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

concern for many years before Bhopal, a concern expressed in several expert committee reports. It was in Bhopal that the consequences of such a development became obvious.

In the 10 years since the disaster, the world has seen the Indian state's concern for the victims dwindling. The provision of medicare has followed set patterns of focusing on superspeciality care rather than ensuring that the day-to-day needs of the victim population is being met. The authorities could well have evolved a different 'community-based' approach to medicare here, but did not do so for more or less the same reason why the approach is given such desultory treatment in the country's health care system: it is not visible; it means that control of services, however minimal, passes on to the people, and; the health bureaucracy experiences loss of control and power, following upon which, the political leadership too cannot use the provision of services as a pawn in petty games.

Similarly, little serious attempt has been made to equip the victims with new skills and provide them with opportunities for economic self-sufficiency. The land and infrastructure set aside for the purpose of providing employment to the victims are, according to reports, being sold at high prices to entrepreneus who have no intention of creating jobs for the victims. No serious thought has been given to improving the living conditions of victims: at one point the local administration demolished a section of the bastis of the victims, and those remaining are in a worse state than before; the water supply such as there is, has been further contaminated.

One may justifiably say that the non-establishment health and medical community has not exactly covered itself with glory in Bhopal. The private health sector is booming: fortunes it is said have been made by doctors and lawyers in Bhopal. Why did the conscience keepers of the medical community, presumably, the Indican Medical Council not ever examine the large-scale unethical practices in Bhopal? Nor have the NGOS in health shown either the maturity or the concern which should have overridden petty considerations.

What is chilling is that what is happening is Bhopal is happening in a slow and long-drawn out fashion all over the country. The powerless and those without a voice are becoming victims of continuing disasters, small and large, within factories and outside. The fragmentation in welfare services is more or less complete and is today further detached from provision of basic economic necessities: by the rules of the current eonomic policy regime, welfare services form part of the 'safety net' which is to take care of those affected by supposedly short term consequences of the new policies. The truth however, is very different. And it is more than likely that Bhopal will not be a unique occurrence, but will be repeated many times in many developing countries.

—Padma Prakash

Disease, Death and Local Administration
Madras City in Early 1900s

V R Muraleedharan
D Veeraragahavan

A complex of forces contributed to the shaping of the contours of colonial health policy. This article, which looks at the process of policy making in the port city of Madras in the early 1900s, explores the following: the different opinions which prevailed among municipal councillors regarding the effectiveness of certain policy measures, such as the maternal and child health scheme, the need for a special infectious diseases hospital, etc and the real and imagined constraints to the intervention of the colonial state in public health.

WHILE the broad outlines of the development of colonial health policy both at an all-India level and at regional levels have been fairly well drawn, the policies pursued in certain important urban centres, such as in the port city of Madras, have received far less attention.[1] Such micro-level studies can provide a better appreciation of the nexus of forces that shaped the policy making process and the decisions that emerged ultimately. In this paper, we take up the case of the colonial port city of Madras in the early decades of the present century, and give an account of the role of the municipal council of the corporation of Madras in shaping the nature and direction of its public health policy. We do not attempt here to evaluate the impact of the policies pursued by government. We are more concerned with understanding the perceptions of policy makers' on the nature of health problems specific to urban centres and the basis on which certain decisions were made. The following are some of the specific questions we are concerned with: what were the different positions adopted by the municipal councillors regarding the effectiveness of certain specific policy measures?; how much of importance did they give to prevention?; what sorts of constraints did they foresee and did they advance as reasons for supporting or opposing certain policy measures?, etc.

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Concern over High Mortality

The question of high mortality rate in the city of Madras often drew the attention of the municipal council but with little K C Desikachariar, a vocal members of the council, demanded an explanation for the increased mortality rate in the Madras city in the year 1904, the president of the