INTERNATIONAL AID IN HEALTH SECTOR AND PUBLIC HEALTH PLANNING

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CERTIFICATE

This dissertation entitled "**INTERNATIONAL AID IN HEALTH SECTOR AND PUBLIC HEALTH PLANNING**" *is submitted in partial fulfilment of six credits for the award of the degree of* **MASTER OF PHILOSOPHY (M.PHIL.)** *of the Jawaharlal Nehru University. This dissertation has not been submitted for the award of any other degree of this university or any other university and it is my original work.*

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CONTENTS

Acknowledgment

Abbreviation

Page No.

INTRODUCTION 1-5

The problem

Objectives of the study

Methods

Plan of chapters

CHAPTER I HISTORY OF INTERNATIONAL AID 6-20

The origin of foreign aid

International lending and United States

The Bretton Woods Institutions: Vision vs Reality

Changing role of IMF and World Bank

The origin of Structural Adjustment Programme

Purpose of giving aid

From poverty to adjustment and back again

CHAPTER II DISCOURSE ON INTERNATIONAL AID 21-50

Defining international aid and its forms

International private capital and international aid

Types of foreign aid

The evolution of development doctorine and the role of foreign aid in LDCs –1950-2000

Why do we need international aid?

International aid – contrasting viewpoints

International aid to India – Salient features

CHAPTER III PUBLIC HEALTH PLANNING IN INDIA 51-82

Earlier official understanding of causes of low level of health in India

First five-year plan

The health sector planning from second to third five-year plan

Fourth five-year plan

Fifth five-year plan
Sixth five-year plan
Seventh five-year plan
Eighth five-year plan
Ninth five-year plan
Tenth five-year plan – Illusions continue
International influence on national programme strategy – an example

CHAPTER IV INTERNATIONAL AID AND PLANNING PRIORITIES – A FOCUS ON HEALTH **83-117**

Assistance from WHO
Assistance from UNICEF
Assistance from DANIDA
Assistance from NORAD and SIDA
Assistance from ODA(UK)
Assistance from USAID
Assistance from World Bank
Assistance from UNFPA
Assistance from others

CHAPTER V THE INDIAN EXPERIENCE OF INTERNATIONAL AID – A DISCUSSION **118-133**

Shifting pattern of aid
Implications of international aid for health sector planning
Summing up

REFERENCES **134-140**

ANNEXURE I

ANNEXURE II

LIST OF TABLES

Table No.	Title	Page No.
Table 1.1	Schematic overview of main developments in the history of foreign aid	15
Table 4.1	Deaths at specific age periods as percentages of the total deaths at all ages	51
Table 4.2	Expenditure on various categories of medical schemes	55
Table 4.3	Expenditure on different categories of public health schemes	55
Table 4.4	Plan outlays for various programmes	60
Table 4.5	External assistance during the seventh plan period	71
Table 5.1	Percent share of loan and grant in public sector outlay	83
Table 5.2	WHO assistance for health	85
Table 5.3	WHO assistance for family welfare	86
Table 5.4	Assistance allocated by WHO/UNDP	88
Table 5.5	WHO country budget assistance (1993-94, 1995-96)	88-89
Table 5.6	WHO country budget assistance (1996-97)	89
Table 5.7	DANIDA assistance for health	93
Table 5.8	DANIDA assistance for family welfare	93
Table 5.9	ODA (UK) assistance for health	95
Table 5.10	ODA (UK) assistance for family welfare	96
Table 5.11	Utilization position of US assistance during the last five financial years	99
Table 5.12	Share of CDCP and family welfare in health sector budgets	101
Table 5.13	Estimates for the ninth five-year plan	101
Table 5.14	World Bank assistance for health	103
Table 5.15	Details of World Bank assistance as against total external assistance received by disease control programmes for 1999-2002	103
Table 5.16	World Bank assistance for family welfare	104

Table 5.17	Present share of various donor agencies in assistance for ADPs	105
Table 5.18	UNFPA assistance for family welfare	115
Chart	Total external assistance received over the last decade	106
Graph	India's debt outstanding liability of foreign loans	106

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Nisha Gupta

LIST OF ABBREVIATIONS

ARI	Acute Respiratory Infections
CBR	Crude Birth Rate
CDCP	Communicable Diseases Control Programme
CPR	Couple Protection Rate
CSSM	Child Survival and Safe Motherhood
EPI	Expanded Programme of Immunisation
ESIS	Employees State Insurance Scheme
FPP	Family Planning Programme
GNP	Gross National Product
HFA	Health For All
ICDS	Integrated Child Development Scheme
ICPD	International Conference of Population and Development
IMF	International Monetary Fund
IMR	Infant Mortality Rate
LDC	Less Developed Countries
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MNC	Multi National Corporation
MOHFW	Ministry Of Health and Family Welfare
NCD	Non-Communicable Diseases
NGO	Non-Government Organisation
NLCP	National Leprosy Control Programme
NLEP	National Leprosy Eradication Programme
NMEP	National Malaria Eradication Programme
NPCB	National Programme for Control of Blindness
NTP	National Tuberculosis Programme
OECD	Organisation for Economic Cooperation and Development
OPEC	Organisation of Petroleum Exporting Countries
PHC	Primary Health Care

RCH	Reproductive Child Health
RNTCP	Revised National Tuberculosis Control Programme
RTI	Respiratoty Tract Infections
SAP	Structural Adjustment Programme
UIP	Universal Immunisation Programme
WDR	World Development Report
WHO	World Health Organisation

INTRODUCTION

Indian health planning started with the aim of providing health care to all irrespective of people's ability to pay. Over the years it had been repeating its resolve in more forms than one, like – health is basic to development and it shall be the ultimate objective of the state to ensure a better quality of life and human development.

The Bhore committee developed the concept of building basic health services that provides the minimum necessary health care in 1946. It proposed provision of integrated basic care to all of India's population. Although, its recommendations did not emphasize the centrality of overall development in achievement of respectable health standards, it fully recognized the interdependence of disease and poverty. Supposedly, it assumed that such an understanding should come naturally to the health planners, and therefore need not be categorically outlined in a health policy guideline. This faith on the conceptual understanding and integrity of the planning fraternity has led India into a complex situation. Overall development remained the thrust of planning but only in terms of growth rates. By the time issues of distribution and equity became central, ill managed diseases of poverty like undernutrition and communicable diseases and increasing non-communicable diseases, together had become the bane of the planning process.

Theoretically, the social nature of health, factors affecting health and disease causation, and complex systems for ensuring health of a population are well known. Planning for organization of health services and other specific issues related to health requires locating health within overall development process. All this calls for an integrated approach for public health planning.

In the course of my learning process, I realized that except for the success in small pox eradication, India has not registered even a single success story, inspite of having technical expertise and financial resources for handling any health issue. My search for the reasons pointed towards poor conceptual understanding of health resulting in displaced priorities of our planners. Either there was an eagerness to eradicate malaria without adequate preparation, or there was undue thrust on family planning. The understanding that poor living conditions are the main causes of spread of communicable diseases was lost and development being the best contraceptive was an idea, which could not survive the greed of populist agendas. I realized that a health

programme gets importance not on the basis of the gravity of the problem it addresses but on the amount of funds it receives. This led to another query as to why is our financial outlay skewed towards programmes of dubious public health concerns rather than attending to the issues repeatedly identified by our five-year plans. The attempt to resolve this query pointed towards the international linkages of health sector planning. Methodologically we have the following description of the problem, which is further developed in chapter I and II.

THE PROBLEM

Readings about the origin, growth and significance of international health institutions, the debates on policy guidelines promulgated by these institutions, and the studies on experiences of various countries like china, Cuba, Sri Lanka who adopted a socialist democratic model of growth, and US that has a capitalist economy, suggested that it was not the rate of economic growth that determined the standards of health. Sri Lanka though has a lower rate of growth has health standards much higher than India. China has been registering constantly high rates of economic growth post 1979 with a simultaneous increase in health inequalities. In other words, changes in the economic policies geared towards economic growth alone do not necessarily have a positive effect on the health of the population. Rather it required basic structural changes in the economy, which ensure more equality in the redistribution of wealth, to make any substantive effect of health.

Inspite of so many researchers pointing towards faulty programme priorities in the health sector, criticizing the validity of the methods adopted to deal with diseases and fertility as a public health problem, our planners seemed to be totally oblivious of the problems. They kept on emphasizing the same programmes over the years and introducing 'health sector reforms' which further increased the distance between the needy and the services. Some examples of such questionable interventions are childhood preventable infections through UIP ((Banerjee 1999), leprosy control (Chatterjee 2001) and high focus on contraceptive approach (Bose 1998).

My search into the reasons for such a parochial strategy adopted by our planners pointed towards problems in the economics of health care planning. It was realized

that health sector, which, till late 70s was a non productive social sector, later got recognition as an important area of investment for the development of a healthy human resource. The reason was that health service which was perceived as welfare for individuals, with growing private sector came to be seen as human capital. And therefore investments in health as investments for productive labor force. Also increasing privatization of the health sector led to increase in the number of polyclinics, nursing homes, hospitals and now corporate hospitals. This increased markets and attracted foreign inputs. It was the 80s and early 90s, therefore that saw a dramatic increase in the size of private sector and in the amount and the number of donors in the health sector. There seemed to exist a strong link between the existing international health priorities (like AIDS, tuberculosis and non communicable diseases) and the choice of disease control programme in India. This too had a basis. Research in the area of drug and equipments is increasingly becoming costly. Therefore it is more feasible for pharmaceutical giants to narrow down their focus to few diseases (for which market is large and the possibility to find a cure are more probable), and pool in their finances for research purposes. These diseases then go on to become international priorities and are promoted by international agencies (funded by these giants) in the developing world. Further, once the technology is in the market, it depends on the purchasing power of the people to make it successful. The cost of such technology is high because of heavy investments in research and profit motives of the multi national drug companies. The rich can purchase from open markets but the poor remain marginalized. Therefore adjustments are made in the state machinery, which covers the marginalized sections so that these technical interventions can be sold to the poor as well. These strategies thus become central to adoption of health sector reforms and increase in funding for health sector by the World Bank. "We have entered a new era of public policy. This era is defined by increasing overlaps between domestic and foreign policy and national and international interests as well as by a widening range of new actors at the local, national, regional and international level" (Leppo, 1997). Therefore it was found important to delve into this area of international funding in the health sector and study the implications it has had for public health planning in India.

OBJECTIVES OF THE STUDY

This study is an attempt to understand the dynamics of international aid in the health sector and its implications for public health planning in India. The objectives of this study are:

1. To understand the origin, historical significance and changing role of international donor agencies. To understand the rationale behind giving and taking of international aid.
2. To study the discourse on international aid, its relevance, dynamics and political economy at the global as well as the national level.

International aid is a vast area and therefore, to understand its dynamics better, it is essential to focus in a particular field. Thus in this study we have focused on Indian public health planning and the influence of international aid on it. We have critically analyzed Indian planning and marked the changes it has undergone since independence. To analyze the implications of the flow of international aid on public health planning in India, we studied the amount and priorities of the flow of international aid in the Indian health sector. This was also done to find out linkages, if any, between Indian planning priorities and the flow of international aid.

METHODS

Both primary and secondary data sources have been used for the purpose of this study. The sources, which have been consulted, are all the five year plans of India, Annual reports of the ministry of health and family welfare*, External assistance published by the ministry of finance and company affairs*, various health committee reports since independence, various World Bank reports, the health and population policies of India, books and journals, parliamentary proceedings of the year 2001-2002* and the internet (www.planning commission.org).

PLAN OF CHAPTERS

The plan of arrangement of chapters is as follows:

The first chapter traces the history of international aid, its origin and the changing roles of international aid agencies, particularly the International Monetary Fund (IMF) and the World Bank. It discusses the rationale behind this international phenomenon

* These documents provide primary data on amount, type and area of international assistance, which has been used in the study.

marked by generosity and feelings of mutual cooperation towards building a better world. Our analysis shows that there exists no one view aiding development. It changes with the motives of various donors for giving aid. Therefore it is essential to understand the various definitions of international aid and the dynamics of such discourse. This has been dealt with in the second chapter. It also discusses the various forms, types and categories of aid. It thus tries to put forth a clear picture that aid is a planned tool of foreign policy and much beyond international generosity. This chapter also focuses on the changing role of international aid with the changing development paradigms over the decades from 1950s to 1990s. Contrasting viewpoints on aid and its efficiency and the need for taking such aid has also been discussed in greater detail in this chapter.

