At the end of the Second World War, as post-colonial nations rushed to their trysts with destiny, seeking liberation from direct colonial rule, they attempted with limited success, but success nevertheless, to make a break with the historical structures of global inequity that underlay their underdevelopment. As a result of such policies as self-reliant import-substituting growth, some measure of land reform, and attempts at establishing industries, there was a reduction in the flow of resources from the countries of the Third World to those of the First. In short, there was a decline in the rate of exploitation of the former, as they sought to protect themselves and recover from the ravages of globalisation, militarily imposed, that they had been victims of for centuries. This was in most cases partial, and half-hearted, but nevertheless real. There was thus a reversal of secular trends in food availability, in value added in production, in per capita incomes, and so on. At the same time, there were efforts to provide a modicum of health, nutrition and education. Reflecting all these changes, there were improvements in health indices as life expectations increased, morbidity and mortality rates declined, and birth rates increased.

The nature and pattern of development in the health sector was, however, marked by a singular feature: the overwhelming hubris of science and technology in relation to the social problem of maldistribution of wealth and resources. While largely ignoring the broader determinants of health, urban hospital-based services were developed, which also had the consequence of countries like India opening up their markets for medical technologies and products. This was accompanied by the launch of technology-centred ‘vertical’ programmes, the most spectacular being those for malaria and family planning. In 1960, for instance, the WHO’s budget for malaria eradication was greater than the rest of its budget put together. In India, the family...
planning programme, for its part, lurched from one approach to another – from extension education, to the intra-uterine device, to the vasectomy camp, to forcible male sterilisation, and finally to female sterilisation – increasingly sucking in funds and thus determining the contours of health sector development. Both programmes were premised on a ‘magic bullet’ belief that there were technological solutions to complex epidemiological problems.

The vertical programmes, midwifed by international agencies, had certain unique characteristics. Planning these programmes was not always guided by epidemiological considerations. They were often initiated without an understanding of the nature of the disease, its distribution, its underlying causes and inter-linkages, its behaviour over time and, indeed, often even its scale. Focusing on these programmes meant that general services that could provide health care to the population were not developed. By the early seventies it was increasingly being realised that this model of health sector development had led down a blind alley. Both the malaria eradication programme and the family planning programme were now acknowledged to be failures. It was obvious that without universal and comprehensive health care, and without linking health to overall development, health improvement was bound to be chimerical.

Widespread international disillusionment with vertical programmes, the recognition of the need to provide sufficient coverage to rural populations, and the faltering integration of preventative and promotional programmes, together contributed to the WHO-UNICEF initiative that led to the declaration of the goal of ‘Health for All’ through primary health care at Alma Ata in 1978. At this point, the WHO saw a ‘major crisis on the point of developing’ in both the developed and the developing world as a result of the ‘wide and deep-seated error in the way health services are provided’. This coincided with the growing awareness among international agencies of the failure of the family planning approach to the problem of poverty. They accepted the need for integrated programmes and the satisfaction of the minimum needs of the population in order to meet demographic goals. The World Bank and the Population Council both endorsed this ‘developmentalist’ perspective. The sense of hope and optimism among those rallying for ‘Health for All’ was connected to the strength of the call for a ‘new international economic order’ that was adopted by the UN General Assembly in 1974.

The 1970s, then, were exciting times in health sector development, when everything appeared possible. With China’s entry into the WHO in 1973 (made possible by ‘ping-pong diplomacy’), it was impossible to ignore
alternative models of health care. Between the late 1950s and early 1970s, life expectancy in China more than doubled. Despite famine deaths, life expectation increased from around 22 years to 46, a feat that had taken the Western world more than a century to achieve. With no assistance from the WHO or any other international agency, an ‘underdeveloped’ country with a fifth of the world’s population had created an extraordinary system of basic health care for its vast rural population. The problems of hunger and infection, and thus the diseases of poverty, had been fought not with magic wands, nor by doctors trained on western lines, but with food and employment.

