

How one might understand the economic and health realities confronting India: an exploration into the realm of the political economy of health.

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Abstract: This paper seeks to examine the actual economic and health realities that exist in India. It serves as an introduction into economic realities that have existed in India since 1991, while examining economic and health reforms that have been considered since 1991. Additionally, the paper provides a cursory glance into perceptions, and how perceptions impact public policy.

Introduction

The year 1991 saw India make the choice to move from a more isolated, autarkic economic system to a more internationally involved system, that saw a move away from state involvement within the economic and social system within the country. Health policy, capacity and capabilities play a vital role in the course of a nation's economic, social, and political progress. Health policy and services have been noted as being fundamental to a nation's economic capacity.

Yet, often health policy earns less than a tertiary consideration within the more “liberalized” economic systems, particularly from the vantage of the International Financial Institutions (IFIs), such as the International Bank for Reconstruction and Development, commonly known as the World Bank (WB), or the International Monetary Fund (IMF). More frequently than not, the paradigm development comes to the fore, with a variety of policies recommended for its success. As has been noted, “development is a multidimensional concept that focuses on human development through the removal of poverty, ill-health, illiteracy and other social deprivations.”¹

Talking about the political economy of health services, policies, and capacity in India requires an understanding of the economic realities that have confronted India, particularly since

¹ Basudeb Biswas. “The Effects of Economic Growth and Public Support of Health Services on Longevity: A Panel – Data Analysis.” Chapter 13 from *Economic Institutions in India: Sustainability under Liberalization and Globalization*. (2003) edited by Parthasarathi Banerjee and Frank Jurgen Richter. New York: Palgrave MacMillan

the mandated liberalization programs India had to tailor its policies around. Often health and other social services and policies are compelled to take a tertiary seat to the mandates of the IMF, World Bank, and other Western dictates. Since India's nuclear tests in May of 1998, India has pursued a policy of nuclearization coupled with a military modernization program that adds greater competition for scarce governmental resources.

Political Economy and Economic Realities for India.

The late 1990s saw a financial crisis emerge within South East Asia that saw economists and financial leaders press for continued liberalization, following the policies of the IMF and World Bank. Often the programs that were pressed were considered stabilization, austere programs, purported to provide a firmer, sounder economic system. These programs built upon policies and recommendations that had come to epitomize "economic liberalization" and the fundamentals of forcing governments throughout the lesser industrialized world out of their economies along with curtailing government expenditures on social services. The direct opposite of what one finds within the advanced industrialized countries (AICs).

Often the reforms proposed by these institutions and the AICs was the Washington Consensus. This term, the "Washington Consensus" was what was a label coined for the reform agenda proposed by the IFIS and AICs. This consensus revolved around ten reforms that included:²

1. Fiscal discipline
2. Reordering public expenditure priorities
 - a. These expenditures include not only military expenditures, which typically are considered the "ultimate prerogative of sovereign governments and accordingly

² John Williamson. "From Reform Agenda: A short history of the Washington Consensus and suggestions for what to do next." *Finance and Development*. September 2003. pp. 10 - 13

off limits to international technocrats.” There are also three other “major expenditure categories, subsidies, education and health, and public investment.”³

3. Tax reform
4. Liberalization of interest rates
5. A competitive exchange rate
6. Trade liberalization
7. Liberalization of inward foreign direct investment
8. Privatization
9. Deregulation
10. Property Rights

Structural adjustment purportedly produces “a more stable economy followed by policies to alter the structure of the economy to make it better suited to a global market environment.”

Additionally, the International Labour Organization notes that,

“The term ‘structural adjustment’ can be given various meanings, but it is usually taken to characterize ‘the kind of policies now recommended to developing countries that are heavily indebted or for other reasons have balance of payments deficits with the aim of enabling them to pay their debts, become creditworthy again, and lay the foundations for subsequent sustainable growth.’”⁴

Furthermore structural adjustment towards the end of the 20th century, and at the beginning of the 21st would characteristically be composed of features that had the following: “trade and exchange rate liberalization, reduction of budget deficits, removal of subsidies from petroleum products and other basic commodities, privatization of state-owned enterprises and the reduction of public sector employees.”⁵

The notion of economic liberalization remained, and still remains skewed not only in theory, but practice. The IMF and World Bank both have been proponents of liberalization and austerity measures, despite their supposedly being representatives for the entire global

³ John Williamson. “What Washington Means by Policy Reform.” Chapter 2 from *Latin American Adjustment: How Much Has Happened?* Edited by John Williamson, published April 1990. taken from the *Institute for International Economics*. <http://www.iie.com/publications/papers/paper.cfm?ResearchID=486>

⁴ International Labour Organization. “Structural Adjustment and Tripartite Consultation.” [<http://www.ilo.org/public/English/dialogue/govlab/legrel/papers/brfnotes/tricons3.htm>]; originally cited, H. Singer, “Foreword”, in G. Standing and V. Tokman: Towards Social Adjustment: Labour market issues in structural adjustment (Geneva, ILO, 1991), pp. v

⁵ International Labour Organization. “Structural Adjustment and Tripartite Consultation.” [<http://www.ilo.org/public/English/dialogue/govlab/legrel/papers/brfnotes/tricons3.htm>]

community, they in practice have taken their direction from the United States Department of Treasury, and other Western (AIC) finance ministries.⁶