In order to understand the implications of international aid in the Indian health sector, we have analyzed all the five-year plans in India. This has been done in reference to their overall objectives, their stand regarding reliance on international aid as a part of plan outlay and their idea of development and the strategy to be adopted thereof. Emphasis has been given to health sector planning which has been analyzed in greater detail to find out shifts in planning perspective and plan priorities. The third chapter contains discusses the details of this analysis. It traces the shifts experienced by Indian planning under international influence for example Alma-Ata and Cairo Conference. It deals with policy changes like liberalization and privatization and its implications on Indian health sector planning in conjugation with changing international priorities.

The fourth chapter delves further into the questions raised by the previous chapter regarding the exact role of various international agencies in influencing Indian health planning. It examines the details of each donor to the Indian health sector since 1980. the amount, type of aid and the programmes funded by these donors has been studied and their priority areas of funding has been critically analyzed. Based on the analysis of the third chapter, the relevance of such aid for the Indian health sector has been traced. This shows the shifts in Indian planning and the role international aid had played in determining these shifts.The last is the discussion chapter, which highlights the implications international aid has had for Indian public health planning. This compiles the changes in the Indian health sector and shows how those changes are guided by policy guidelines suggested by major donor agencies like the World Bank.

Chapter-I
HISTORY OF INTERNATIONAL AID

Aid is an international operation channeling tens of billions dollars to developing countries each year and employing large number of people in a multitude of organizations. Aid has grown through various stages, from modest origins in the nineteenth century to being securely established following the Second World War (including the success of the Marshall plan), the cold war and the wave of independence from 1945 onwards. Since then further changes have taken place. Institutions (*the rise of multilateral donors institutions in the 1970s and NGOs in the 1980s*), types of aid (*the decline of food aid and the rise and fall of financial programme aid*) and the aspects of donor ideology (mainly the perceived role of state), are the major ones.

Despite many changes over the years, there has been one constant in the history of aid, namely that the development objectives of aid programmes have been distorted by the use of aid for donor commercial and political advantage. This is not to say that aid has never been used for development nor achieved any beneficial effects. The Soviet aid has been the product of nothing more precisely definable than a general desire for good relations with India. However, it can be assumed that the primary Soviet foreign policy is defensive-to keep India out of the western military camp and in the economic sphere to limit influence from and dependence on the west, and to which end economic aid was considered the most appropriate tool. Soviet Union's most notable diplomatic successes have been affected by their support for India's cause in Kashmir and Goa, but economic aid has played a useful role in gaining popular support.

Unlike the United States, Soviet Union did not concern itself with problems of overall economic balance. It was involved in the success of particular projects. The full weight of Soviet resources, capital, technical and managerial skills, were concentrated on a small number of carefully selected projects, which in most cases had been accorded the highest priority in India's five-year plans. Of particular attraction to India was the importance accorded to training and managerial responsibility for Indians during the establishment of the project, which on completion was turned over to full Indian control. The Bhilai steel mill project and oil exploration ventures in Gujarat have been clear successes. On the other hand the Ranchi heavy machine-constructing plant has suffered from serious administrative difficulties on the Indian

side and has experienced a slackening of demand during recession of 70s. On balance, however, the successes clearly outweigh the failures (Eldridge, 1969).

When foreign aid first appeared on the international scene after the World War II, it was hailed as panacea for the ills of economic underdevelopment. The tremendous success of the Marshall plan added strength to the view. In the general exuberance, views of doubt were brushed aside. Over the years, huge volumes of aid flowed from the developed to the underdeveloped countries - India being one of the major recipients of this aid flow. Unfortunately the foreign aid panacea has failed to work. Disenchantment with the very philosophy of foreign aid is growing. There are more poor in the world than ever before. Sizeable chunks of our own population are not able to meet their own basic needs. Despite aid we are still saddled with innumerable bottlenecks, breakdowns and failures of economic and social infrastructures. Thirty-five thousand children die everyday from malnutrition and related diseases and fifty million people live in extreme poverty (in the developing world).

In order to understand the reasons behind the present situation we need to first understand the history of foreign aid, how it started, for whom and how has it changed in form and nature over the years.

THE ORIGIN OF FOREIGN AID

The launching of the point four programmes by President Truman, in 1949, can be considered as the beginning of international development assistance. This programme made it 'the policy of U.S. to aid the efforts of economically underdeveloped areas to develop their resources and improve their living conditions'. After World War II several countries had already introduced funds to finance development and welfare programmes in their colonies. In 1946 the UN also placed development assistance on its agenda, but funds were limited and the recipient countries were not yet independent. In the early years priority was given to financing the reconstruction of countries after the war, rather than to investment programmes in developing countries.

All these institutions go on to portray aid as a disinterested international generosity. Infact to see international aid as a weapon of the foreign policy of the donor countries needs a deeper historical understanding. For instance, President Kennedy said in 1961 that 'Foreign Aid is a method by which the U.S. maintains a position of influence and control around the world, and sustains a good many countries which would definitely collapse, or would pass into the communist bloc.' A former senior of USAID, Prof. Chenery, admitted that, 'economic assistance is one of the instruments of foreign policy that is used to prevent political and economic conditions from deteriorating in countries where we value the preservation of the present government'.

"The roots of aid can be traced to at least the nineteenth century. Two events in the history of U.S. overseas aid at different ends of that century exemplify the tension in aid programmes between – relief and assistance, and attempts to serve donor commercial and political objectives.

The same conflict is evident in the early years of British aid. The 1929 Colonial Development Act allowed for loans and grants for infrastructure, the purpose of which was explicitly seen as obtaining inputs for British manufacturing. The Colonial Development and Welfare Act expanded the programme to allow funding of social sector activities. Nevertheless, the minister of food in the post war labor government stated that 'by one means or another, by hook or by crook, the development of primary production of all sorts in the colonial era...is...a life and death matter for the economy of the country. (Cited in Gupta 1975: 320). One labor Member of Parliament went so far as to call for rapid development of the colonies so that Britain could become independent of the United States.

The continued support of colonial powers, notably Britain and France, to their colonies after the Second World War is one of three main features of the international aid scheme in that period. There was considerable continuity from colonial to post-colonial institutions. One example of this was the renaming of the Colonial Development Corporation as the Commonwealth Development Corporation in the 1960s. And aid financed efforts drew from the experience of both British and French authorities (as in case of the community development movement).

International activities in the wake of Second World War comprise the major basis for the development of today's aid machinery. Indeed, several institutions developed from organizations originally created to cater for the aftermath of war. For example: Oxfam first catered to refugees from Greece, CARE was originally the Centre for American Relief in Europe (Europe later became Everywhere); and the development work of the UN began with the United Nations Relief and Rehabilitation Agency (UNRRA) founded during the Second World War (1943). Also, the International Bank for Reconstruction and development, or IBRD (now commonly referred to as the World Bank), began with loans for war reconstruction, making its first loan to a developing country only in 1950 (to Columbia). And the success of the Marshall Plan, which involved the above institutions in the reconstruction of post-war Europe, provided the impetus for turning focus to the problems of the developing world. A final feature of importance in the post-war international scene was the first wave of independence, creating a constituency for aid" (Tarp, Finn. 2000).

INTERNATIONAL LENDING AND UNITED STATES

"World war I changed America's standing in the international financial community. The United States was virtually the only industrialized nation to emerge from the war with its manufacturing base intact – the only nation with money to invest abroad. Now the rest of the world needed money to rebuild, and the American investors – large and small – were able and eager to supply it.

In this frenzied atmosphere, few bankers were inclined to look too closely at the creditworthiness of would-be borrowers. In 1927 and 1928, for eg. a syndicate of the top American firms floated 100 million worth of Peruvian Government bonds, though one advisor had warned them that "the government treasury is flat on its back and is gasping for breadth."... Five years later Peru defaulted on those bonds.

As the debts mounted, governments began taking out new loans in order to pay off the old ones... Irresponsible salesman weren't the only ones to blame. The United States was pursuing policies that made it difficult or even impossible for America's borrowers to repay their debts.

With the collapse of Kreuger Empire, defaults of countries, and the ongoing depression in 1930s, what money Americans had, they kept to themselves. The United States was no longer the world's banker. Withdrawal of American investors from the world market deepened the global depression of the 1930s... Though the World War II interrupted the downward spiral, it did not eliminate the causes. There was widespread fear that peace would bring a return to ruinous trade battles, which have a history of leading to battles of other sorts. Thus the allies – in particular the U.S. and Britain – were convinced that their future security depended as much on reforming international trade as on winning the war.

THE BRETTON WOODS INSTITUTIONS: VISION VS. REALITY

The first serious proposal for a new post-war economic order was put forward by an American economist – Harry Dexter White. He wanted a 'stabilization fund' that could keep world exchange rates in equilibrium and 'a bank for reconstruction and development'. His reason for the bank was –"though the U.S. would emerge from the war with a reasonable robust economy, it would suffer from lack of healthy trading partners. It would therefore be necessary to reconstruct Europe and bring the countries of Africa Asia and Latin America up to world market standards, a feat that would require massive investments. Americans would have the money to invest, but after the experiences of 1920s and 1930s they would be reluctant to do so. White's bank would foster needed investments by guaranteeing to cover any defaults on loans of which it approved" (Caufield, [illegible], 1996).

Keynes visualized the establishment of three separate international institutions to serve three specific objectives, during the Bretton Woods Conference in 1944. These he proposed to ease the tension and crisis amongst countries after the two world wars and recession of 1930s. "First a central Bank of central banks, with its own currency (named Bancor) to help ease the balance of payments difficulties of the member countries. This bank, contrary to the current practice, was to penalize countries holding trade surplus (i.e. production more than consumption), with a global tax of 1 percent per month, on the ground that they were keeping the world effective demand low by their under purchase of goods produced by other countries. The proceeds of such global taxation were to be utilized for international buffer stock operations in

primary goods. Second, a fund for the economic reconstruction of war devastated Europe. Third, an international trade organization (ITO), which would maintain and operate this buffer stock of primary goods, in order to stabilize their prices. The buffer stock operation was supposed to be anti-cyclical; ITO making purchases when the world prices were low and selling them when the prices became high" (Dasgupta, [illegible] 1997).

It is important to remember that, in the original conception of Keynes, the development of less developed countries (LDCs) was not on the agenda. The final outcome of the deliberations of the Bretton Woods Conference was, however, different from Keynes' proposals. The fund and the bank were established but did not have all the proposed features. World Bank had never to engage in tasks assigned to it by the conference and European reconstruction was carried out by U.S.sponsored Marshall Plan. ITO was never born because of U.S. opposition. Both World Bank and International Monetary Fund were to operate in the interest of developed countries alone.

"The World Bank was not intended to compete with private banks. The original idea was that it would guarantee loans made by private lenders. However, the private lenders were still reluctant, the bank found that it could offer loans itself at lower rates of interest then private lenders. It would lend only when foreign exchange was not available on reasonable terms from private lenders. Thus, it could deal with high risk loans, but would minimize the risks by ensuring that its loans were used, in Keynes' words, "only for proper purposes and in proper ways"... Reducing its risk would enable the bank to charge lower interest rates, which would in turn reduce the likelihood of default.

The key aspect of the bank's operation was that it would lend only foreign exchange and it would insist on being repaid in the currencies it lent. Therefore the projects it funded would have to earn foreign exchange.

A right wing American critic, John F Neylan, called Keynes a "brilliant exponent of the project of substituting economic imperialism for political imperialism"... "The Bretton Woods agreement does not contemplate a new world order based upon

freedom and expanding development of all human race. It is a document which seeks to create an economic strait jacket for the benefit of a continent which for centuries has drained the treasure of the rest of the world to finance its wars and to support it in intervals of peace." As one student of the Bank's early days put it," The British returned from the savannah feeling that the IMF and the World Bank were little more than schemes of the United States to gain control of world trade" (Caufield, 1996).

CHANGING ROLE OF IMF AND WORLD BANK

During later decades, because Soviet Union opted out of both (IMF and WB) with the onset of cold war and the fact that voting power was linked to the contributions or 'quotas' of the members, these twins came under clear domination of rich, which gave them a promarket and anti-state focus.

From the early days, conditionalities had been a part of IMF loans, but these were few and not rigorously enforced. The conditionalities were oriented towards improving macro-economic management. Those seeking long-term financial support went to world bank, which acted as an international banker, assessed the viability of a project in terms of its capacity of repaying the loan with interest, and offered loans on the basis of guarantees provided by the governments. While IMF was concerned with macro-economic management, World Banks' concern was micro project based lending, to make private sectors the main actors in the economic scene and to reduce the role of state in the economy to the minimum. Over the past two to three decades, both have undergone important changes. With the abandonment of gold standard and the floating of currencies in 1971, IMFs role declined, as the rich countries found other ways of funding their deficits eg. From global capital markets. Since then IMFs activities have remained exclusively confined to developing countries and LDCs. It plays no global surveillance role in the world economy and it carries no influence with the rich country governments. World bank too now operates exclusively in developing and LDCs. With the emergence of an integrated global capital market, backed by modern means of communication, rich countries with good credit ratings face no difficulty in mobilizing required funding from that source. Only counties with low credit rating, having no other source of funding, now come to World Bank.