New winds seemed to blow across continents. The West was plunged in students’ struggles for democratisation, the civil rights movement surged in the USA, and second-wave feminism took on the health establishment. The decade began with the growing successes of the liberation struggles against Portuguese colonial rule in Africa, and ended with the Iranian revolution. And with the defeat of the US in Vietnam giving a piquant new twist to Cold War politics, the Soviet Union attempted to take a new leadership role, not least by pushing the WHO towards Alma Ata. The USSR, long critical of vertical programmes in general and the malaria programme in particular, argued that they hampered health sector development. The Soviet delegate at the WHO stated that ‘the Soviet Union was prepared to show participants what had been done over the last 50 years’. The Alma Ata declaration, promising something revolutionary for health in Third World countries (since it was evident that the goal of ‘Health for All’ could only be achieved through broad and equitable development), thus had a complex political heritage.

But this period of optimism proved to be extremely short-lived. The primary reason for this was of course the new wave of globalisation. The 1980s saw the Keynesian world increasingly under attack from neoliberalism, and by the end ‘actually-existing socialism’ also had been overthrown. In these circumstances, the goals of Alma Ata became impossible to achieve. ‘Health for All’ was soon replaced by the oxymoron of ‘Selective Primary Health Care’, and both UNICEF and the WHO beat a retreat from Alma Ata. A secondary reason was the widespread misconception that primary health care was something that concerned only poor countries, and that it only had to do with the provision of the most essential health care. What was, above all, forgotten was that health is only partly an outcome of health interventions. But with neoliberal globalisation even those interventions were now to be increasingly based on market principles. As the prospects for health for all receded, the magic bullet approach to health policy reappeared,
accompanying what Renaud cuttingly but aptly described as eliminating society from disease.\textsuperscript{11}

All this was epitomised by the World Bank, whose rejection of the ideas of Alma Ata was unequivocal. In its influential 1987 document \textit{Financing Health Services in Developing Countries: An Agenda for Reform}, the World Bank stated, ‘the approach to health care in developing countries has been to treat it as a right of citizenry and to attempt to provide free services for everyone. This approach does not work’.\textsuperscript{12} The role of the state, then, was to be confined to regulation – and hence the salience of the word ‘governance’ – while the private sector was to be encouraged, often through state subsidy, to take on the provision of health services, with the exception of a minimum clinical package, that ironically included family planning. The role of the World Bank in health sector development increased enormously, while that of the WHO shrivelled; indeed World Bank loans for one programme, malaria, exceeded the entire budget of the WHO.\textsuperscript{13} By the end of the century, the Bank had become ‘the largest single source of healthcare finance in developing countries with an unparalleled degree of policy-making authority’.\textsuperscript{14} New players, international NGOs, were now doing to public health what had been earlier done with population control – divorcing it from its determinants and building a market for technologies. At the same time, the health sector in developing countries emerged as a leading source of multi-national profits as it was prised open for investment in a range of areas, from high-level technologies to insurance, and indeed also in routine technologies such immunisation.

\textbf{THE CONTEXT OF GLOBALISATION}

Neoliberal globalisation is the product of economic policies that reflect an ideological commitment to unbridled market principles. One of the significant lessons of post-war economic growth had been the singular role that the capitalist state could play, and indeed needed to play, to avoid recurrent periods of crisis due to falling demand. For instance, state involvement in public health had been considered critical, not simply because health is a merit good, but also because state provision of such goods was at the heart of the strategy to stabilise the economy and to increase productivity. In the new environment of the 1980s, these Keynesian policies increasingly came under fierce attack. The new neoliberal consensus involved a profoundly cynical view of the state, especially in relation to developing countries, although neoliberal free-market rhetoric often contrasted sharply with the actual practices of the Reagan and Thatcher governments in their own countries where the state was increasingly subsidising the rich.\textsuperscript{15} Indeed, neoliberal
globalisation has been described as a global project to restore upper-class privileges to the levels that prevailed early in the twentieth century, in a profound *trickle up* of wealth and resources. Reducing the role of the state and increasing that of the market, irrespective of the social and indeed long-term economic costs, was thus at the centre of this model of capitalist therapy.

