contributed to this, the cumulative experience of NGOs, health activists, trade unionists, medical professionals and the progressive movement in Bhopal has been a major contributor to the deepening of our understanding of the political economy of medicine and health care. In the microcosm, Bhopal illustrates several elements of the progressive critique on health.

First the disaster itself. Let us look at the 'ifs': if the Union Carbide had not found it necessary to use and store toxic chemicals; if the rules of industrial safety were more stringent the disaster would not have occurred. If the industrial locational policy had been better structured then the juxtaposing of habitats and a hazardous industrial plant would not have occurred, and then, even if a disaster had occurred, it would not have affected such large numbers. If the state had taken its 'development' concerns more seriously there would not have been the population of under- and unemployed who had migrated in search of work and were managing to eke out a living—unhealthy, unhappy—in the vicinity of the factory.

Events immediately after the noxious gases escaped illustrate well just how anti-people the collusion between the medical establishement, corporate interests and the state can turn out to be—neither the state nor the medical establishment, beneficiaries of the Union Carbide's generosity at various times, were in a position to insist on information regarding the nature of the fumes, the antidotes and the method of treatment.In the following months the scientific and medical research establishment showed its incompetence. A country with 'the one of the largest community of scientists' could not put together relevant studies and surveys — not because it lacked expertise, but due to the fact that the scientific and medical research infrastructure had long lost the flexibility, the creativity and the sensitivity necessary for the furtherance of knowledge. Again, the delinking of medical research from health policy had been a matter of