This implies that while their role as international organizations has diminished, their importance has grown more than proportionately in the economic life of LDCs. The conditionalities accompanying their loans now shape the economic policies of the recipient countries. Thus we find that while they were set up to perform two different tasks, over time, they have come closer in their mode of functioning and treatment of issues. Also the idea behind their birth is completely different from the tasks they perform today. Also that these organizations were formed to provide a forum for the world (especially the developed countries) to interact on an equal plane. Instead, today these organizations are fed by the understanding of developed west, but are working in LDC's predominantly.

Also, it needs mentioning that these organizations, in their charters were recognized as international institutions, affiliated to United Nations, and it was expected that their reports would regularly go to the Economic and Social Council of UN (ECOSOC) and that their heads would attend the meetings of ECOSOC

ECOSOC rather than IMF and World bank, was supposed to be the agency coordinating the economic activities of nations, and was to play a role in the world economy that was parallel to the role of Security Council in the political and military affairs. In practice, neither the World Bank nor IMF ever play any subordinate role to ECOSOC and over time have gained ascendance over it. One major reason for this was that, with the beginning of the cold war, the rich countries played down the role of ECOSOC and patronized World Bank and IMF. While ECOSOC was always short of funds, the rich western countries generously funded these twins.

One reason for the western preference for World Bank and IMF, over ECOSOC, was its decision making procedure where voting is linked to contributions to the initial fund. As a result the LDCs are excluded and more than half the voting power is controlled by G-8 countries.

THE ORIGIN OF STRUCTURAL ADJUSTMENT PROGRAMME (SAP)

Looking back, 1970s was a decade of massive economic upheavals, prompted by the two oil crises of 1973 and 1979-80. The sudden and steep rise in oil prices created a

feeling of despair in the west, as it was going to involve a massive outflow of resources from the rich western countries. Had the two sets of developing countries, i.e. Organisation of Petroleum Exporting Countries (OPEC) and other LDCs, agreed to work on the basis of common understanding, the surplus capital accumulated by the OPEC countries could be transferred to capital starved LDCs. But this couldn't materialize as the ruling elite of these OPEC countries depended on the military might of the west for their political survival. Thus this petro-dollar was recycled back to west, more specifically to international banks. This again created a new situation. The international banks now having surplus funds were willing to lend to anybody. Lending took place on a massive scale and major borrowers were Africa and Latin America.

After a few years, with slump in agricultural exports and their prices, these banks started calculating the risks they had taken. To make matters worse, the coming of monetarist regimes in U.K. and USA under Thatcher and Regan respectively, resulted in a rise in interest rates, thus, accentuating the debt burden. The international banks, now, instead of extending further loans, wanted their money back, with interest. The inevitable debt crisis that followed, beginning with the public proclamation of bankruptcy by Mexico, gravely undermined the international banking system, with a high and increasing risk of large-scale default on the part of LDC borrowers. These political-economic changes in the international scenario changed the face of aid from munificence to conditionalities or SAP.

Whatever the official explanation given for SAP, it is clear that the real concern was to resolve the impending disaster facing the global banking system based in the west. The other motive consistent with the rich country self-interest was the urge to find markets in the LDCs, particularly for the multinational companies based in U.S. They faced a stiff competition from cheap and quality products from Japan, Germany and China. This compelled U.S. MNCs to lower their cost of production by shifting their manufacturing units to countries where labor was cheap and government and competition were weak. SAP further weakens the government control and opens the economy for easy penetration.

Peter Hjertholm and Howard White in their work – Foreign Aid in Historical Perspective, Background and Trends; have illustrated these points in a chronological discussion of the history of aid –

TABLE: 1.1 SCHEMATIC OVERVIEW OF MAIN DEVELOPMENTS IN THE HISTORY OF FOREIGN AID

Duration	Dominant or rising institutions	Donor ideology	Donor focus	Types of aid
1940s	Marshall plan and UN system (including world bank)	Planning	Reconstructio n	Marshall plan was largely programme aid
1950s	United States, with Soviet Union gaining importance from 1956	Anti-communist but with role for state	Community development movement	Food aid projects
1960s	Establishment of bilateral programmes	As for the 1950s with support for states in productive sectors	Productive sectors (eg. support to the green revolution) and infrastructure	Bilaterals gave technical assistance and budget support; multilaterals supported projects.
1970s	Expansion of multilaterals (especially World Bank, IMF and Arab-Funded Agencies).	Continued support for state activities in productive sectors and meeting basic needs	Poverty, taken as agriculture and basic needs (social sectors).	Fall in food aid and start of import support
1980s	Rise in NGOs from mid-1980s	Market based adjustment (rolling back state)	Macroeconom ic reforms	Financial programme aid and debt relief
1990s	Eastern Europe and FSU become recipients rather than donors; emergence of corresponding institutions	Move back to state towards the end of the decade	Poverty and then governance (environment and gender passed more quickly)	Move toward sector support at the end of the decade.

Adapted from Hjertholm and White (2000)

PURPOSE OF GIVING AID

For the club of rich countries i.e. Organisation for Economic Cooperation and Development (OECD) and for the World Bank, the official purposes of aid at the beginning of the twenty-first century may be stated as basically three:

- Reducing material poverty, chiefly through economic growth, but also through provision of public infrastructure and basic social services;
- Promoting good governance, chiefly in effective, honest and democratically accountable institutions to manage the economy and the legal order, but also in promoting civil and political rights; and
- Reversing negative environmental trends.

If seriously pursued, such aims would shift aid on to promising new paths. For as enforced by its most powerful institutions up to now, many aid policies have not favored emancipatory politics or economics. Except for a brief period in the mid-1970s, anti-poverty measures and human rights never enjoyed real support at the top of the aid system. Aid has failed to work well because it was hijacked for selfish political and commercial purposes. It has favored the wrong countries, the wrong leaders and the wrong sectors, and has been badly accounted for (Sogge, 2002).

Paula Hoy summarizes the reasons for which donors to provide aid – "the United States is clear about its motivations for providing aid – the primary objective of U.S. foreign aid is to preserve its own territorial and political security. Foreign aid also provided to ensure the political security and cooperation of the United States' strategically important allies. And, as the OECD stipulates, aid is given to promote economic growth in developing countries, which serves to open new markets for U.S. goods and provides investment opportunities. USAID, the agency responsible for distributing most U.S. foreign aid, points out that trade generated from aid has more than offset initial costs; between 1990 and 1995, exports to developing countries increased by $ 98.7 billion, which supported roughly 1.9 million jobs in the United States. Humanitarian concerns also figures in the argument in support of foreign aid,

voiced by moral concerns that wealthy governments have an obligation to assist those in need, including those beyond national borders.

The United States is not unique in making national interests the foundation of its aid rationale. There is not a donor country in the world that would deny the impact of interdependence and the impact of creating an orderly world in which international trade would flourish... Ten percent, or $ 700 billion, of the U.S. gross national product (GNP) is in the export sector, and the developing countries are vital consumers, purchasing nearly 40% of total U.S. exports. But international trade is not the only rationale behind foreign aid budgets. Environmental degradation, contagious diseases, political instability, and population growth are the other concerns and these international interests motivate international aid."

"Actual foreign aid expenses often come straight back to the donor countries in revenues. On average, a quarter of all aid is tied to the recipient country's purchase of the donor country's goods and services. By law, nearly all U.S. aid must be spent on U.S. produced items...for the developing country receiving such aid; this often means that it has to pay an estimated 15 percent more than prevailing prices. Other kinds of aid, although not explicitly tied, are given in the sure knowledge that the money will be spent in the donor country.

A measure of success from the point of the economies of U.S. and some other western countries is the fact that, despite lending by World Bank and IMF, there has been a consistent net 'outflow' of financial resources from the countries operating under SAP since 1980. From 1981 to 1991, the net transfer out of the LDCs accounted to $ 20 billion per year.

Aid has derisively been summed up as people in the rich countries helping rich people in poor countries. Unfortunately, this statement contains some truth. The ten countries holding nearly two-thirds of the world's poorest people receive only one-third of all aid. On the other hand, the richest 40 percent of the developing countries receive twice as much aid as the poorest 40 percent. India, which has 27 percent of world's absolute poor, receives merely $ 7 per person in ODA while Egypt receives $ 280 per person (Hoy, 1998:).

The majority of aid not only fails to reach the countries most in need but also fails to support the sectors most critical to poorest populations of the world. Despite the fact that the livelihoods of the majority of people in the developing countries depend on agriculture, today less than one-sixth of all aid resources supports agriculture. Only about a tenth of all international aid goes to social sectors such as education and primary health care. In the U.S. aid budget, only 0.1 percent goes to basic education and a mere 0.3 percent to basic health care.

The commission on Macroeconomics And Health reports that donor financing in health has been very small relative to the size of the donor economics and the recipient country needs. Total bilateral flows for 1997 to 1999 averaged $2.55 billion, which represented just 0.01 percent of donor GNP. Of this support, approximately 23 percent of the total ODA went to support population programmes (WHO, 2001).

FROM POVERTY TO ADJUSTMENT AND BACK AGAIN

Tarp et.al.(2000) give a detailed account how international priorities in terms of lending have changed over the years and for reasons which have not been matched with the needs of the recipient countries, rather they were those which served the rich country interests or that of the lending agency. The 1970s saw two conflicting trends: the first oil price shock and falling commodity prices required quick disbursing assistance (QDA) made available in the first instance by the IMF, then by the emergence of import support aid and, by 1980, the start of world bank structural adjustment loans (which is programme aid). These facts are part of the explanation for the increasing share of multilateral assistance in the 1970s. Yet, at the same time the donors announced a reorientation towards a greater poverty focus. Notably the World Bank did so, under president McNamara, but so did Bilateral donors, such as the United Kingdom in its White Paper 'more aid for the poorest' in 1975 and the United States, which established the International Development and Food Assistance Act in the same year. This bill stipulated the 75 percent of PL-480 aid should go to the countries with per capita income less than $300.

Although the poverty focus enjoyed a brief period of ascendancy in the late 1970s, the advent of balance of payments problems at about the same time and the emergence of

the debt-crises in the early 1980s, resolved this conflict in favor of adjustment and aid to adjustment programme (programme aid, including debt relief). As such, the increase in adjustment lending was not a response to a 'development crisis'. In general, there was no such crisis, although some African countries had begun a downturn. Rather it was a response (though not exclusively) to balance of payments and debt problems, including the attendant risk of financial crisis in the developed countries. The experience thus clearly illustrates how aid programmes may readily respond to the needs and interests the major donors. The initial focus on macro-economic policy also gave the World Bank and the IMF, particularly the former, a preeminence they had not enjoyed before (hence the expression of Washington Consensus). The World Bank is without doubt the most important development institution, leading both policy and dialogue and increasingly the research agenda. Economic crisis in the west and changes in government also led some donors – again Britain is an example – to be open about their own commercial benefits.

The eclipse of poverty redressal was not without its critics, who found their most effective voice first in the UNICEF report 'The State of World's Children' (grant 1990) and the UNICEF financed study 'Adjustment with a Human Face' (Cornia et.al.1987). These works argued that adjustment policies neglected the poor and should be redesigned accordingly. By the late 1980s these arguments were having some effect and the World Bank began work in designing a poverty policy, which culminated in the 'New Poverty Agenda' in the 1990 world development report (World Bank, 1990). This publication is often given as the starting point for poverty reappearing on the agenda of donor agencies (and agencies have based their strategies on that of the World Bank). As such it provides an example of how the World Bank can 'take over' activities even though the original initiative came from outside the World Bank and was initially resisted by World Bank.

Today there exists a lot of contradictory literature on the effectiveness of aid. Those anti-aid, or focusing on the malices of aid, put their point very pointedly as there exist many country examples as Mexico, Sub-Saharan Africa and Latin America etc. where aid has had little or no positive impact. Researchers who find that aid does work are more cautious while making such conclusions. They have looked at the pros and cons of aid affectivity and outrightly never state that aid is effective. Instead they

cautiously manouver through a series of carefully carved conditions under which aid works – as good institutions, policies and good governance etc. Such observations are leading to greater selectivity while disbursing loans/aid to the countries by donor institutions. An interesting point to be noted in such reports is that these (pro) aid researchers tend to neatly dodge the core issue of development in human living standards. They tend to emphasize success of aid more in terms of helping LDCs open their economies smoothly or getting technical cooperation for some advanced scientific program, which may not always serve the primary needs of people.