Deflation, liberalisation and privatisation were applied broadly across Latin America and Africa in the 1980s – what Patnaik described as imperialist globalisation. In the agricultural sector, where the majority of the population of the world still worked, this led to the reinforcement of colonial patterns of agricultural production, stimulating the growth of export-oriented crops at the cost of food crops. The problem at the heart of this pattern of production is that it was implemented at a time when the prices of primary commodities were the lowest in history. Indeed by 1989, prices for agricultural products were only 60 per cent of their 1970 levels. Thus the more successful these countries were in increasing the volume of exports (in competition with other Third World countries exporting similar products), the less successful they were in raising foreign exchange to finance their imports. It is not surprising that many countries shifted back in time to being exporters of unprocessed raw materials and importers of manufactured goods, albeit with a sharp deterioration in the terms of trade against developing countries in general and agriculture in particular, plunging the peasantry into crisis.

These policies increased the indebtedness of Third World countries, shifted wealth from productive to speculative sectors, raised levels of exploitation of wage-workers across the globe, and led to the growth of casual, poorly paid and insecure forms of employment. Funding cuts in education and health also meant that already weak and under-funded systems of health, education and food security collapsed. It is not accidental that these policies increased levels of poverty in already poor countries, even as a section of the population became richer. They obtained access to consumer goods hitherto available only in the rich countries, and with the vociferous support of the electronic media called for further globalization. In India, while this portion of the middle and upper classes has been described as having seceded from the nation, some sections, largely upper caste, supported the growth of the rightwing crypto-fascist party, the BJP. Having benefited in the past from state intervention, they now forgot India’s anti-imperialist history, abandoning ideas of democracy and secularism, and were impatient to integrate into the global economy, albeit as a junior partner of the US. Supporting them financially with dollars, and with laughable intellectual capital, were large segments of an extremely successful body of diasporic
Indians, in the USA in particular, dying to say with pride, we are Hindus.\textsuperscript{20}

A major consequence of economic globalisation has been commonly described as the ‘feminisation of poverty’, as women increasingly strive to hold families together in face of increasing economic insecurity. In many countries, more women entered the labour force but typically at lower wages and with working conditions inferior to those of men; in others, women lost jobs as levels of unemployment increased markedly. In India, the extent of unpaid labour in households, performed largely by women, increased as public provision of basic goods and services declined. Young children, especially girls, were sometimes withdrawn from school to join the vast and grossly underpaid informal labour market or to assist in running the household. Rising food prices, along with cuts in subsidies for the poor, meant that an increasing proportion of families with precarious resources were pushed under the poverty line. This had a disproportionate effect on women and girls. It also meant that more young women were driven into the sex industry.

It is not surprising that under these conditions hunger and morbidity levels rose, even as poor people were increasingly unable to access health institutions, which under structural adjustment ‘reforms’ typically introduced the requirement for patients to pay fees for health services. Given the rising levels of under-nutrition, rates of infant and child mortality, which had hitherto shown a secular decline, either stagnated, as in India, or in the case of some countries actually increased. So unambiguous and deleterious were these changes, and so extensively documented, that even UNICEF issued calls for structural adjustment programmes to be given ‘a human face’.\textsuperscript{21} Increasing inequalities in income and in health were also apparent in other countries that had followed similar economic trajectories. In a number of the developed industrial countries, mortality differentials rose sharply in parallel with widening disparities in socio-economic status.\textsuperscript{22}

HEALTH AND HEALTH POLICY IN INDIA UNDER NEOLIBERALISM

Shortly after Alma Ata, the Indian government made a commitment to provide health care for all by 2000.\textsuperscript{23} Towards this end, during the 1980s efforts were made to strengthen rural infrastructure while the government itself spoke of the failures of vertical programmes and the need to provide integrated services.\textsuperscript{24} The decade thus saw some investment in rural infrastructure and social support programmes such as nutrition programmes, including the creation of a network of publicly-funded healthcare institutions – subcentres, primary health centres and district hospitals all over the country. These were
largely used for family planning, and were by and large avoided by those who could afford to do so. In any case, the bulk of the funding, meager as it was, went to urban institutions, medical colleges and the new vertical programmes. Over the same period, there was also increasing attention paid to the private and NGO sectors. In effect, the dual structure of Indian health services reappeared in a reinforced form: a public one – derelict, short of staff, funds and infrastructure – for the poor who also lacked access to the determinants of health; and a private system for those who could afford to pay. Given the increasing weakness of the public system, more and more people opted for the hugely exploitative private system.