At the dawn of the 21st century, India has come to be recognized as a leader information technology, and other computer related software and increasingly high technology aspects. Yet, it was only a little more than a decade ago that India was forced to seek international assistance, primarily from the IMF. In 1991, India was compelled to seek IMF assistance, though it was not the first time that India has sought the institution's help. India had gone to the IMF in 1980 – 81 in a request for credit, that also saw the country begin its gradual away from the 'license raj.' This IMF loan introduced selected economic liberalization programs, first under Prime Minister Indra Gandhi and subsequently her successor, Rajiv Gandhi.⁷ When India went before the IMF for a second loan it had the equivalent of 2 weeks worth of foreign currency reserves.⁸

There were three primary elements to the reforms that India had to follow. First, India had to deregulate and liberalize her markets. Second, greater competitiveness had to be allowed in all spheres of the economy. And third, the government would have to live within its budget. Every aspect of licensing and control were to be abdicated.⁹

As the diktat of the Washington Consensus demanded, the first program tackled was that of governmental expenditures. Governmental expenditures declined as portion of GDP from 11 percent during the 1986 – 1991 period to 10.1 percent during the period of 1992 – 95. Social programs became collateral damage under stabilization. Government expenditures on rural development and social services declined. While the economy started to pick up after the IMF

⁶ Jeffrey Sachs. "The IMF and the Asian Flu." *The American Prospect*. No. 37 (March – April 1998) No. 37, pp 16 – 21 [<http://epn.org/prospect/37/37sachfs.html>]

⁷ R. Nagaraj "What has happened since 1991? Assessment of India's Economic Reforms." *Economic and Political Weekly*. Vol. 32, No. 44 & 45 (November 8, 1998) pp. 2869

⁸ Surendra K. Kaushik. "India's Evolving Economic Model: A Perspective on Economic and Financial Reforms." *American Journal of Economics and Sociology*. Vol. 56, No. 1 (January 1997) pp. 77

⁹ Arjun Sengupta. "Financial Sector and Economic Reforms in India." *Economic and Political Weekly*. Vol. 30, No. 1 (January 7, 1997) pp. 40

programs, public investment had declined.¹⁰ Many had argued that India's "bloated" and seemingly "self-serving" public sector had been the cause of India's woes. Some had argued that the corruption was not only rampant, but that in total, the government of India had caused the most harm to the poor and helpless of society.¹¹ Thus, India since 1991 had "increased the role of markets in the economy, directly through privatization, or by way of reductions in state investments and interventions, and indirectly through domestic deregulation and trade liberalization."¹² This might have helped translate into higher GDP growth rates, as well as improving the economic situation of many within the country, but it also served as a means of minimizing and delegating the poor to the fringes of social conscious.

What many forget then and still today was that "somehow the plight of the working poor, urban and rural, became lost amidst reams of macroeconomic data."¹³ The drive for economic efficiency and less government involvement in national economic and social aspects were paramount. The poor, regardless of their being rural or urban played little part in the formulation of national priorities. Priorities that should be set for the betterment for a nation were set by "Westernized elites" and technocrats based within the IMF, World Bank, and Western capitals.

The economic realities that exist in 2005 are completely different from that which existed at the time of independence in 1947, 25 years ago, even 14 years ago. Today India has emerged as an potential economic juggernaut which competes internationally in a variety of sectors. Yet, the reality also remains that much needs to be done to ensure not only the economic livelihood of

¹⁰ R. Nagaraj. (1998) pp. 2871 - 2872

¹¹ Kaushik Basu. "Structural Reform in India, 1991: Experience and Agenda." *Economic and Political Weekly*. Vol 28, No. 48 (November 27, 1993) pp 2599 – 2600, 2603; Anand P. Gupta. "Political Economy of Privatisation In India." *Economic and Political Weekly*. Vol. 31, No. 39 (September 28, 1996) pp. 2687

¹² R. N. Ghosh. "The Globalization Process and Economic Liberalization in India: Lessons from Classical Economics." In *Economic Institutions in India: Sustainability under Liberalization and Globalization*. (2003) edited by Parthasarathi Banerjee and Frank Jurgen Richter. New York: Palgrave MacMillan, pp. 266 - 267

¹³ International Labour Organization. "Structural Adjustment and Tripartite Consultation." [<http://www.ilo.org/public/English/dialogue/govlab/legrel/papers/brfnotes/tricons3.htm>]

hundreds of millions of destitute Indians, but also for their health and social wellbeing. Why should one care about economic realities, and capabilities of a nation? The answer is simple. The economic system, realities, and capabilities of a nation often are translated in the capacity to improve not only the economic well being of a nation's citizenry, but the people's health and social status as well. Additionally, an avowed policy of providing health services for a country's citizenry also pays dividends that translate into a healthy workforce, population, better able to work and participate within the economy. As prominent economist Jagdish Bhagwati noted,

“Since the 1980s, a majority of policy economists around the world have begun to favor economic reforms that increase global integration, in the strong belief that such reforms would, *ceteris paribus*, promote growth and would, both directly and indirectly (by raising resources for spending on social programs...) help to improve living standards among the poor.”¹⁴

Bhagwati also notes that many of the “prominent economists” who advocated reforms were also the ones who had previously advocated the policies that had been the paradigm three decades earlier.¹⁵ These prominent economists seemed to have forgotten the lessons elucidated by Adam Smith.

Not only did Adam Smith, the father of economics note that the duty of the state was to provide for justice, some involvement in the regulation of an economy, or for public works such as roads, canals, and other projects that would be difficult for the private sector to provide.