In the following chapters we attempt to examine the evidence that helps us understand the role and importance of aid. This is done by first examining the Indian planning process and then looking at specific aid programmes and their implications for health in India.

Chapter-II

DISCOURSE ON INTERNATIONAL AID

International aid deserves a closer look. The questions, which come to my mind, are varied. Could we not achieve the deplorably low rate of growth that we have, and living standards that exist, without the use of foreign aid? Why has aid failed to act as a catalyst in the development process? Why is it that we have come to care more about what aid-donors think of our various policies than how they impact Indians especially the poor? These and similar questions deserve serious thought. But before explaining the reasons why, we must first address the question, what exactly is aid?

DEFINING INTERNATIONAL AID AND ITS FORMS

'Some call it foreign aid, others prefer international assistance, and still others development cooperation, even partnership. These labels are normative statements, but whatever the designation, the subject is 'huge, complex and fragmented' (Tomasevski, 1993:).

Different donor countries define international aid differently. The OECD defines aid as official direct assistance (ODA) only when it qualifies following criteria:
It has to be taken by official agencies; it has to have the promotion of economic development and welfare as its main objectives; and it has to have a grant element of 25 percent or more. The 'grant element' measures the degree of concessionality of an aid transfer compared with market terms, which is taken to include a rate of interest of 10 percent. Thus, an outright grant-in-aid has a 100 percent grant element; a loan at 10 percent has zero grant element; a soft loan will lie somewhere in between.

This definition of aid excludes some concessional flows, namely those of the private voluntary agencies. It also excludes official flows of little or no concessionality. Grants, soft loans, or military aid is also specifically excluded. But food and technical cooperation are included (Cassen, 1994.)

" Inherent in this definition, as sociologist Gunnar Myrdal points out, is the assumption that any resources flowing from the north to the south must be good for the south and conducive to development, a supposition that many so-called beneficiaries in the south would certainly dispute. The OECD definition dates back to

1969, and although its interpretation has broadened over the years, it is important to bear in mind that this is a definition drafted by donors not recipients" (Hoy, 1998).

A) Grants and Loans

Foreign aid may be in the form of either grants or loans. "Grants" are that part of foreign aid, which does not have any repayment liability. "Loans" on the other hand, are that portion of the foreign assistance, which have to be serviced either in local currency or in foreign currency.

B) Gross and Net aid

"Gross" aid may be described as the total external aid received during a particular period. On the other hand, "Net" aid may be defined as the total external assistance received minus interest and amortization payments during a particular period.

C) Hard and Soft Loans

Loans to a developing country may be hard or soft. "Hard loans" are those loans, which are repayable only in foreign currencies, have a very little grace and maturity periods and carry very high rates of interests. "Soft Loans" can be of many varieties such as long-term loans with a maturity period of fifty years or more, loan repayable in foreign currencies ay very low rates of interest, loans with a long grace period (10 years or more). Loans repayable in local currencies are also considered "soft".

INTERNATIONAL PRIVATE CAPITAL AND INTERNATIONAL AID

International or foreign aid may be distinguished from international private capital. International private capital moves from one country to another on the basis of commercial considerations of profit and private expectations. On the other hand, the objective of international aid is assumed to be the desire on the part of more developed countries to assist the less developed countries in their economic development. Properly defined ' international aid' or external economic assistance is the transfer of capital and know-how from one country to another which is made on concessional terms, that is, on terms more favorable than those operating currently in the world capital and labour markets. So grants of freely convertible currency constitute aid in full sense, while loans contain only some element of aid. Aid

components depend on the length of grace and maturity periods as well as low interest rates.

If we accept the stricter form of definition, credits given by some public international agencies cannot be classified as aid because the scheduled repayment are for less than ten years and the interest rates charged are more than six percent or so, as in the case with loans from the world bank. And yet, loans from the World Bank are described as 'aid' because individual countries benefiting from these loans would not be in a position to raise on their own similar sums on comparable terms from the world capital markets. P.N. Rosenstein Rodan has described external assistance as " that part of the capital inflow which normal market incentives do not provide".

TYPES OF FOREIGN AID

As discussed in the previous chapter, international aid has evolved into various categories or kinds of aid over the years. This evolution was guided more by the changing donor policies to meet their diplomatic and political ends than by the recipient needs. These types of aid vary in popularity among the donors, but none of them can be considered as an outright gift. These categories are:

A) PROJECT AID

This is a grant or a loan provided to a government or an organization designated for a specific project or outcome. Example - A dam or a road. Despite its lack of an integrated and long-term approach to development, this type of aid has been popular among the donors and the recipients alike.

B) PROGRAM AID

It a policy based loan given to a recipient government to create certain economic conditions in that country or to support balance of payments. This form of aid became the preferred package during the debt crisis.

C) TECHNICAL ASSISTANCE

It consists of provision of experts and/or equipment for a specific sector or outcome, for example in health, agriculture. There have been questions about who are the real

beneficiaries of this type of aid. The fact that 90 percent of the $ 12 billion spent on technical assistance each year goes to the foreign expertise, despite the availability of national experts who need jobs, provides a disturbing answer to the question.

D) HUMANITARIAN AID

The least controversial form of foreign assistance, which provides grants, food materials, supplies etc. to meet the immediate demands of victims of disasters.

E) FOOD AID

It consists primarily of cereals, dairy products, fats and cooking oils that are sold or, in emergencies, given to developing countries. Food aid is a vital source of support and survival for countries facing natural or man-made emergencies, like famines. Non-emergency food aid, however, is a far more complicated and contentious issue.

F) MILITARY AID

A less benign form of foreign assistance, which is to strengthen the military of the recipient government and so, contributes nothing to the economic development of the recipient nations.

There exists a history behind the time, origin and role of these different types of aid. The role of aid has been changing over the decades based on the prevalent development doctrine of that particular time period. The next section deals with this aspect of international aid.

THE EVOLUTION OF DEVELOPMENT DOCTORINE AND THE ROLE OF FOREIGN AID IN LDCs - 1950-2000

It is interesting to understand the reasons behind the shifts in the nature, amount and role of international aid over the years. Thorbecke (2000.), in his work, provides an interesting and analytical account of how the concept of foreign aid as a contributing factor to the development of the third world evolved historically within the broader framework of development theory and strategy over the course of the last five decades of the twentieth century i.e. 1950-2000. They mention that the "socio-economic development of the aid recipient countries is only one of the objectives of the donor

countries. Political and commercial objectives play an important role in the allocation of foreign aid in the programmes of many donor countries". They recognize the role that non-developmental goals play in the allocation of aid, but do not dismiss altogether the developmental benefits of aid- whether they resulted directly from developmental motivation by donors or indirectly, as a side effect of politically motivated resource transfers.

Thorbecke argues how the conception of the role of foreign aid changed as a function of the development paradigm in vogue entering a given decade. He contrasts the prevailing situation in the 1950s, 1960s, 1970s, 1980s and 1990s respectively to highlight in a systematic fashion the changing conception of the development process.

A) THE DEVELOPMENT DOCTRINE DURING THE 1950S

"Economic growth became the main policy objective in the newly independent less developed countries. Other economic and social objectives were thought to be complementary to – if not resulting from – GNP growth. Clearly, the adoption of GNP growth as both the objective and yardstick of development was directly related to the conceptual state of art in the 1950s". The major theoretical contributions, which guided the development community during that decade, were the 'big push' (Rosenstein-Rodan 1943), 'balanced growth' (Nurkse 1953), 'take-off into sustained growth' (Rostow 1956) and 'critical minimum effort thesis' (Leibenstein 1957).

What all of these concepts have in common is equating growth with development and viewing growth in less developed countries as essentially a discontinuous process requiring large and discrete injection of investment. The Harrod-Domar model was widely used as an analytical framework, because of its completely aggregated and simple productions, with only investment as an element, emphasizing, at least implicitly, investment in infrastructure and industry.

The prevailing development strategy in the 1950s follows directly and logically from the previously mentioned theoretical concepts. "Industrialization was conceived as the engine of growth, which would pull rest of the economy behind it. The industrial sector was assigned the dynamic role in contrast to agriculture, which was, typically,

looked as a passive sector to be 'squeezed' and discriminated against." Therefore, the bulk of investment was directed to industrial activities.

Role of foreign aid

Within the dominant perspective the main economic rationale of foreign aid in the 1950s was to provide the necessary capital resource transfer to aloe developing countries t achieve a high enough savings rate to propel them into self-sustained growth. The role of aid was seen principally as a source of capital to trigger economic growth through higher investment.

Two other interrelated factors made aid attractive as an instrument of growth: first, the faith that governments could plan successfully at the macro level as evidenced by the large number of five-year plans formulated during this period and, second, the simplicity of the Harrod-Domar model to calculate the amount of aid required to achieve a target growth rate. In retrospect it was this totally aggregate planning framework and the focus on industrialization-first that led to the neglect of the agricultural sector.

In any case, whatever the development rationale of aid in the 1950s, it was clearly already subservient to security objectives in the aid programmes of the US and probably Western Europe. The US aid was intended as a weapon to address the security threat of spreading communism.(

B) THE DEVELOPMENT DOCTRINE DURING THE 1960S

An analytical framework based on economic dualism dominated the decade of the 1960s. Whereas the development doctrine of the 1950s implicitly recognized the existence of the backward part of the economy complementing the modern sector, it did not explain the reciprocal roles of the two sectors in the development process. "The naïve two-sector models following Lewis (1954) continued to assign to subsistence agriculture an essentially passive role as a potential source of 'unlimited labor' and 'agricultural surplus' for the modern sector. It assumed that farmers could be released from subsistence agriculture in large numbers without a consequent reduction in agriculture output while simultaneously carrying their own bundles of food (i.e. capital) on their backs or at least having access to it.

As the dual-economy models became more sophisticated, the interdependence between the functions that the modern industrial and backward agricultural sectors must perform during the growth process was increasingly recognized. The backward sector had to release resources for the industrial sector, which in turn had to be capable of absorbing them. However, neither the release of resources nor the absorption of resources, by and of themselves, was sufficient for economic development to take place. Recognition of this active interdependence was a large step forward from the naïve industrialization-first prescription because the above conceptual framework no longer identified either sector as leading or lagging. This meant in concrete terms that a gross flow of resources from industry to agriculture may be crucial at an early stage of development to generate an increase in agricultural output and productivity that would facilitate the extraction of a new transfer out of the agriculture to the modern sector.

The models that were designed in the 1960s can be divided into three types: (i) two-gap models, (ii) semi-input-output models and (iii) simple general equilibrium models. The first type tried to incorporate into a macroeconomic model the role of foreign aid (Chenery and Strout 1966). The underlying logic of these models is that the two independent constraints may limit economic growth. The first constraint on skills and savings, if it were the binding one, is described as the investment-limited growth. Alternatively, when the balance of payments constraints are effective, trade limited growth would follow. This is a model, which assumes that developing countries are characterized by limited structural flexibility – with either the investment-saving gap or the balance-of-payments gap binding at any one point in time. The conception of economic development in the 1960s was largely centered on GNP growth as the key objective.

Role of foreign aid

The role of foreign aid in 1960s, in the light of the two-gap models, was considered important in removing either a savings deficiency through an increased flow of foreign savings or a deficit in the current account of the balance-of-payments by providing the necessary foreign exchange.

"Ruttan (1996) ') summarized well the two directions in which development thought and foreign aid shifted in the 1960s:

First, shortages in domestic savings and foreign exchange earnings were identified as potentially limiting factors on growth. The counterpart in official policy was to extend programme type lending to fill the foreign exchange gaps in the less developed countries. A second focus of the 1960s, influenced by the emergence of the dual-economy literature, was on sectoral development and, in the late 1960s, on sector lending for agriculture. As sectoral development processes began to be better understood, the importance of investment in human capital and of policies designed to overcome resource scarcities through technical assistance began to be appreciated. (Thorbecke, 2000)

C) THE DEVELOPMENT DOCTRINE IN THE 1970S

By the 1970s the seriousness of a number of development problems and issues, combined with the failure of GNP-oriented development strategy to cope successfully with these problems in a number of developing countries, led to a thorough re-examination of the process of economic and social development. The major development problems that became acute and could no longer be ignored during this decade can be briefly summed up as: (i) the increasing level and awareness of un- and underemployment in a large number of developing countries, (ii) the tendency of income distribution within countries to have become more unequal or, at least, to have remained as unequal as in the immediate post world war II period, (iii) the maintenance of a very large and perhaps rising number of individuals in a state of poverty, i.e. below some normative minimum income level or standard of living, (iv) the continuing and accelerating rural-urban migration and consequent urban congestion and finally (v) the worsening external position of much of the developing world reflected by increasing balance-of-payments pressures and rapidly mounting foreign indebtedness and debt servicing burdens.