The distance between the two systems particularly grew through the 1990s. In early 1991 India’s foreign exchange reserves – helped by capital flight – fell to the value of two weeks of imports. India came close to defaulting on her commercial debt. The IMF hurriedly approved a $1.8 billion loan for India, staving off the impending default, followed later in the year by another $2.3 billion loan, which committed India to negotiate a further structural adjustment loan of $5 billion.\(^{25}\) One of the IMF’s conditions for this loan was that state expenditures, including for health and education, were to be sharply reduced, and in fact public health spending declined from 1.4 per cent of GDP in the mid-eighties to 0.9 per cent in 2002. The universal public distribution of food – which provided a certain amount of subsidised food – was sharply curtailed. Other policies affecting the agrarian sector – such as reduced spending for irrigation, infrastructure and rural credit – meant that the per capita availability of food has shown an alarming decrease. As Patnaik has forcefully pointed out, per capita annual food grain consumption declined from 178 kilograms in 1991 to 154 in 2004, even as India exported food grain for animal feed in the West. Utilising the accepted daily required calorie norm of 2,400 calories, 75 per cent of the rural population could be classified as poor in 1999-2000 (instead of the figure of 27 per cent which the Planning Commission obtains by arbitrarily reducing the calorie norm to 1900 per day).\(^{26}\)

The full effect of these policies in terms of preventable and communicable diseases remains to be seen. In the 1990s, although life expectancy had increased and infant and child mortality rates had declined, these positive changes were relatively modest, and infant and child mortality still took an unconscionable toll of the lives of 2.2 million children every year. Despite the 1983 National Health Policy target of reducing the Infant Mortality Rate (IMR) to less than 60 per 1000 live births in all the states of the country, the rate of decline in the IMR decelerated from 27 per cent over the decade of 1980s to only 10 per cent over the 1990s. The same is true for the rate
of decline in the mortality rate of children under five, from 35 per cent in the 1980s to 15 per cent in the 1990s. Today, it is clear that India will not reach the Millenium Development Goals for reducing infant and under-five mortality. The 1983 National Health Policy target was also to reduce the Maternal Mortality Rate to less than 200 per 100,000 live births by 2000. In fact, between 115,000 and 170,000 women died in childbirth in 2000, accounting for about one-quarter of all maternal deaths worldwide. Far from declining over the 1990s, maternal and neo-natal morbidity and mortality rates in India at best plateaued, or even increased. High and unconscionable as these levels of maternal mortality are, it is nevertheless critical to bear in mind that they represent just a fraction of the morbidity and mortality load borne by women in India. Communicable diseases take a much higher toll.

Thus, instead of an expansion of the state’s commitment to public health as promised in the early 1980s, over the two decades since India embarked upon structural adjustment we have witnessed a decline from already low levels. The 2002 National Health Policy admitted that India’s public expenditure on health was the fifth lowest in the world as a percentage of GDP. In 2006 general government spending on health was less than 20 per cent of all health expenditure. The decline in public investment in health was matched by growing subsidies to the private healthcare sector, the largest and one of the least regulated in the world. Evidence from across the country indicates that access to health care has declined sharply over this period. The policy of levying user fees has had a negative impact on access to public health facilities, especially for poor and marginalised communities, and for women more generally. As the 2002 National Health Policy also acknowledged, medical expenditure had by then already emerged as one of the leading causes of personal indebtedness. Equally significant have been other changes. Inter-regional, rural-urban, gender and economic class differentials in access to health care in India were already well-documented before the 1990s. But since the onset of the liberalisation policies, these differentials have considerably widened.