Adam Smith also noted that the populace needed to have social program, particularly with regards to education, which by extension would lend itself to health and all other social projects that would prove beneficial to commerce, and society.¹⁶ Another seminal economist, and Nobel

¹⁴ Jagdish Bhagwati. “Poverty and Reforms: Friends or Foes?” *Journal of International Affairs*. Vol. 52, No. 1 (Fall 1998) pp. 34

¹⁵ Bhagwati. (Fall 1998) pp. 34

¹⁶ Adam Smith. *An Inquiry into the Nature and Causes of the Wealth of Nations*. (1976) Chicago: The University of Chicago Press (for more specifics, refer to Volume Two, Book 5, Chapter I)

Prize winner for economics, Amartya Sen notes that “economics is supposed to be concerned with real people,”¹⁷ and not labour under the pretensions of theory not disconnect with reality.

Economic and health reforms

When one starts discussing the reform agenda of IMF and World Bank, as well as the policy prescriptions of western capitals, the idea of “reform of public services is premised on the view that the public sector is unable to act as sole provider of services within a context of economic recession.”¹⁸ Historically, health services reforms within developing countries had entailed “altering pre-existing inequalities in the organization and distribution of health services established during the colonial era.”¹⁹ Thus following the discussion of economic realities and Liberalization, the issue of reform seems to hold that the state should only “run essential services.”²⁰

The reforms that have been advocated by the IMF and World Bank, et al., seem to indicate that their reforms were meant to provide a betterment for the nations they provided the recommendations. With the reforms, and the mandates provided initially to the World Bank and subsequently incorporated into the mission of the IMF, both institutions took to making recommendations. The problem that has evolved has been that the IMF and World Bank have “never made it explicit for whom their ‘reforms’ were meant.”²¹ Reforms were proposed and forced upon developing countries such that “the state or the public sector would provide essential

¹⁷ Amartya Sen. *On Ethics and Economics*. (1998) Malden, Massachusetts (USA): Blackwell Publishers Inc. pp. 1

¹⁸ Kasturi Sen. “Health Reforms and Developing Countries- A Critique.” In *Public Health and the Poverty of Reforms: The South Asian Predicament*. (2001) edited by Imrana Qadeer, Kasturi Se and K.R. Nayar. New Delhi: Sage Publications India Pvt. Ltd., pp. 138

¹⁹ Kasturi Sen. (2001) pp. 137

²⁰ Kasturi Sen. (2001) pp. 137

²¹ Imrana Qadeer, Kasturi Sen, and K.R. Nayar, editors. *Public Health and the Poverty of Reform: The South Asian Predicament*. (2001) New Delhi: Sage Publications India Pvt Ltd. Pp. 29

services such as ‘clinical packages’ for the needy whilst the tertiary sector opens up to full global competition.”²²

The reforms as advocated by outside forces seemed to think that health and other social services areas where actors other than a national government might have better capacities of providing services. As Imrana Qadeer notes,

A massive onslaught was launched against public sector participation in health care through colorfully illustrated “data-based” packages of *World Development Report 1993*, whose quality was as unreliable as the cause they advocated.²³

Thus the plans that “South Asian countries agreed to were plans which were conceived for them, but not by them,” which saw cuts in the social sector, as well as the movement of “privatization,” which meant the “marginalization of the public sector,” in all aspects of the economy, even in the health sector.²⁴ These reforms ultimately saw the health being declared a “‘non-essential’ service.”²⁵

The reality is that for there to be any type of equitable solution, outcome, health policy must be revitalized. Specifically, “health policy must be oriented towards the priorities of the poor.”²⁶ Health policies should reflect that which is important to the poor, which would mean redoubled efforts that concentrated renewed efforts on “child mortality and focusing on the health and survival problems of children.”²⁷ Officials should be cognizant of the bias towards urban population centers as opposed to the rural areas, as “health – seeking for treatment tends to

²² Kasturi Sen.(2001) Op Cit. pp. 145; original citation: Qadeer, I. (1994) World Development Reoprot 1993: The Brave New World of Primary Health Care. *Social Scientist*. 22 (9 – 12): 27 - 40

²³ Imrana Qadeer. “Impact of Structural Adjustment Programs on Concepts in Public Health.” In *Public Health and the Poverty of Reforms: The South Asian Predicament*. (2001) edited by Imrana Quadeer, Kasturi Se and K.R. Nayar. New Delhi: Sage Publications India Pvt. Ltd.,pp. 121

²⁴ Imrana Qadeer. “Impact of Structural Adjustment Programs on Concepts in Public Health.” Op Cit. pp. 120

²⁵ Imrana Qadeer. “Impact of Structural Adjustment Programs on Concepts in Public Health.” Op Cit. pp. 120; original citation, Ghosh, J. (1997) *Frontline*, 30 May

²⁶ A. K. Shiva Kumar. “Health and Human Security: Some Considerations for Priority Setting.” *The Indian Journal of Labour Economics*. Vol. 42, No. 3 (July – September 1999) pp. 417

²⁷ A. K. Shiva Kumar. Pp. 417

be higher in urban than in rural areas where public provisioning of health services, and hence access is relatively better.”²⁸ The urban bias also tends to be more pronounced for that is where the concentration of people tend to be. It should be noted that India has the dubious distinction of having Mumbai, (formerly Bombay) and Calcutta ranked as mega cities. A mega city is an “urban agglomeration of 10 million persons or more.”²⁹ Mumbai alone with an official population of 18 million, and unofficial of potentially 30 million definitely would fall into such a category, demanding significant levels of services, public and private. Yet, the country of India has hundreds of millions who depend upon agriculture for their livelihood. Should they be made to suffer for those who live within the urban centers of the land? What are the appropriate policy prescriptions? The politicians and elites who formulate policy regarding human development, health and other aspects of society should promote the ideas that best serve the totality of their populations.