By the mid-1970s, the dominant and widely accepted objective of GNP growth as being synonymous with economic and social development came under critical scrutiny. The changing meaning of development as a process that should have as simultaneous objectives growth and poverty alleviation, both influenced and was influenced by a number of conceptual and empirical contributions like that of

integrated rural and agricultural development, the concept that informal sector and its activities represent an important and potential source of output and employment growth (became revitalized in the Kenya Report of International Labour Organization 1973), the interdependence between economic and demographic variables and the determinants of rural-urban migration.

With the changing development objectives, the development strategies also underwent a major change. From a belief that growth was a necessary and sufficient condition for the achievement of economic and social development, it became increasingly recognized that even though necessary, growth might not be sufficient. The first step in the broadening process of moving from a single to multiple development objectives was a concern with, and incorporation of, employment in development plans and in the allocation of foreign aid to projects and technical assistance. Two partially overlapping variants of a distributionally oriented strategy surfaced during this decade. These were 'redistribution with growth' and 'basic needs'. The first step in this strategy was the shift in the function away from aggregate growth towards poverty reduction. This strategy, which was favored by the World Bank, focused on the redistribution of at least the increments of capital formation in contrast with the initial stock of assets. Since the bulk of the poor are located in the rural and the informal urban sector, this strategy had to be directed towards increasing the productivity of the small farmers and landless workers and making small-scale producers (mainly self-employed) in the informal urban sector more efficient.

The second alternative strategy inaugurated in the 1970s was the basic need strategy; which involved two elements: (i) certain minimal requirements of a family for private consumption, such as adequate food, shelter, and clothing and (ii) essential services provided by and for the community at large, such as safe drinking water, sanitation, health and education facilities.

Role of foreign aid

The launching of the World Employment Programme by the ILO in 1969 signaled that the primary objective of aid should be to raise the standard of living of poor through increased employment opportunities. The generation of new or greater

productive opportunities was considered a means toward the improvement of the welfare of the poor.

There was a fundamental re-examination of the function and goal of foreign aid. As Brown points out "If development was no longer so closely identified with economic growth then aid should not be perceived so exclusively as a source of domestic and external savings. A greater focus on poverty, and on people's welfare in general, would require new types of investment and new forms of intervention."

The World Bank and USAID – two major donors became very vocal in their advocacy of anti-poverty programmes. The major change in their foreign aid strategies took two forms: first, a shift away from investment projects in power, transport and telecommunications and toward projects in agriculture and rural development and social services including housing, education and health (Brown 1990); and second, a much greater emphasis on direct interventions to benefit the poor and on technical assistance projects. Examples of direct interventions include food for the malnourished, mass inoculation programmes, adult literacy campaigns and credit provision for small farmers.

The shift in emphasis towards poverty-alleviation aid is evidenced by the share of poverty-oriented lending rising from 5 percent of the total in 1968-70 to 30 percent in 1981-83. Also, a relatively new instrument of channeling aid – sector loans (particularly to agriculture and education) – became more extensively used.

D) THE DEVELOPMENT DOCTRINE IN THE 1980S

A combination of events including an extremely heavy foreign debt burden, combined with higher interest rates and a recession in creditor countries, changed radically the development and aid environment at the beginning of the 1980s. The Mexican financial crisis of 1982 soon spread to other parts of the third world. The magnitude of the debt crisis was such that, at least for a while, it brought into question the survival of international financial system.

Suddenly, the achievement of external (balance-of-payments) equilibrium and internal (budget) equilibrium became the overarching objectives and necessary conditions to

the restoration of economic growth and poverty alleviation. The debt crisis converted the 1980s into the 'lost development decade'. Before the development and poverty alleviation path could be resumed, the third world had to put its house in order and implement painful stabilization and structural adjustment policies (Thorbecke, 2000).

The development strategy of the 1970s – centered on redistribution with growth and fulfillment of basic needs – was replaced by an adjustment strategy. The magnitude of the debt crisis and the massive internal and external disequilibrium faced by most countries in Africa and Latin America and some in Asia meant that adjustment became necessary (although not sufficient) condition to a resumption of development.

The main policy objective of third world governments became macro-economic stability, consisting of a set of policies to reduce their balance-of-payments deficits (example devaluation) and their budget deficits (through retrenchments). Complementary elements of the prevailing adjustment strategy of the 1980s included outward orientation, reliance on markets and a minimization of the role of government. The outward orientation was meant to encourage exports and industrialization.

Under the influence of ideological changes in the western world (example during the U.S President Regan's and U.K Prime Minister Thatcher's administration) developing countries were strongly encouraged – if not forced – on the operation of the market and in process minimize government activities in most spheres – not just productive activities.

Inherent contradictions and conflicts arose among the elements of the broad adjustment strategy of the 1980s. The successful implementation of the adjustment policies called for a strong political intervention. The major contradiction was caused by the stabilization goal of reducing the balance-of-payments diequilibrium, while simultaneously liberalizing trade – mainly through elimination of quantitative restrictions and reduction and harmonization of tariff rates. The latter measures would invariably lead to a significant rise in imports that would make it more difficult to restore balance-of-payments equilibrium.

Role of foreign aid

With the advent of the debt crisis and the debt overhang, the role and conception of foreign aid changed in a fundamental way. The primary purpose of aid became (i) a stop-gap measure to save in international financial system – by allowing third world debtor countries to service at leas part of their public and private debt and keep their creditors afloat, and (ii) to encourage the implementation of appropriate adjustment policies through conditionalities attached to programme lending.

"In this decade, characterized by pro-market and anti-government rhetoric, there was a strong sentiment to do away with aid altogether and have private capital flows substitute for it. Thus, in the early 1980s, the Regan administration created a fertile environment for conservative critic of foreign aid who felt that 'economic assistance distorts the free operation of the markets and impedes private sector development'. Clearly, the debt overhang put a damper on going too far in eliminating aid. Both public and private creditors in the industrialized world had too much at stake. Furthermore, private capital was not going to flow to African and Latin American countries until some modicum of macro-economic equilibrium had been restored. In the meantime, there was an effort in many donor countries to privatize aid through channeling greater flow to NGOs and private sector". Organizations like the Ford Foundation, USAID, and World Bank came to be the major players in this sector during this decade.

E) THE DEVELOPMENT DOCTRINE IN THE 1990S

Stabilization and adjustment were still the dominant objectives in the first half of the 1990s. In the second half of the 1990s the Asian financial crisis hit east and Southeast Asia, resulting in a sharp reversal of the long-term poverty reduction trend. Simultaneously socio-economic conditions deteriorated so drastically in the former soviet republic that poverty alleviation in the broadest sense – including improvements in health, nutrition, education, access to information and of public goods and a participation in decision making – resurfaced as a major if not overarching objective of development assistance.

In many aspects, the development strategy of the 1990s was built upon the foundations of the preceding decade and retained most of the latter's strategic elements. However as the decade evolved, the adjustment-based strategy of the 1980s came under critical scrutiny. In sub-Saharan Africa a great majority of countries were facing serious adjustment problems. A widely debated issue was whether adjustment policies; without complementary reforms; could provide the necessary initial conditions for a take-off into sustained growth and poverty alleviation. Two conflicting approaches to adjustment and diagnosis of its impact on performance were put forward. The orthodox view, best articulated by the World Bank argued that an appropriate stabilization and adjustment package pays off. In contrast, the heterodox approach, best articulated by the concept of 'adjustment with a human face', embraced by UNICEF, while supporting the need for adjustment, argued that the orthodox reforms focus extensively on short term stabilization and do not address effectively the deep rooted structural weaknesses of African economies that are the main causes of macro-instability and economic stagnation. Accordingly, major structural and institutional changes are needed to compliment adjustment policies to induce the structural transformation (such as industrialization, diversification of the export base, the build-up of human capital and even land reform) without such sustainable long-term growth in Africa (and by extension in other developing countries facing similar conditions) is not possible.

The UNICEF and heterodox critical evaluation of the impact of adjustment policies on long term growth and poverty alleviation sensitized bilateral and multilateral donors to the need to focus more significantly on the social dimensions of adjustment. It made a strong case for the implementation for a series of complementary and reinforcing reforms, ranging from greater emphasis on and investment in human capital and physical infrastructure to major institutional changes- particularly in agriculture and industry. In 1993, the World Bank published a very influential report on the East Asian miracle. However the Asian financial crisis that wrought havoc to much of East and South-East Asia in 1997, forced a critical re-evaluation of an international trade and financial system based on excessive trade and capital liberalization and financial deregulation. The large increase in the incidence of poverty that followed in the wake of the crisis sensitized the development community to again focus on poverty alleviation and improvements in the socio-economic

welfare of vulnerable households as the over arching objectives of development. Thus, at the end of the decade, the World Bank made it clear the poverty reduction – in its broadest sense – measures in terms of outcomes (e.g. health, education, employment, access to public goods and services) rather than inputs in the primary goal to strive for.

Despite this once India accepted SAP, its human face was forgotten and the welfare sector suffered the severest cuts. It was the tardy implementation of SAP rather than the safety net that actually saved India from a severe economic crisis. Over the years however, the decade saw a shift of emphasis on social security, one in terms of infrastructure and secondly, in health, which was now a major source of technological market.

Role of foreign aid

There was an absolute decline in net disbursement of official development assistance (ODA) after 1992 and the decline in net ODA disbursements expressed as ratio of donor GNP from 0.38 per cent in 1982 to 0.22 percent in 1997. The sectoral composition of foreign aid shifted in favor of social infrastructure and services (e.g. education, health, water supply and sanitation) and economic infrastructure and away from productive sectors.

"A critically debated issue of the 1990s was that of the effectiveness of aid conditionality. First of all, given fungibility, is it really possible to use aid to 'buy' good policies or even a sound programme of public expenditures from aid recipients? From the point of political economy of international aid, structural adjustment can be looked at as a bargaining process between bilateral and multilateral donors on the one hand, and the debtor government on the other. Both the sides may have a vested interest in following soft rules in their lending and borrowing behavior, respectively. This tends to foster the dependency relationship that may well be fundamentally inconsistent with a viable long-term development strategy for the recipient countries " (Thorbecke, 2000).

This debate on effectiveness of aid conditionality revolves around the possibility of buying "good" and "sound" policies and programmes of public expenditures from aid

recipients. It however, does not debate that these policies are good for whom? Are Structural Adjustment Policies good for the poor, or do they safeguard the interests of the rich industrialists of the first world, who find easy markets and cheap labor in the third world? This is an important point to be resolved. Unless this is done, structural adjustment shall remain a bargaining process between donors and recipients, but largely at the cost of the poor.

Thus we find that the conception of the role of aid evolved in parallel with the evolution of the development doctrine. In the 1950s, the role of aid was seen mainly as a source of capital to trigger economic growth through higher investment. Faith in the capacity of recipient governments to plan successfully and use aid efficiently was strong. In the 1960s, the role of foreign assistance was considered important in either removing a savings deficiency through an increased flow of foreign savings or removes the deficit in the current account of the balance-of-payments by providing the necessary foreign exchange. The 1970s witnessed a major change in the role of aid, i.e. that the primary objective of foreign assistance was to raise the standard of the poor largely through increased employment. The focus on poverty alleviation required new types of investment and new forms of intervention. With the advent of the debt crisis and debt overhang, in the 1980s the role and conception of aid changed in a major way. The primary purpose of aid became twofold; as a stop gap measure to save the shaky international system and to encourage the implementation of adjustment policies in the third world countries through conditionality attached to programme lending. In that decade, characterized by pro-market and anti-government rhetoric, a strong sentiment was expressed to reduce aid drastically and have private capital flows substitute for it.

Finally, the decade of 1990s was marked by the rising fear that foreign assistance was generating dependency relationships in poor countries. The issue of the effectiveness of aid conditionality was also critically debated. The socio-economic disaster created by the Asian financial engendered a fundamental re-examination of the role of aid and the uncritical acceptance of the Bretton Woods rules.

WHY DO WE NEED INTERNATIONAL AID?

A) THE DOMINANT VIEWPOINT

This view emphasizes the importance of foreign assistance in economic growth. It nevertheless, does debate on questions regarding allocational and quantitative aspects and their use.

q Id – Sd or q =M – X

Where q = quantum of foreign aid required

Id Domestic investment during the period of development plan.

Sd Domestic savings during the same period.