State support for private health care grew with the initiation of various kinds of private-public partnerships. This was given an international imprimatur, particularly specifically for HIV/AIDS, tuberculosis and malaria, through an alliance between a tired, financially emasculated and visionless WHO and ruthlessly energetic new international NGOs. These provided a new impetus to vertical programmes, but with a difference: private funds also made their entry through these partnerships. For instance, under the aegis of Global Alliance for Vaccines and Immunisation (GAVI) and
WHO, plans are underway in the Indian Ministry of Health and Family Welfare to introduce a range of epidemiologically unnecessary, and expensive, vaccines. It is remarkable that GAVI conditions for support include a guarantee for ‘reasonable prices’, support for sustainable markets (in vaccines), and prohibitions on compulsory licensing that would enable their manufacture in the country. India has accepted the support of GAVI for the introduction of hepatitis B vaccine in selected pilot projects. Thus, the creation of new markets was combined with the neglect of the determinants of diseases. This effectively undermines comprehensive public health care: in several of India’s states routine immunisation rates have declined.

A range of incentives has also been offered to the private health sector. These include the provision of land at throw-away prices, customs duty exemptions for importing sophisticated medical technology, and loans from financial institutions at low interest rates. The period thus witnessed the emergence of a corporate health sector, increasingly influential in policy-making. The institutions involved have not always provided free services to the poor as they were expected to under the terms of their contracts. A committee set up by the Government of Delhi found gross violations on every commitment made. The report of course gathers dust.

The incentives offered to the private health industry have led to the burgeoning of high-technology diagnostic centres in urban areas, with excess capacity. But government employees can now obtain reimbursement for medical expenditure at these institutions, creating effective demand for high cost medical care. In India’s private health sector, supply creates demand. Over the same period there has been a burgeoning of medical colleges in the private sector, charging exorbitant fees for admission. Given the urban concentration among doctors, it is not surprising to find small-scale studies providing evidence of severe competition leading to unethical medical practices. By offering higher pay the private sector also sucks out personnel from the public health system. The incentives given to the private sector have led to India’s emergence as a major destination for health tourists, including as a centre for reproductive health. Thus while India produces more than enough doctors – but not enough nurses – for her public health system, she is facing an acute crisis in human health resources for the public health system.

India has also emerged as a major exporter of human health resources. The emigration of skilled workers does bring some benefits to the migrants and their families, with further benefits to the state in terms of foreign exchange flows, but it comes at a heavy price for the country. It was already estimated in the 1990s, for instance, that 4,000 to 5,000 doctors, trained at
public expense, emigrated every year at an estimated annual cost of US$160 million to the Indian exchequer.48 A more recent study carried out at India’s premier public medical institution, the All India Institute of Medical Sciences (AIIMS) in New Delhi, estimated that 50 per cent of doctors trained in India migrated overseas or internally to the private sector between 1989 and 2000, with those from the privileged upper-castes especially tending to migrate abroad.49 This makes the reservation of places in medical schools for the less-privileged castes all the more important, not just for affirmative action but also for public health.50

At the same time there were far-reaching changes in drug policies. India used to be known for its relatively low costs of drugs and pharmaceuticals and for its significant indigenous production of drugs. With her accession to the WTO, India has witnessed a greater concentration of drug production, a larger role for multinationals, a higher proportion of imported drugs and a dramatic increase in the cost of drugs.51 This too has contributed to the steep rise of medical care costs.

All these policies have combined to bring about marked shifts in healthcare utilisation. It was already the case in the mid-1990s that among people who sought out-patient services more than 80 per cent did so in the private sector, and this was visible even in the poorer states of the country.52 The same was true of in-patient care: in 1995-96, 55 per cent of patients in rural areas and 57 per cent urban areas were treated in private hospitals, compared to 40 per cent in both rural and urban areas in 1986-87. By the mid-point of the current decade things had worsened. A further 4 per cent in rural areas and 5 per cent in urban areas had shifted to private services by 2004. In short, more people were turning away from the collapsing public system, a collapse that was an outcome of public policy. An increasing proportion of people borrowed or sold assets in order to access medical care in the private sector.53