The noted Pakistani economist Mahbub Ul Haq postulated had advocated greater deliberation of public policy. Haq stated that “the human development paradigm performs an important service in questioning the presumed automatic link between expanding income and expanding human choices.”³⁰ The notion that a discord exists between “expanding income and expanding human choices” might well prove heretical to many of those who fall into the camp “prominent economists” as defined by Bhagwati. Further,

A link between growth and human lives has to be created consciously through deliberate public policy – such as public spending on social services and fiscal policy to redistribute income and assets.... We must be careful. Rejecting an automatic link between income expansion and flourishing human lives is not rejecting growth itself. Economic growth is essential in poor societies for

²⁸ A. K. Shiva Kumar. Pp. 421

²⁹ *World Urbanization Prospects – The 2003 Revisions: Data Tables and Highlights*. (March 24, 2004): United Nations. Department of Economic and Social Affairs – Population Division.; <http://www.un.org/esa/population/publications/wup2003/2003WUPHighlights.pdf>; pp.2

³⁰ Mahbub Ul Haq. *Reflections on Human Development*. (1995) New Delhi: Oxford University Press, pp. 15

reducing and eliminating poverty. But the quality of this growth is just as important as its quantity. Conscious public policy is needed to translate economic growth into people's lives.³¹

As Haq notes, the prescription might very well “require a major restructuring of economic and political power.”³² What needs to be the focus of development and public policy is the human condition, and the alleviation of disease, poor health, and poverty.³³

The esoteric notions of development based upon national income figures proves little other than translating the human condition into something quantifiable.³⁴ Just as economics should be concerned with the human condition,³⁵ so should public policy and health decisions reflect the necessity of promoting, improving, and sustaining human life. As Sen notes, “Economics can be made more productive by paying greater and more explicit attention to the ethical considerations that shape human behavior and judgment.”³⁶

Orientalist perceptions of India in the world, does perception matter when it comes to health?

Often when thinks or hears of India, the thoughts that come to mind are of a land teeming with masses, snake charmers, the Taj Mahal, religious and sectarian strife. India also brings to mind a land where people are often portrayed as “taking good American jobs,” and the villains of outsourcing, as was the situation during the 2004 American Presidential elections. India has experience a plethora of depictions throughout the world that far predate Alexander the Great's invasion millennia ago.

Many times the outside depiction of a society, particularly a non-western, lesser industrialized (developed) country tends to be viewed through the lens of orientalism.

³¹ Mahbub Ul Haq. Op Cit. pp. 15

³² Haq. Op Cit. pp. 15

³³ Haq. Pp. 78

³⁴ Haq. Pp. 40

³⁵ Sen. Op Cit. pp. 1

³⁶ Sen. Op Cit. pp. 9

Orientalism may be defined as “any trait, quality mannerism, etc... associated with the people of Eastern culture.”³⁷ In addition, orientalism may be considered to entail any and all studies of “eastern culture,” all that is non western, by western scholars.³⁸

Historically, the orient had been considered all places adjacent to Europe. Orientalism has become a methodology which saw “thought based upon an ontological and epistemological distinction made between ‘the Orient’ and ‘the Occident.’”³⁹ As one prominent scholar elucidated regarding orientalism,

It is rather a *distribution* of geopolitical awareness into aesthetic, scholarly, economic, sociological, historical, and philosophical texts; it is an *elaboration* not only of a basic geographical distinction but also of a whole series of “interests”.... It is above all, a discourse that is by no means in direct, corresponding relationship with political power in the raw, but rather is produced and exists in an uneven exchange with various kinds of power, shaped to a degree by the exchange with power political, power intellectual, power cultural, power moral.”⁴⁰

Thus, one might describe orientalism as the study of the orient, the east. Perhaps a more accurate description might be to state that “orientalism is the study of all regions that are not of the occident, or west. It entails the study of all non-western, non Christians, by those from the West.” Additionally, many within the LICs themselves might become swayed by this pedagogy, and view their own societies through the orientalist lens, seeking to mirror their societies, their economic and social systems along Western lines.

Depictions of India often have it as a dichotomous nation, a land of extremes, of rajahs and teeming, hordes of impoverished masses. India’s complexity portrayed to the outside world by media and scholars, by those of the West and its own “ambassadors” never comes across with

³⁷ Jean L. McKechnie, general editor. *Webster’s New Universal Unabridged Dictionary*. 2nd Edition. (1979) New York. Simon and Schuster pp. 1261

³⁸ Jean L. McKechnie. *Ibid*.

³⁹ Edward Said. *Orientalism*. (1978) New York: Vintage Books. pp. 1 & 2

⁴⁰ Edward Said. *Op Cit*. pp. 1 & 2

the vast intricacies that is India. Depictions in the late 1990s of India portrayed the country as that of “nationalist parties” such as the Bharatiya Janata Party (BJP). Indians have been consistently portrayed as the victims of India’s elite, whether it might be the Narmada Dam, or the BJP, who were depicted as “seeking to wreck havoc upon non-Hindus.” Why should one deign to feign concern about how India might be painted?

The complete and total acceptance of these norms results not only in the automatic colouring of one’s perception of India, but the decision making process by Indian policy makers, and those advising India. Yet, while it may well be true that the masses may be subjected to the whims of the elites, one must also recognize the very baggage that is associated with a discussion about a society through the lens of an outsider, or expatriate. The very language that one uses, that which is spoken, written and read by itself also influences a policy analysts perspective. Yet, what to do? Should one just say that is bad, and leave things as they are? Should one seek to make changes, improvements that better the lives of others? Such an answer remains difficult. The analyst and advisor should recognize his / her own ontological biases, and seek to understand and provide assistance not only to the best of the individuals ability, but also seek to work within the framework of the given society. To do otherwise might well prove not only cumbersome, but difficult.