M Total value of import of goods and services during the plan period.

X Total value of export of goods and services in the same period.

'q' shows the excess of domestic investment over domestic saving or an excess of imports over exports during a given period of time, which is the appropriate method of "gap-filling" assistance essential to sustain a targeted rate of investment and growth. Thus, in absence of domestic savings the inflow of foreign aid is indispensable for accelerating the rate of growth. India found herself in need of substantive foreign aid when she decided upon a policy of planned economic development. During the first plan, India's need for international aid was not very high because the first plan was a modest plan. As our plans became more and more ambitious, the need for foreign aid on a massive scale increased correspondingly" (Sharma, 1977).

The perpetrators of this view hold that foreign aid is required to supplement domestic resources and also to meet the foreign exchange requirements of a developing economy. The development programmes of the countries require heavy investment outlay, which cannot be sustained by the level of their domestic savings. Development generates imports and creates balance of payment problems. The excess of domestic investment over domestic savings create the need for foreign aid. Economic growth necessitates capital formation for building the productive base of an economy. Capital formation is dependent on the surplus generating capacity of the economy, which in turn is the function of productivity gains emanating from the capitalist techniques of production. Thus there cannot be capital without accumulation of surplus and there

cannot be accumulation of surplus without capital. The real problem with which an economy launching for economic growth is confronted is how to break through this vicious circle. In the case of growth in the context of a welfare economy, wherein the population cannot be rack-rented, there cannot be any choice optional to external assistance for breaking the vicious circle.

In a low income country, the rate of savings being very low, the country has to draw on foreign saving. Foreign resources thus are supposed to accelerate economic growth... foreign resources however for the purposes of growth can only be a supplement to, and not a substitute for domestic savings. For the enhancement of domestic capital formation for which foreign resources are essentially meant to be used would enhance the exigency or need for domestic savings as complementary resources. If the domestic rate of savings does not rise so as to commensurate with the growth in capital formation, the growth rate of economy will be adversely affected. For, inadequacy of domestic savings will give rise to underutilization of the installed capacity.

Such an impasse in the growth process requires more foreign aid to absorb basic aid in the event of later being project tied or specific. If the external resources are not use-specific, some of them can be diverted for feeding the installed capacity. Thus, for rapid and continuous growth process resources should be so distributed between the twin uses of productive capacity creation or capital formation and capacity utilization that under utilization of productive capacity may be nil or negligible. For, otherwise, the target growth rate will not be realized despite the fulfillment of the target rate of investment supported by foreign resources" (Adhvaryu, 1972: 3,4).

Like all developing countries, India also suffered from shortage of resources. Underdeveloped countries are caught in a vortex of what is commonly known as "vicious circle of poverty", in which poverty breeds poverty. Professor ranger Nurkse has said- "on the supply side, there is the small capital to save, resulting from low level of real income. The low level of real income is a reflection of low productivity, which in turn is due largely to the lack of capital. The lack of capital is a result of small capacity to save, and so the circle is complete. On the demand side, the inducement to invest may be low because of the small buying power of people, which

are due to their small real income; which again are due to low productivity. The low level of productivity, however, is a result of small amount of capital used in production, which in turn may be caused at least partly by the small inducement to invest."

The vicious circle of poverty could not be broken unless adequate savings were available to undertake investment in productive sectors, but economy as it was functioning at a low level could not generate those savings. It was suggested, therefore, that domestic resources should be 'supplemented' by foreign aid. Thus, despite the strong aversion to external resources (especially for the private sector) characteristic of preindependence days, the indispensability of external resources came to be recognized for economic development in India, and as a consequence of which the Government of India resolution of1948 threw wide open the doors to foreign assistance in all its forms. The vague, and vacillating attitude towards foreign capital thus was shaken off and the place of external assistance in all its forms was finally confirmed in the economic growth of the country.

B) THE CRITICS OF AID

The critics argue that foreign assistance is not indispensable for the development process provided the internal economic policies of a country are strong and favorable for growth. Arun kumar argues that India is not a capital deficient but capital surplus economy provided it regulates its black economy. The growing black economy since independence, is the major reason for the flight of capital from the country, leaving little to invest. The reason for the growth of this black economy, he finds in the unstable political system and unfriendly economic policies of the Indian state. Rich capitalists and agriculturists, both, have little faith in the stability of the Indian economy and so instead of investing their surplus in India they prefer to remove it from the country, depriving India of the much needed invest able capital.

Similarly Krishna Bharadwaj also argues that the qualitative leaps in an economy occurs not because of external factors (assistance) but are generated from within the economy. According to Bharadwaj, external forces can be the conditions of change but ultimately the basis for it is provided by internal factors. "In a suitable

temperature an egg changes into a chicken but no temperature can change a stone into a chicken because each has a different basis" (Bharadwaj, 1980).

INTERNATIONAL AID – CONTRASING VIEWPOINTS

Clearly there are two sets of perceptions among donors, recipients and analysts. One who see it as absolutely essential and in the best interest of the recipient country. And the other who find it as a shift from political to economic imperialism. A token of concern, power and expertise, aid is given with a glow of satisfaction. A badge of candidate-membership in the club of modern nations, aid is received with gratitude. Givers and receivers, at least in their public utterances, applaud foreign aid as a good thing that should continue.

Thus, theory does not appear to provide any consensus on the nature of the relationship between aid and the nature of growth. Several authors have surveyed the empirical evidence on impact of aid. These authors do not seem to agree on whether the effectiveness is positive or negative. Some critics argue that there is no statistically significant correlation in any post-war period, either positive or negative, between inflows of development aid and growth rate in developing countries. Mosley, refers to the micro-macro paradox: "most micro-project related studies on aid are quite positive about the effectiveness of aid, whereas most macro-studies do not find any evidence for positive effects of aid" (Lensink, R. and Hermes, N. 2001, pp 3).

Yet where it dominates, pride and ambition have given way to dependence and deference. Exempt from punishment if things go wrong, aid planners have returned again and again with new, improved, fail safe strategies involving yet another flight into future (Soggy, 2002:7). On the other hand there are those who question the validity of this route to development. There are several studies which show that aid does not necessarily go to the poorest countries, it often does not go toward meeting crucial development needs, and is never a cash donation given with no strings attached. More often, it is a loan provided by a government or international agency, that the recipient must pay back within a specified period.

From the above discourse, it is evident that there exists a clear dichotomy about views on foreign aid. Some find it beneficial and necessary for the development of the third world countries whereas there is another set of intellectuals who find foreign aid interventions unsuccessful in catalyzing the development process. They see it merely as a tool for control of the third world by the rich countries. Changes in nature and amount of aid over the years are perceived as a strategic shift from political to financial imperialism.

Advocates of development aid argued that an increase in aid is necessary to finance boost finance a boost in investment, which may help a country to escape from the poverty trap. Many authors have heavily criticized the aid advocates by pointing at several major drawbacks in this understanding. Critics have argued that aid may negatively affect domestic savings, probably even in such a way that all favorable effects on growth would disappear. According to them an increase in aid primarily increases consumption. Thus, aid becomes a substitute for, instead of an addition to domestic savings. This may even be the case with funds tied to investment projects, since governments may have wanted to finance these investment projects anyway. The aid inflow allows them to free part of their resources for consumption purposes. In other words, aid may be fungible.

The assessing aid report (World Bank, 1998) has provided a new stimulus to the debate on macroeconomic effectiveness of development aid. It states that aid does help to increase growth, but only in countries with sound economic management, or 'good governance', which signifies 'good economic policies and building strong institutions' (the SAP to be precise, as prescribed by the Bretton Woods Institutions). The main conclusion of the report is that aid should be given to countries according to their policy environment. In other words, aid may increase growth, but only when the government of a country carries out 'good' fiscal, monetary and trade policies. These inferences in the World Bank report are based on the background studies by the likes of Burnside and Dollar (2000) and Collier and Dollar (1999).

The analysis of aid effectiveness in the report has received major criticism especially from the academic circles. They mainly point towards three paradoxes. "The first paradox is that donors attempt to 'buy' reforms with their aid, while the reforms are

good for the country anyway (Streeten, 1987). If these policies enhance the welfare of the recipient country, why do the countries need to be induced with aid? And, if governments of recipient countries are convinced that these reforms are the good policies, why not get them pay for the good advice, instead of being rewarded with loans?

Secondly, the giving of aid money itself may reduce the incentive for recipient countries to carry out reforms. This is the risk of 'moral hazard' on the part of the recipient (de Vylder, 1994). For example, an important policy condition is usually the reduction of the budget deficit – yet if countries receive aid, they can finance excess expenditure, and no longer need to carry out tax reforms or to cut expenditure.

Thirdly, there is a contradiction between the setting of many conditions and the content of one of these conditions, namely the demand for more democratization and more accountability on government's actions. Conditions often involve 'parliaments' approving a law, for example, on the privatization of a state enterprise or on a tax reform. Obviously, some national sovereignty is needed in order to achieve democratic decision-making. This inconsistency raises the question of the legitimacy of policy conditionality." (Dijkstra, A. Geske. 2002). An analysis of eight countries done by Dijkstra leads to the conclusion that donors' political and governance demands can be effective in some cases, especially if demands are specific, and thus of less significance. Recipient countries tend to give in on these specific issues, but renege on others. Demands with respect to political system were not honoured in any country, and whilst donors may have some influence in the fight against corruption, this happens only if corruption also happens to be seen as a domestic issue.

Advocates of aid promulgate it as a genuine help, all for altruistic purposes to help reduce poverty. These are mere beliefs, not facts. For at least three decades, research has exposed them as seriously misleading. The exposes stand out in books like: The Myth Of Aid, Aid As Imperialism, Aid As Obstacle, Giving Is Taking, Lords Of Poverty, The Road To Hell: The Ravaging Effects Of Foreign Aid And International Charity, Masters Of Illusion etc. these are reasoned and carefully documented studies, whose authors want a fairer world, and public measures to achieve it. They start from

an optimistic view that genuine help is a good and necessary thing. In brief, the conclusion these studies have reached is

- Aid system is a financial service industry, promoting exports and loans on easy terms, and quietly insuring creditors against bad debts;
- A technical service industry, improving know-how and infrastructure;
- A political tool stocked with carrots and sticks to train and discipline clients; and
- A knowledge and ideology industry, setting policy agendas and shaping norms and aspirations.

Each aid-giving nation displays its own mix of these and other roles. Yet, as may have repeatedly observed, official aid is just another instrument to project power beyond national borders, a tool of foreign policy. Foreign aid has traditionally been the domain of policy elites and certain outwardly oriented business groups. Most foreign aid is not about beneficence, but about power. Command over ideas is often more decisive than mere transfer of resources. That helps explain why elites keep backing aid institutions despite the lack of good evidence that aid regularly achieves its advertised objectives and despite mounting evidence that aid can help make things worse.

INTERNATIONAL AID TO INDIA - SALIENT FEATURES

International aid to India comprises of loans and grants, provided by various bilateral and multilateral sources. World bank extends assistance through its concessional lending window – International Development Agency (IDA), semi-concessional lending through International Bank for Reconstruction and Development (IBRD) and Asian Development Bank (ADB). These form the principal source of multilateral assistance to India. The significant bi-lateral sources offering external assistance include Japan, Germany and United Kingdom. While external assistance does not play a significant part in the Indian economy in terms of financing of plan outlays (as stated by GOI, External Assistance 2001-2002), gross capital formation etc., this has been a major source for financing major infrastructure projects, projects in the social sector (which includes health), building up institutional capacity and in managing balance of payments.

The salient features of external assistance extended by each donor is mentioned in the following pages (as mentioned/stated by GOI, External Assistance 2001-2002. here I shall specifically mention those donors who extend assistance for health sector.)

a) Australian development assistance to India

It started in 1951. Assistance is now channeled through Australian Agency for International Development (AusAID). At present Australia provides grants in the form of technical assistance and equipment supply necessary for the implementation of development cooperation projects. AusAID have committed an estimated total aid flow of Aus $ 22.1 million (Rs. 55 crore approx.) for the financial year 2002-03.

b) Denmark

Denmark has been giving assistance to India since 1963, in the form of soft loans and grants. Tied grants were meant for large value projects and untied ones for local cost projects. Upto 31.3.2002, a total of D. Kr.5273.14 million has been committed by Denmark to India, of which D.Kr. 1326 million as loans and D.Kr. 3947.14 million as grants. At present DANIDA assistance is entirely in grant.

c) Germany

It has been providing assistance fro India's economic development since 1958. FRG has extended a total financial assistance of the order of DM 1580.60 million till 31.3.2002. FRG provides both financial and technical assistance to India under the Indo-German Bilateral Development Cooperation Programme. Financial assistance is provided as soft loans, grants and commercial credits.