Class inequality in the use of health facilities has also increased. In rural areas class differences in the in-patient use of public hospitals, insignificant in the mid-1980s, turned statistically significant in the mid-1990s. In urban areas, inequality in the use of public facilities did not worsen significantly, but inequality in use of private facilities did. The steep fall in rural hospitalisation rates, along with increasing use of hospitals by the better-off, indicates that the poor are now being squeezed out. User fees are one important reason for this. In other words, the type of market-oriented policies on health famously advanced by the World Bank in its 1993 World Development Report succeeded in doing exactly the opposite of what was ostensibly their raison d’être: to reduce the utilisation of public services by the better-off in order to
increase access for the poor. What people need to pay for both out-patient and in-patient care increased sharply in both rural and urban areas of India after the mid-1980s. In rural areas, private out-patient costs increased by 142 per cent as against 77 per cent in the public sector. In urban areas, private out-patient costs increased by 150 per cent compared to 124 per cent in the public sector. The increase in what people had to pay for in-patient care is even more striking: average charges rose by 436 per cent in rural areas and 320 per cent in urban areas. The counterpart to poor public financing is that India has one of the highest levels of private medical expenditures in the world: out-of-pocket personal expenditure accounts for 83 per cent of the total health expenditure. At the same time, the proportion of people not getting any type of medical care due to financial reasons had already increased between 1986-87 and 1995-96: from 10 to 21 per cent in urban areas, and from 15 to 24 per cent in rural areas. Since then, even the middle classes are finding it increasingly difficult to meet medical care costs.

As economic inequalities have increased, so have health inequalities: between the states, between rural and urban areas and between different social groups. Such was the evident mismatch between the country’s economic growth and her stagnation in health that the government initiated a series of moves to improve health infrastructure. The results of the National Rural Health Mission, initiated in 2005, partly as a consequence of the influence of the Left political parties on the government at the time, are yet to unfold.

One important feature accompanying health sector reforms has been its NGO-isation. Some NGOs have been doing excellent work in health and family planning; some have served as models. A range of NGOs is involved on issues of primary health care with no assistance from either state or foreign donors. It is nevertheless important to question the current policy romanticisation of NGOs, and their increasing utilisation, often at public cost, to implement health and family planning schemes. NGOs comprise a broad and heterogeneous category in terms of ideology, activities, funding, outreach and effectiveness, and any generalisation about them would be extremely weak, if not foolish. But they are not necessarily either more effective or efficient than publicly-funded institutions and cannot be used as a substitute for them, for a variety of reasons. First, by definition, NGO activities are discretionary and not mandatory: they are not legally obliged to serve all people, as public institutions are. Thus they can be socially exclusive, and indeed the fear that NGO-isation may be against the interests of dalits has been frequently voiced by dalit activists and scholars. Second, they are not necessarily accountable. Thus, while a politician has the (admittedly
infrequent) chance of being voted out for incompetence or corruption by his constituents, NGOs do not. Third, the whole issue of monitoring and regulation of the private and NGO sectors is a vexed question, but we have only to remember that the scandal of quinacrine sterilisations in the country was largely carried out by NGOs.\textsuperscript{62}

Notably, a study in Delhi revealed that ‘people repose little hope in civil society agents to negotiate their problems: 94 per cent of the respondents held the government responsible for providing medical care to the people, while a negligible percentage (1 per cent) felt that it is the job of NGOs’.\textsuperscript{63} But the myth that NGOs are somehow more ‘representative’ than political bodies has been so assiduously created in the age of neo-liberalism that this fundamental point has often been ignored. So has the problematic fact that the space afforded ‘civil society organisations’ in policy-making bodies rigorously includes NGOs while excluding other more representative organisations such as trade unions.

**IN CONCLUSION**

Health sector developments in India, then, did not meet the goals set out at Alma Ata. India has always had a dual system of health care, and public health, for the haves and have-nots. What the last many years have done is to widen this chasm. They have reinforced state policy tendencies towards a selective and targeted approach; declining public investments, especially in primary care; increasing use of private sector facilities for both in-patient and out-patient care; falling levels of efficiency and effectiveness in the public sector; and even a further squeezing-out of the poor from access to publicly-funded health care. At the same time, the private sector has grown, with active support from the state.