Prescriptions for the “orient” have been formulated in the Western world. These prescriptions are imported that advocate “rapid growth and industrialization.” Furthermore, they tend to “encourage leaders... to drag their peoples into the industrial age as quickly as possible.”⁴¹ Yet as mentioned by Haq earlier, public policy should be created to serve the

⁴¹ Doug Bandow. “The First World’s Misbegotten Economic Legacy to the Third World.” From *The Revolution in Development Economics*. (1998) Edited by James A Dorn, Steve H. Hanke, and Alan A. Walters. Washington, D.C.: The Cato Institution, pp. 209; original citation, Robert Rothstein. *The Weak in the World of the Strong*. New York: Columbia University Press, 1977, pp. 179

betterment of a population, the entire population, not for a privileged segment of the society. To put it simply, many of those who have historically advocated and promoted “development” have had significant “distrust, if not contempt for, the ordinary, poor, uneducated masses of the Third World.”⁴² As one writer put it, “Leading Westerners simply believed nonwhite non-Westerners to be incapable of organizing their lives and economies as had people of European extraction.”⁴³ Further, the position of many seems to be that the biggest culprit has been the state. As Jean Dreze has noted that many, particularly within the NGO community “feel that the state is often part of the problem rather than part of the solution, and that state action is not really what is needed to address development issues.”⁴⁴ Yet, she notes that “this might be the case within some situations.” Dreze also notes that,

The agency of the state is an essential ingredient of the development process. It is, after all, the state that has the bulk of the resources, the infrastructure, the information, and the administrative capacity that are needed to have a real impact on living conditions. The state often needs to be reformed and challenged, but attempting to dispense with the agency of the state altogether, by creating some kind of parallel delivery system would be very unrealistic in most situations.⁴⁵

Dreze also notes that one should also “re-emphasize the positive role that the state can play in enhancing the quality of life in developing countries,” through careful and thoughtful policy deliberations, as well as through the “provision of social security and public services.”⁴⁶

Realities of the Economic system, and some priorities of governmental expenditures

“Public action can play a powerful role in improving the quality of life in developing countries, even at an early stage of economic development.”⁴⁷ Taking a simplistic view, “the

⁴² Bandow. Op Cit. pp. 209 – 210; original citation, Deepak Lal. *The Poverty of Development Economics*. London: Institute of Economic Affairs, 1983, pp. 204

⁴³ Bandow. Op Cit. pp. 210

⁴⁴ Jean Dreze. “Economic Development, Public Action and Social Progress.” *Canadian Journal of Development Studies*. Vol. XV, No. 3 (1994) pp. 331

⁴⁵ Jean Dreze. Op Cit. pp. 331 - 332

⁴⁶ Jean Dreze. Op Cit. pp. 332

⁴⁷ Jean Dreze. pp. 330

nexus between poverty, under-nutrition and morbidity implies low productivity of the country's human resources."⁴⁸ It remains imperative that minimal standards that must be met. "Health attainment is critical from the point of view of poverty alleviation, social security and human development."⁴⁹ Further, if any type of global health programs or goals are to be conceived and implemented, then "the targets for child health, maternal health and communicable diseases requires improvements in public health systems, not quick fixes or isolated technological interventions."⁵⁰

The existing reality regarding health does not flatter India. Ajay Mahal notes that "health subsidies are not particularly well targeted to the poor in India, especially among those living in rural areas and in the poorer states. The distribution of health subsidies is primarily driven by the magnitude of the subsidies and utilization patterns related to hospital – based care."⁵¹ As noted in the section on orientalism, one must be cognizant of one's own ontological perspective. Debabar Banerji notes that "analysis of health services must be located in the socio-cultural, ecological, economic and political settings of the country."⁵²

A national health system, a public health system has as its "key goal the reduction of a population's exposure to disease."⁵³ Additionally while the services of a health system may not

⁴⁸ K. Seeta Prabhu, and V. Selvaraju. "Public Financing for Health Security in India: Issues and Trends." Paper prepared for the National Consultation on Health Security, Organised by Institute of Human Development with support from the UNDP and the Government of India, New Delhi, 26 and 27 July, 2001; [<http://hdrc.undp.org.in/content/events/2001/JUL/nchsi-health.pdf>] pp. 2

⁴⁹ Prabhu and Selvaraju. Op Cit, pp. 2

⁵⁰ Colin I. Bradford. "Global Health and Global Governance: Prioritizing Health within the Framework of the Millennium Development Goals." *The Brookings Institution*. January 14, 2005 , pp. 2, [<http://www.brookings.edu/views/papers/20050114bradford.pdf>]

⁵¹ Ajay Mahal. "The Distribution of Public Health Subsidies in India." In *Health Policy Research in South Asia: Building Capacity for Reform*. (2003) edited by Abdos Yazbeck and David H. Peters. Washington, D.C.: The World Bank, pp. 33

⁵² Debabar Banerji. "Landmarks in the Development of Health Services in India." In *Public Health and the Poverty of Reforms: The South Asian Predicament*. (2001) edited by Imrana Qadeer, Kasturi Sen, and K.R. Nayar. New Delhi: Sage Publications India Pvt. Ltd, pp. 39

⁵³ Monica Das Gupta and Manju Rani. "India's Public Health System: How Well Does It Function at the National Level?" *Policy Research Working Paper 3447*. Washington, D.C.: The World Bank. November 2004, pp. 1

always be completely visible to the public, they are there for them, and the public tends to utilize those services when “the need for them develops.”⁵⁴ These services are vital for the maintenance of the public's health and well-being.⁵⁵ “These services produce ‘public goods,’ and are of high priority for assuring good health outcomes.”⁵⁶