During the negotiations in 2001, the German side identified the following areas for future cooperation –

- Health, family planning, HIV/AIDS.
- Environment policy, protection and sustainable utilization of natural resources
- Strengthening the economic sector, especially the private sector potential
- Energy.

d) JAPAN

Japan has been extending financial assistance for India's development since 1958. JBIC is a financial institution of the government of Japan with a mandate to support the efforts of the developing countries towards establishing a more integrated and balanced development.

Japan has emerged as the largest bilateral donor to India over the last ten years. Japanese assistance is mainly in terms of soft loans and a small part as grant and technical assistance.

Japanese ODA would go primarily in the areas of economic infrastructure, environmental protection and basic human needs like health, education, water and sanitation.

e) NETHERLANDS

Netherlands has been extending economic assistance to India since 1962-63. The Netherlands government now wishes to adopt a sectoral approach instead of conventional project approach and would like to concentrate in few states like Gujarat, Kerala and Andhra Pradesh. Netherlands support has been mostly in the form of grant assistance which has been utilised for several project in India.

f) NEW ZEALAND

New Zealand has been extending financial and technical assistance in the form of equipment, cash grants, services if experts and training facilities in New Zealand. Development assistance to India is now limited to provision of training awards.

g) NORWEGIAN ASSISTANCE

This is in form of grant, and is extended through Norwegian Agency for Development Cooperation (NORAD). The volume of their aid to India has shrunk to almost one-third of what it used to be in 1990. In 1990 the Norwegian Government took a decision to reduce aid to India and to shift its focus on to the industrial sector.

Previously, approximately 60 percent of the aid allocated was oriented towards social sectors and for eradication of poverty.

h) SWEDEN

India has been a recipient of Swedish assistance since 1964. After 1976, Swedish assistance is in the form of a 100 percent grant and is mainly focused on the social sector and energy sector.

i) UNITED KINGDOM

U.K. has been providing bilateral assistance to India since 1958. It was in the form of loan upto 1975 and thereafter in the form of grants.

j) UNITED STATES OF AMERICA

U.S. economic assistance to India started in 1951 and till 31st March 2002, the total aid to India has been around US $ 13.4 billion. The aid mainly comprises development assistance, food and technical assistance. The four priority areas are:

- Improve financial and regulatory environment;
- Increase productivity of Indian expertise;
- Promotion of smaller and healthier families; and
- Prevention of HIV/AIDS.

k) EUROPEAN COMMUNITY

EC has been extending economic assistance to India since 1976. The EC assistance to India is entirely in the form of grant, which can be used to finance the rupee costs and the foreign exchange costs of identified projects. There has been a shift of focus on the part of EC from project assistance to sectoral funding. There are two ongoing sector development programmes, one in the education sector (DPEP) and the other in the health sector with a total contribution of Euro 200 million (approximately Rs. 900 crores) for health sector.

l) UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)

UNDP is the largest source of development cooperation in the UN system. UNDP derives its funds from voluntary contributions from various donor countries. India has

been contributing US $ 4.5 million per year to UNDP since 1999 and is the largest contributor to UNDP from amongst the developing countries.

UNDPs assistance is now based on the Sustainable Human Development (SHD), which encompasses a variety of dimensions like poverty elimination, good governance, building equity, employment, empowerment and environmental regeneration.

UNDP has now changed its approach from projects to programmes. Instead of several scattered projects across the country, UNDP will now concentrate on few programmes. The areas in which UNDP assistance has been receiving range from research and development in science and technology to agricultural cooperation, transport and communication, environment, industry etc.

m) UNITED NATIONS CHILDREN'S FUND (UNICEF)

The United Nations Children's Fund (UNICEF) has supported programmes in India to assist the improvement of status of women and children, since 199. UNICEF's current programme cycle for India covers the years 1999-2002 with a budget allocation of US $ 120 million in general resources and US $ 180 million in special resources. The priority areas during the programme cycle are:

- Early childhood care for survival, growth and development, with a focus on the 0-3 age group, to give children the best start in life delivered through the Integrated Child Development Services network.
- Reduction of infant and under 5 mortality rate to at least 50 and 70 per thousand live births.
- Reduction in maternal mortality rate from around 500 to less than 300 deaths per 100,000 live births.
- Decrease severe and moderate malnutrition to at least half the 1990 levels.
- Universalize access to quality primary education.
- Eliminate child labour, especially bonded and hazardous child labour.
- Universalize access to safe drinking water.
- Increase access to sanitation from the present level of 38 percent to at least 75 percent of households.

n) World Food Programme

WFP has provided more than $ US 1 billion in food and development assistance to India since the start of its first project in the country in the year 1963. WFPs five year country programme (1997-2002) in India had following goals and objectives:

- Improve nutrition and quality of life for the most vulnerable at critical times of their lives.
- Make suitable arrangements in household food security for the poorest, especially for women and children, and invest funds in development of long-term security.
- Strengthen channels for locally produced food grains and support local entrepreneurship.
- Advocate for eco-restoration through participatory methods and development.

Currently, WFP targets 2.6 million beneficiaries of ICDS, for about 25 days a month, through over 1,500 ICDS centers spread over 41 districts in six states (Rajasthan, U.P., Madhya Pradesh, Assam, Kerala and Orissa). About 40,000 MT of food is allocated for the purpose annually. The programme aims at improving the health and nutrition status of expectant/nursing women and children (0-6 years) and promoting early childhood development. The activities include provision of supplementary nutrition (fortified blended food: Corn Soya blend/ Indian mix) and strengthening of the delivery of other ICDS services such as nutrition/health education, pre-school education and growth monitoring etc.

A total of 75661 metric tones (US $ 27 million) of food aid comprising wheat, rice, pulses, vegetable oil, corn soya blend/India mix was supplied in the year 2000. In addition, USD 3.3 million was generated through food for work activities.

o) World Health Organization (WHO)

WHO has had a significant input in the implementation of the National Health Programme, which strives to sustain the gains achieved in the past for improving the health care delivery system. In line with Declaration on Health Development in the South East Asia Region, and also endorsed by India, efforts are being made to develop national health plans and programmes to improve the health management

information system and to integrate the policy guidance laid down in the declaration into the national health policy and plan. The National Health Policy for India was brought out recently and WHO provided significant inputs to the document.

In line with WHO's priority areas for support, adequate attention is being given to prevention and control as also eradication of specific communicable diseases. The government is making efforts for eradication of poliomyelitis, elimination of neonatal tetanus, elimination of leprosy and control of measles. National capability to manage AIDS and STD programmes in India has been one of the major outcomes of collaborative programmes. The RNTCP has been receiving continued support and the implementation of DOTS strategy is being supportedfor the demonstration areas. WHO has also been providing inputs into the elimination of leprosy. It is also supporting activities for elimination of lymphatic filariasis and for control of hepatitis B.

A number of officials from various departments/ministries have received training in different health related areas through WHO fellowship and study tours both within the region and in Europe and America. During the biennium 2002-03, WHO is expected to provide financial assistance to the tune of US $ 11.6 million under the regular budget towards implementation of the WHO/GOI collaborative programmes in different health-related and disease prevention areas.

p) The World Bank (IBRD and IDA)

The International Bank for Reconstruction and Development (IBRD) was established in 1945 and began its programme of economic assistance in June 1946.Its member countries subscribe to its capital and its lending operations are financed primarily from its borrowings in the international capital markets, from retained earnings and the flow of repayments of its loans. IBRD provides loans to member governments at relatively cheaper rates than that available from international markets. India has been a major borrower of such loans from the IBRD. IBRD assistance to India commenced in 1949, and so far 187 development projects have been financed by it. The current rate of interest per annum on IBRD single currency loans (SLCs) is 2.7 percent (15 May, 2002).-IBRD loans carry commitment charges on undisbursed balances at 0.75

percent per annum, subject to waivers notified by bank. The repayment period is 20 years including 5 years grace period.

The International Development Association (IDA) was established in 1960, as an affiliate of the World Bank to make concessional long-term loans. IDA credits carry no interest charge but a service charge of 0.75 percent on the undisbursed and outstanding portion of the credit. Though IDA credits carry commitment charge of 0.5 percent per annum on the undisbursed balance, these have been waived by the Bank from 1989-90 onwards. The credits extends upto 30th June 1987 are repayable in 50 years, inclusive of a grace period of 10 years and those approved from 01 July 1987 are repayable in 35 years inclusive of a grace period of 10 years. Since inception, IDA in India has financed 253 development projects.

IDA assistance focuses mainly on human and rural development sectors like agriculture, irrigation, urban development, health and family welfare and dairy development. IBRD assistance has been extended to sectors, which are commercial in nature like railways, power, fertilizer and telecommunications. This categorization is not exhaustive or mutually exclusive.

The total amount of loan/credit assistance by IBRD and IDA upto the end of March 2002 stood at US $ 49,907 million.

Details about total assistance provided by each donor till date, or their annual contribution in Indian economy is not available. This makes any sort of comparison between the different donors regarding their contribution in the Indian development very difficult.

In addition to the above-mentioned countries and organizations, there are several other bilateral and multilateral sources of international assistance like USAID, Ford Foundation etc. aiding the development process in India.

In this chapter we learned that aid does not comprise only of grants, as is the popular understanding. Rather, it combines the loans also alongwith the grants (which actually forms a small part of the entire aid). These loans are given on concessional terms i.e. a

long grace period and lesser rates of intrest as compared to that in the international financial markets. Also aid is not always initiated due to altruistic motives. Role of aid has been changing over the years, and the reasons for giving aid have been more economic and political rather than the general goodwill in favour of the developing world. It has been used more as an instrument for influencing development policies in the third world, for larger benifit of the donor countries. This becomes clearer as we discuss planning of health sector programmes in India, and the role international aid has played in influencing such planning, in the following chapter.

Chapter-III

PUBLIC HEALLTH PLANNING IN INDIA

The report of the health survey and development committee, also known as the Bhore Committee and the activities of the central council of health, set the context of health policy making after 1947. Its four-volume report, gave a detailed analysis of the available data, evidence of expert witnesses, and its recommendations. The report said that the state of public health in British India was low as shown by the wide prevalence of disease and the consequent high rates of mortality in the community as a whole and, in particular, among such vulnerable groups as children and women in the reproductive age period. The death rate for the general population in British India was, in 1937, 22.4 Per 1000 inhabitants and for infants (children under one year of age) 162 per 1000 live births. In 1941 the corresponding rates were 21.8 and 158 respectively. The high rates of mortality in the community at all ages were reflected in the very low expectation of life in India, which was 6.91 for men and 26.56 for women (1921-30). The report mentioned that India had a long way to go before health of the people was raised to standards already reached by other countries. In all countries in which health administration had made definite progress, the expectation of life for women was higher than for men. India was an exception and the reason was seen as high rate of mortality among women due to causes associated with pregnancy and child bearing.

TABLE: 4.1 DEATHS AT SPECIFIC AGE PERIODS AS PERCENTAGES OF THE TOTAL DEATHS AT ALL AGES

	UNDER ONE YEAR	1-5 YEARS	5-10 YEARS	TOTAL UNDER 10 YEARS
British India (average for 1935-39)	24.3	18.7	5.5	48.5
England and Wales (1938)	6.8	2.1	1.1	10.0

Source: Government of India (1946). Report of the Health Survey and Development Committee.

The rates of mortality among infants and children and among mothers were examined in greater detail. Deaths among infants and children under ten years of age in British India and in England and Wales are given in table 4.1 as percentages of total deaths at all ages in the two countries.

In India nearly half of the total deaths were among children 10 years of age and, of the mortality in this age group, one half takes place within the first year of life. The percentage for England and Wales in every age group was very much smaller.

Maternal mortality: About 20,000 women died every year in British India from causes associated pregnancy and child bearing and, probably, about four millions suffered from varying degrees of discomfort and disability as a result from the same causes.

The incidence of diseases: At least 100 million people suffered from malaria every year, and the annual mortality from the disease, either directly or indirectly, were approximately 2 million. The report states that about 2.5 million active cases of tuberculosis existed in the country and 5,00,000 deaths took place each year from this cause alone. The common infectious diseases, namely cholera, smallpox and plague, were also responsible for a large amount of morbidity and mortality, the extent of which varied from year to year. Among different countries of the world for which data were available, India ranked high as one of the largest reservoirs of infection in respect of all the three. These and the other two, all being preventable diseases, their incidence could and should have been brought under effective control long ago. In addition, endemic diseases such as leprosy, filariasis, guinea worm and hookworm disease were responsible for a considerable amount of morbidity in the country, although their contribution to mortality was relatively small.