The characteristic feature of the approach to health that international institutions such as the World Bank have fostered – and not just in India – is the tendency to deal with disease and health merely at the individual level, and to conceive of populations merely as aggregates of individuals, disregarding the social and economic context of diseases.\textsuperscript{64} Central to this approach was the ideology of introducing market principles into hitherto sacrosanct areas of public goods, converting health care into a market-driven, profit-maximising enterprise. To do so required a philosophical commitment to methodological individualism in public health, an oxymoron, but nevertheless achieved globally not only through the World Bank but also the WHO and its Commissions on Macroeconomics and Health. Their focus on proximate causes led to what has been described as individualising and psychologising health.\textsuperscript{65} This reflects the dominance of the behavioural
approach to public health, which has always characterised the major schools of public health in the US: this is not only hubris but also profoundly cynical, given the US’s own dysfunctional healthcare system.

The three most influential people in India’s financial policies today are all former World Bank employees. The Prime Minister, Dr. Manmohan Singh is one of them, as is the Governor of the Reserve Bank of India and the head of the Planning Commission. The political class in India does not now even require the imprimatur of the West and its institutions: they are confident that they have arrived at a muscular new India on the global stage. The yearning to be part of the global US project, the aching for a nuclear India accepted globally, leads to a search for a mantra that would do away with India as it really is – an Indian rope trick. If the film Slumdog Millionaire can do it, why can’t public policy?

The sabotage of Alma Ata was neither accidental nor innocent. It emerged out of a new political economy both globally and within India. The consequences for health are profound.

NOTES

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4 Ibid.
9 Sung Lee, ‘WHO and the developing world’, p. 42.
14 Kim et al., *Dying for Growth*, p. 143.
15 Gershman and Irwin, ‘Getting a grip’.
20 ‘Garv se kaho hum Hindu hai’ (Say with pride that we are Hindus) was the war cry of the ‘Hindu’ fascists as they destroyed the historic Babri mosque in 1992, plunging the nation into a communal cauldron, but, sadly, reaping rich electoral dividends.


Two states, leading in PPPs, Andhra Pradesh and Gujarat, have entered into PPPs in the health sector with Satyam computers, at considerable cost to the state exchequer. Satyam has recently been revealed to be India’s biggest corporate fraud, its CEO the Bernard Madoff of India. The PPPs however continue.


There was uproar in Parliament on 8 June 2009 regarding what was described as the ‘auctioning’ of seats in private medical colleges, said to be charging 10-20 million rupees for a post-graduate seat. See ‘Govt under fire over capitation fee scam in both houses’, *Times of India*, 9 June 2009.


There is a flourishing trade, a black market of body parts, in the private sector in India, including reproductive ones. Newspapers frequently report kidney removal scandals. There is also a burgeoning industry in assisted reproduction, including commercial surrogacy.

There is indeed a great deal of anecdotal evidence about unemployment among doctors in India, concentrated in urban areas, and fiercely competing for practice with little attention to medical norms or rational prescription practices. Reflecting this, it appears that doctors are the second largest category of applicants to the Indian Administrative Services exams. But, of course, we have no firm data. However unreliable government data in India are, the private sector is even averse to academic enquiries.


The question of reservations, or affirmative action, for the backward castes in India is a hugely divisive political issue playing out on familiar tropes from racist debates in the West, with of course peculiarly Indian complexities. Doctors, largely upper caste, and the dominant section in the media, also largely upper caste, have opposed reservations on the grounds of merit, on the grounds of maintaining standards and so on. Indeed, they implicitly argue that characteristics such as intelligence, merit and efficiency have a genetic basis and in their protests, medical students have swept streets and polished shoes, considered quintessentially lower caste occupations. See Abhay Mishra, ‘Anti-quota protests: complaints against students’, *Indian Express*, 8 May 2006.


Sen et al., ‘Inequalities in utilisation of health services’.


Baru et al., ‘Inequalities in utilisation of health services’.


Hartmann perceptively noted in the early 1990s that ‘In India, the government’s recent capitulation to the IMF and consequent intensification of population control efforts are being accompanied by what activists call a “buying-up” of NGOs by USAID. In the state of Uttar Pradesh alone, USAID is planning to spend 325 million dollars to reduce population growth in a scheme which