If the health system were to ever fail, as in the case of the “1994 plague epidemic in Surat, in Gujarat state,” the losses could result in a “high price in illness, debility, and death” and in this situation the associated economic costs were estimated by the WHO at \$1.7 billion.⁵⁷ The occurrence of the plague in Surat “was an outcome of conditions that epitomize the state of the public health system and nature of urban growth in the country [India].”⁵⁸ Within India, the “private health services dominate the public health sector.”⁵⁹ Privatization and liberalization, with the abdication of the state for the provision of services had been the norm since 1991. In the case of Surat, what happened was that “private capital had not come forward to invest infrastructure projects like water, and sewage.”⁶⁰ Let know one be deceived. The predominance of the private sector in health does not mean the provision of services to the poor and the weak members of society. Neither does it mean that the private sector stepped in to take over the state's role in surveillance and monitoring for public health. The private sector failed to materialize and provide for the public good, as Adam Smith noted would occur. The economic restructuring programs demanded by the IMF and World Bank have “encouraged the

⁵⁴ Monica Das Gupta and Manju Rani. Op Cit. pp. 1, original citation from, American Public Health Association (<http://www.apha.org/ppp/science/10ES.htm>)

⁵⁵ Monica Das Gupta and Manju Rani. pp. 1

⁵⁶ Monica Das Gupta and Manju Rani. pp. 1

⁵⁷ Monica Das Gupta and Manju Rani. pp. 1; WHO citation, World Health Organization. *Removing Obstacles to Healthy Development*. [<http://www.who.int/infectious-disease-report/index-rpt99.html>]

⁵⁸ Ghanshyam Shah. “The Plague, the Poor, and Health Services.” In *Public Health and the Poverty of Reforms: The South Asian Predicament*. (2001) edited by Imrana Qadeer, Kasturi Sen, and K.R. Nayar. New Delhi: Sage Publications India Pvt. Ltd, pp. 459

⁵⁹ Ghanshyam Shah. Pp. 471

⁶⁰ Ghanshyam Shah. Pp. 473

establishment of five-star hospitals sponsored by and meant for the rich. It has already excluded a large section of the society from its purview.”⁶¹

Rather, the “weakening of the public health system” resulted in a “fractured monitoring and surveillance of communicable diseases.”⁶² The diminished involvement of the government (federal and state level) meant the “systematic demolishing” of monitoring and surveillance systems for public health. Thus any capacity to detect “early signals of the possibility of a resurgence of the plague in the country were ignored, and the plague surveillance departments were made either defunct or virtually closed down.”⁶³

Thus given the very serious potential of an HIV/AIDS pandemic, the Surat plague epidemic of 1994 pointed to the “need to maintain, restructure and strengthen, and efficiently run the public health system.”⁶⁴ This proves all the more vital in the face of emerging potential threats to human life, be it a naturally occurring pathogen, such as the avian flu that has concerned much of the world or a bioterrorist attack. Today, little research is “conducted on diseases that primarily affect poor countries, such as malaria and tuberculosis.”⁶⁵ The statistics are as follows:

According to WHO (1996), 50 percent of global health research and development in 1992 was undertaken by private industry, but less than 5 percent of that was spent on diseases specific to less developed countries. Even for disease that affect both rich and poor countries, research tends to focus on products that are best suited for use in rich countries.⁶⁶

⁶¹ Ghanshyam Shah. Pp. 473

⁶² Ghanshyam Shah. Pp. 472

⁶³ Ghanshyam Shah. Pp. 472

⁶⁴ Ghanshyam Shah. Pp. 473

⁶⁵ Michael Kremer. “Pharmaceuticals and the Developing World.” *The Journal of Economic Perspectives*. Vol. 16, No. 4 (Autumn 2002) pp. 68

⁶⁶ Michael Kremer. Op Cit. pp.69, original citation: WHO (World Health Organization), 1996, *Investing in Health Research and Development: Report of the Ad Hoc Committee on Health Research Relating to Future Intervention Options*. Geneva: WHO

Kremer notes that the marketing of pharmaceuticals in LICs differs in several ways from the AICs.⁶⁷

1. Markets: The market for pharmaceuticals tends to be significantly smaller in LICs as compared to the AICs.⁶⁸
2. Different Disease Environment: Developing countries face a significantly different disease environment than developed countries due to both their poverty and their geography.⁶⁹
3. Weak Health Care systems and the Misuse of Pharmaceuticals. The Health care systems in LICs tend often to be weak, and have qualified medical personnel are limited in number, as compared to the AICs. Thus many of the patients tend to rely on private systems, where many of the practitioners are ill trained, if at all. Thus, there tends to be far greater circumstances of self prescriptions in LICs than in the AICs.⁷⁰
4. Pharmaceutical Regulation, and the LICs decision to simply follow the approval decisions of developed countries rather than conducting their own risk-benefit calculations. Thus, the investigators who recommended removing a particular vaccine from the U.S. market advocated conducting a risk-benefit analysis for that particular vaccine in the developing world.⁷¹
5. Industry Factors. (i) pharmaceuticals face high fixed R&D costs, and low marginal costs of production. (ii) patent protections, (iii) pharmaceutical regulation and prescription requirements in AICs facilitate price discrimination across countries by making resale across national borders easier to block.⁷²
6. Limited Intellectual Property Rights. Many LICs have historically provided little or no intellectual property rights protection for pharmaceuticals. India offers patents on pharmaceutical processes but not on products, and has developed a large industry that reverse engineers existing drugs.⁷³

It remains vital to remember that India does face many of the similarities as other LICs. Due to its sheer population size, though India does have a sizable pharmaceutical industry of its own that provides some of the necessary medications for its billion plus population.

The following discussion refers to data from Appendix Table 1. Since the year before its enforced economic liberalization in 1991, India has seen its population increase from 850 million

⁶⁷ Michael Kremer. Op Cit. pp. 69 - 75

⁶⁸ Kremer. Op Cit, pp. 70

⁶⁹ Kremer. Op Cit, pp. 70

⁷⁰ Kremer. pp. 72

⁷¹ Kremer. Op Cit, pp. 72 – 73, original citation, Trudy V. Murphy, et al. “Intussusception and an Oral Rotavirus Vaccine.” *New England Journal of Medicine*. Vol. 344, No. 24 (June 14, 2001) pp. 1866 – 1867.

⁷² Kremer. Op Cit, pp. 73 - 74

⁷³ Kremer. Op Cit. pp. 74

souls in 1990 to 1.079 billion. Its national GDP has increased from \$317 billion to \$581 billion during the same time period.⁷⁴ Additionally, if one were to look at the total Health expenditure as a percent of GDP, it increased from 5.2% in 1998 to 6.1 % in 2002, which favored well in comparison to the United Kingdoms, which saw its expenditures increase from 6.9% to 7.7% in the same time frame.

Comparatively speaking, the United States saw its health expenditure increase from 13% to 14.6% during the same time frame. Yet, it remains fundamental that one look at the make up of the health expenditures. During this period, 1998 – 2002, private health expenditures as a percent of GDP for India rose from 3.82% to 4.8 percent, while public health expenditures as a percent of GDP declined from 1.378% to 1.299%. The United Kingdom saw private health expenditures as a percent of GDP decrease from 1.35% in 1998 to 1.27% in 2002, while the public sector increased from 5.547% in 1998 to 6.42% in 2002. The US during the same period saw private and public increase. The private increased from 7.2% to 8.046%, while the public increased from 5.78% to 6.55%.

Thus, while the public sector plays a significant role with regard to health, and health expenditures both within the United Kingdom and the United States, the public sector has taken a back seat to private in India. This seems quite ironic that the AICs have far greater involvement of the government in the health system than the LIC. Additionally, the number of physicians per 1,000 in the U.S. stands at nearly 5.5 physicians per 1,000, while India many consider fortunate with 0.51 physicians per 1,000. Clearly discrepancies abound, and that India has to make significant strides in its provision of health care.

India has made strides in reducing mortality rates over time, as well as with life expectancies. Yet, one must also recognize that the singular information of prevalence of

⁷⁴ *World Development Indicators Online*. World Bank.

diarrhea in children under the age of 5, at 19.2 % in 1999, remains unacceptable. Additionally, the prevalence of HIV as a percent of the total population, between the ages of 15 – 49 at 0.90% in 2003 represents a significant warning for the country. While a military expenditure that amounted to 2.28% of GDP in 2003 may not seem significant, it does represent a tremendous burden on the government's budget at 14.16%. Much of this military burden may be due to military and strategic necessity, considering India's geographical location amidst historically hostile neighbors such as Pakistan or China. Yet how much of this military expenditure has been allocated towards a nuclear deterrent, and the establishment of secure nuclear capabilities? One simple fact must be realized. All military expenditures are useless unless they are utilized for their ultimate purpose, which is to maim, kill and terrorize humanity. Military expenditures serve to protect a nation against outside aggression, and invasion. But armaments when aggregated tend on average to do little to improve human conditions.

India has significant problems that it must address. Under international law, "the right to health is one of a range of socioeconomic rights for which states accept an obligation."⁷⁵ The goal for India should be for social and human achievement. The human condition, the betterment of the population, the people should be the goal of India, its government and leaders, for its people. Good health should be the watchword for, of, and by the people. Anything less would be tantamount to genocide.

⁷⁵ Tony Evans. "A human right to health?" *Third World Quarterly*. Vol. 23, No. 2 (2002) pp. 197

References

- Bandow, Doug. "The First World's Misbegotten Economic Legacy to the Third World." From *The Revolution in Development Economics*. (1998) Edited by James A Dorn, Steve H. Hanke, and Alan A. Walters. Washington, D.C.: The Cato Institution
- Banerji, Banerji. "Landmarks in the Development of Health Services in India." In *Public Health and the Poverty of Reforms: The South Asian Predicament*. (2001) edited by Imrana Qadeer, Kasturi Sen, and K.R. Nayar. New Delhi: Sage Publications India Pvt. Ltd, pp. 39 - 49
- Banerjee , Parthasarathi, and Frank – Jurgen Richter, eds. *Economic institutions in India: Sustainability Under Liberalization and Globalization*. (2003). New York: Palgrave MacMillian.
- Bhagwati, Jagdish. "Poverty and Reforms: Friends or Foes?" *Journal of International Affairs*. Vol. 52, No. 1 (Fall 1998) pp. 33 45
- Biwas, Basudeb. "The Effects of Economic Growth and Public Support of Health Services on Longevity: A Panel-Data Analysis." *Economic institutions in India: Sustainability Under Liberalization and Globalization*. (2003) edited by Parthasarathi Banerjee and Frank – Jurgen Richter. New York: Palgrave MacMillian. Pp. 342 - 350
- Bradford, Colin I. "Global Health and Global Governance: Prioritizing Health within the Framework of the Millenium Development Goals." *The Brookings Institution*. January 14, 2005 [<http://www.brookings.edu/views/papers/20050114bradford.pdf>]
- Broad, Robin and John Cavanagh. "The death of the Washington Consensus?" *World Policy Journal*. Vol. 16, No. 3 (Fall 1999) pp. 79 -88
- Devarajan, Shantayanan, and Ritva Reinikka. "Making Services Work for Poor People: The poor need more control over essential services." *Finance & Development*. Vol. 40, No. 3 (September 2003) pp. 48 – 51
- Dorn, James A., Steve H. Hanke, and Alan A. Walters,eds. *The Revolution in Development Economics*. (1998) Washington, D.C.: The Cato Institution
- Dreze, Jean. "Economic Development, Public Action and Social Progress." *Canadian Journal of Development Studies*. Vol. XV, No. 3 (1994) pp. 329 - 346
- Evans, Tony. "A human right to health?" *Third World Quarterly*. Vol. 23, No. 2 (2002) pp. 197 - 215

- Ghosh, R. N. “The Globalization Process and Economic Liberalization in India: Lessons from Classical Economics.” In *Economic Institutions in India: Sustainability under Liberalization and Globalization*. (2003) edited by Parthasarathi Banerjee and Frank Jurgen Richter. New York: Palgrave MacMillan, pp. 265 - 287
- Gupta, Monica Das, and Manju Rani. “India’s Public Health System: How Well Does It Function at the National Level?” *Policy Research Working Paper 3447*. Washington, D.C.: The World Bank. November 2004
- Kremer, Michael. “Pharmaceuticals and the Developing World.” *The Journal of Economic Perspectives*. Vol. 16, No. 4 (Autumn 2002) pp. 67 – 90
- Kumar, A. K. Shiva. “Health and Human Security: Some Considerations for Priority Setting.” *The Indian Journal of Labour Economics*. Vol. 42, No. 3 (July – September 1999) pp. 413 - 429
- Mahal , Ajay. “The Distribution of Public Health Subsidies in India.” In *Health Policy Research in South Asia: Building Capacity for Reform*. (2003) edited by Abdos Yazbeck and David H. Peters. Washington, D.C.: The World Bank, pp. 33 - 63
- Mitra, Pramit. “India’s HIV/AIDS Crisis: A Moment of Truth.” *SAIS Review*. Vol. 24, No. 2 (Summer 2004) pp. 55 - 67
- Murphy, Trudy V., et al. “Intussusception and an Oral Rotavirus Vaccine.” *New England Journal of Medicine*. Vol. 344, No. 24 (June 14, 2001) pp. 1866 – 1867.
- Naim, Moises. “Fads and fashion in economic reforms: Washington Consensus or Washington Confusion?” *Third World Quarterly*. Pp. 505 - 528
- Noman, Akbar. “Scoring the Millenium Goals: Economic Growth versus the Washington Consensus.” *Journal of International Affairs*. Vol. 58, No. 2 (Spring 2005) pp. 233 - 244
- Prabhu , K. Seeta, and V. Selvaraju. “Public Financing for Health Security in India: Issues and Trends.” Paper prepared for the National Consultation on Health Security, Organised by Institute of Human Development with support from the UNDP and the Government of India, New Delhi, 26 and 27 July, 2001; [<http://hdrc.undp.org.in/content/events/2001/JUL/nchsi-health.pdf>]
- Qadeer, Imrana, Kasturi Sen, and K.R. Nayar. *Public Health and the Poverty of Reforms: The South Asian Predicament*. (2001) New Delhi: Sage Publications India Pvt Ltd.
- Sen , Amartya. *On Ethics and Economics*. (1998) Malden, Massachusetts (USA): Blackwell Publishers Inc.

- Sen, Kasturi. "Health Reforms and Developing Countries – A Critique." In *Public Health and the Poverty of Reforms: The South Asian Predicament*. (2001) edited by Imrana Qadeer, Kasturi Sen, and K.R. Nayar. New Delhi, Sage Publications India Pvt. Ltd, pp. 137 - 153
- Shah, Ghanshyam. "The Plague, the Poor, and Health Services." In *Public Health and the Poverty of Reforms: The South Asian Predicament*. (2001) edited by Imrana Qadeer, Kasturi Sen, and K.R. Nayar. New Delhi: Sage Publications India Pvt. Ltd, pp, 459 - 474
- Sherman, Peggy B., and Ellwood F. Oakley, III. "Pandemics and Panaceas: The World Trade Organization's Efforts to Balance Pharmaceutical Patents and Access to AIDS Drugs." *American Business Law Journal*. Vol. 31, Issue 2/3 (Winter / Spring 2004) pp. 353 - 411
- Smith, Adam. *An Inquiry into the Nature and Causes of the Wealth of Nations*. (1976) Chicago: The University of Chicago Press
- _____. "Structural Adjustment and Tripartite Consultation." *International Labour Organization*.
[<http://www.ilo.org/public/English/dialogue/govlab/legrel/papers/brnotes/tricons3.htm>]
- WHO (World Health Organization), 1996, *Investing in Health Research and Development: Report of the Ad Hoc Committee on Health Research Relating to Future Intervention Options*. Geneva: WHO
- Williamson, John. "From Reform Agenda: A short history of the Washington Consensus and suggestions for what to do next." *Finance and Development*. September 2003. pp. 10 - 13
- Williamson, John. "What should the World Bank think about the Washington Consensus?" *The World Bank Research Observer*. Vol. 15, No. 2 (August 2000) pp. 251 - 264
- Williamson, John. "What Washington Means by Policy Reform." Chapter 2 from *Latin American Adjustment: How Much Has Happened?* Edited by John Williamson. Published April 1990. *Institution for International Economics*.
[<http://www.iie.com/publications/papers/paper.cfm?ResearchID=486>]
- Yazbeck, Abdos, and David H. Peters *Health Policy Research in South Asia: Building Capacity for Reform*. (2003). Washington, D.C.: The World Bank