EARLIER OFFICIAL UNDERSTANDING OF CAUSES OF LOW LEVEL OF HEALTH IN INDIA

The causes of low level of health in India as identified by the Bhore committee report were associated with the poor state of public health infrastructure. According to the report-" the maintenance of public health requires the fulfillment of certain fundamental conditions, which include the provision of an environment conducive to healthful living, adequate nutrition, the availability of health protection to all members of the community, irrespective of their ability to pay for it, and the active cooperation of the people in the maintenance of their own health". This statement shows that the committee saw public health not only as provision of adequate health care to populations through institutional delivery mechanism but this as a part of a

larger system wherein health was seen more according to the social model i.e. as a result of biological, social, economic, environmental factors in a given period of time.

The report maintained that a large amount of preventable suffering and mortality in the country was mainly the result of an inadequacy in provision of fundamental services to meet the needs of people. Diet surveys carried out in different parts of the country had shown, in typical urban and rural groups, that the food consumed was insufficient to provide the necessary energy requirements in case of some 30 percent of the families, that the diet was almost invariably ill-balanced and that there was, in terms of food factors, a deficiency of fats, vitamins and proteins of high biological value.

FIRST FIVE-YEAR PLAN

The first five year plan also realized similar reasons for the low health status of independent India, and emphasized, that lack of hygienic environment 'conducive' to healthful living, low resistance which was seen mainly due to lack of adequate diet and poor nutrition, lack of proper housing, safe drinking water supply, proper removal of human wastes and the lack of medical care as important factors, in addition to low economic status. These were seen as serious impediments to rapid progress. The constraint due to financial resources was also realized, as was the lack of trained personnel, and the very fact that health development was clubbed along with a broader programme of social development was seen as a major setback for any substantial improvement in the health status of the Indian population.

The concept of health as understood in the first five-year plan was of paramount importance. It saw health as a positive state of well being in which harmonious development of physical and mental capacities of the individual lead to the enjoyment of a rich and full life. It was not seen as a negative state of mere absence of disease. The plan said "health involves primarily the application of medical science for the benefit of the individual and of society. But many other factors, social, economic and educational have an intimate bearing on the health of the community."

Due to limited availability of morbidity data, mortality data was used to assess the state of public health in 1949, mortality of under 1 year child was 8,30,270; under 1-5 year mortality was 6,39,616 and 5-10 year mortality was, 28,265. MMR was 20 per 1000 live births, which was very high. Epidemic diseases together accounted for 5.1 percent of total mortality and respiratory diseases were identified to be next important group, numerically.

Realizing the low state of health and its causes, the first plan identified the following priorities for itself –

- Provision of safe water supply and sanitation
- Control of malaria
- Preventive health care of the rural population through health units and mobile units
- Health services for mothers and children
- Education and training and health education
- Self-sufficiency in drugs and equipment
- Family planning and population control

The pattern of development suggested by the health survey and development committee, was to consist of peripheral primary health units catering to both preventive and curative care of the people with secondary health units and district units providing better and more complete facilities and supervision. The development of primary and secondary health units was given greatest importance, as they were to provide broad based health services to the community. Such centres were proposed in connection with the community development projects.

Health was seen largely as a state responsibility, with central government being responsible for higher education and research. The central government was also assigned the function of development of health services in the country as a whole.

The provision for the medical and public health plans of the central and state governments was 99.55 crores of which center's share was about Rs.17.87 crores. Medical and public health measures being primarily states' subjects, the central government had limited its activities to higher education and research and aiding the

state governments in specific schemes as control of malaria an a national scale. The total amount of Rs.99.55 crores was not all that was to be spent for medical and public health measures of the country. *Support from international agencies as WHO and UNICEF was also sought* for such schemes in various parts of the country.

TABLE- 4.2 EXPENDITURE ON VARIOUS CATEGORIES OF MEDICAL SCHEMES (in Crores)

	1950-51	5 YEARS' TOTAL	ANNUAL AVERAGE
Administration	3.2		
Education and Training	235.2	1891.	378.3
Hospitals and Dispensaries	331.3	2486.	497.4
Other Schemes	43.3	322.1	64.5
Total	613.0	4762.7	952.5

Source: Government Of India (1951). *First Five Year Plan*, New Delhi, Planning Commission.

The table 4.2 indicates the expenditure on various categories of medical schemes undertaken by both the central and state governments (excluding J&K) as compared with such expenditures in 1950-51. Out of this total expenditure, more than 50 percent was to be on hospitals and dispensaries and nearly 40 percent of the total provision was for medical education and training.

The table 4.3 gives the expenditure on different categories of public health schemes undertaken by the central and state governments (excluding J&K) as compared with such expenditures in 1950-51.

TABLE 4.3 EXPENDITURE ON DIFFERENT CATEGORIES OF PUBLIC HEALTH SCHEMES (in crores)

	1950-51	5 YEARS' TOTAL	ANNUAL AVERAGE
Administration	15.6	210.8	42.2
Education	1.0	130.7	26.7
Water supply and drainage	270.5	2334.4	466.9
Anti-Malaria	45.4	1715.2	343.0
Other Schemes	35.5	672.5	134.5
Total	268.0	5063.6	1012.7

Source: Government Of India (1951). *First Five Year Plan*, New Delhi, Planning Commission.

The table clearly shows that water supply, drainage, and anti-malaria schemes were supported with the bulk of the expenditure. The development expenditure in 1950-51 was stated to increase by nearly four times every year in the plan period. The rate of annual expenditure on water supply and drainage was expected to increase by more than 70 percent and the rate of expenditure on anti-malaria operations by more than 750 percent.

Water supply and drainage works under the public health plan comprised of measures for improving drinking water supply, and the provision for urban and rural areas was Rs.12.1 and Rs.11.37 crores respectively, which was almost equal. However Madras and Bombay accounted for a major share of the programme.

Emphasis was given to maintenance of environmental hygiene. Provision of an environment conducive to healthful living was realized as an essential requirement for the maintenance of public health. It was understood that in countries where water supply and waste disposal had been attended to cholera, typhoid fever and dysentery almost did not exist and if rare cases occurred it was due to personal contact or food handling by healthy carriers. The effect of such measures on infant mortality rate and the intestinal parasitic infection rate was well known, as these remained problems for India to be solved.

Provision of safe and adequate water supply was also seen as a basic requirement, which should be given the highest priority. Along with this essential measures for hygienic collection and disposal of community wastes were also supposed to be taken.

And for the implementation of the programme, the need to organize public health engineering services on a strong and sound basis in order to design, execute and maintain water supply and drainage works was felt. Except for a few exceptions almost all part 'A' and 'B' states had a public health engineering set up, while part 'C' states had none. For this, *services of a public health engeeneing consultant were*

obtained from United States of America for a period of one year by the central government.

Poor nutritional status had already been identified as a major reason for poor health status of the Indian population; hence availability of cereals, pulses and other dietary components was also to be ensured. The plan stated that 'state of nutrition has a direct bearing on the productive capacity of an individual'. Thus, the creation of a nutritional section in the state public health departments was seen as an essential first step in organizing work, as was prevention of deficiency diseases. Public health departments were made responsible to supervise through their maternity and child welfare services, feeding of mothers and infants.

Thus, we find that the overall view of health and healthful living as envisioned by the first five-year plan was very holistic. A glance through the plan clearly shows that health was seen more as a matter of right of every citizen and state was held responsible for providing for it. Medical intervention and disease specific steps were given importance. At the same time, relevance and importance of healthy environment, water supply and sanitation, and nutrition was also realized. Problems of unemployment, illiteracy and slow economic growth and their relation to health was also established and recognized. This plan attempted to solve the problem with a multi pronged strategy. Health care was given its due place as an important and critical part of a larger system. This larger system operates to take adequate measures for provision of a healthy environment conducive to healthful living. It believed that disease was a product of poverty and no amount of health care provision would improve the state of public health unless the malice of poverty was adequately dealt with.

THE HEALTH SECTOR PLANNING FROM SECOND TO THIRD FIVE YEAR PLAN

The general objectives of the second five-year plan were –

- To attain a rapid growth of the national economy by increasing the scope and importance of the public sector and in this way to advance to a socialistic pattern of society.

- Emphasis was laid on industrial growth and increasing production.
- To provide better housing, more health services, and greater opportunities for education; especially for the poorer sections of the population,
- To liquidate unemployment as quickly as possible and within a period not exceeding ten years.

Under these broad objectives, the second plan gave a high priority to institutionalized medical care, and so marked the beginning of a transition, which needs to be understood in the larger context. The first five-year plan was designed under the circumstances of shortage of food and raw materials, high inflation, resource constraints and other disturbing circumstances. So goals were modest.

By the second five-year plan, the need for a bold plan was felt. Agricultural prices were declining, unemployment was increasing, and population was increasing. Planning had to be done so as to provide new work for about 1.8 million new entrants into work force every year, and also offer work to a large number of persons who were without jobs and who were underemployed at present. Food and education also remained priorities.

There seems to exist a certain level of urgency for 'growth' (and development) in the second plan. The emphasis was to solve immediate problems-as unemployment-as quickly as possible. Similar was in the health sector. Shortage and inadequacy of proper health care services was seen as a major reason for poor health. Therefore there was a greater urgency to improve on this front. The other interventions for creation of a strong health system were not lost sight of, though it started taking a backseat. Nutrition was seen as the most important single factor in the maintenance of health. With improvement in the production of cereals during the first plan, greater stress was laid on increasing the production of protective foods such as milk, eggs, fish, meat, fruits and green vegetables. Second plan accepted its limitations in providing nutrition at optimum level to everybody, and so it targeted the most vulnerable group i.e. children, expectant, and nursing mothers.

The first plan located the solution of health problems in removal of poverty. The second plan had greater inclination towards technology and ad-hoc measures for solving most pressing and immediate health challenges. In spite of this shift in approach, the state was still responsible for addressing the issue of health. Growth of private sector was given importance but within the programme of production of the plan as a whole. The plan aspired to achieve a balanced growth of the mixed economy, comprehensively covering both the public and the private sectors.

Although there had been considerable development in the field of health and related issues, at the end of the second plan, certain deficiencies were especially marked. As compared to the needs, the institutional facilities were found to be inadequate, especially in the rural areas. Progress in the control of communicable diseases was hampered in several parts of the country due to shortage of trained personnel, supplies and also equipment. Lack of safe drinking water and proper drainage and sanitation facilities further aggravated the problems.

Therefore, the broad aim of the third plan was to attend to above mentioned deficiencies. Supply of good drinking water, especially in rural areas, proper drainage and sanitation facilities was chosen to be a major objective of this plan. The plan also gave importance to expansion of institutional facilities as also to eradication of malaria and other communication diseases as small pox, and control of filarial, cholera, tuberculosis, leprosy etc.

The table 4.4 shows the distribution of outlay for the first three plans for various programmes: The actual outlay for rural and urban water supply and sanitation was Rs. 67 crores and Rs.89 crores respectively i.e. total Rs. 156 crores. This in itself shows how much importance was given to this aspect of public health services. This was also to tackle cholera by the end of fourth plan. In communicable diseases, besides focusing on malaria and small pox, this plan sought to intensify the BCG campaign for tuberculosis and increase institutional support for TB, venereal diseases, filarial control and leprosy. *For control of goiter, a factory in Rajasthan to manufacture iodized salt was established in collaboration with UNICEF during the second plan itself.*

TABLE 4.4 PLAN OUTLAYS FOR VARIOUS PROGRAMMES (Rs. In crores)

Programme	First Plan	Second Plan	Third Plan
Health			
Water supply & sanitation (rural & urban)	49.0	76.0	105.3
Primary health units, hospitals and dispensaries	25.0	36.0	61.7
Control of communicable diseases	23.1	64.0	70.5
Education, training and research	21.6	36.0	56.3
Indigenous systems of medicine, homeopathy and nature cure	0.4	4.0	9.8
Other schemes	20.2	6.0	11.2
Family planning	0.7	3.0	27.0
Total	140.0	225.0 @	341.8

@ The actual expenditure was approximately of the order of Rs.216 crores.
Source Government Of India(1961). *Third five year plan*, New Delhi, Planning Commission.

Table 4.4 also shows the drastic increase in family planning funding during the third plan. This area received high priority under the influence of the Rockefeller foundation funding received by India during this plan. The first plan saw demographic changes as a dependent variable responding to wide ranging shift in sociocultural and economic factors. In the second plan, there was a change in the opposite direction, when it made demographic change as an independent and socio-economic change as dependent variable. In the third plan high priority was assigned to the family planning, specifically contraception, which came to dominate the concern in the field of health. In 1966, family planning was assigned an independent department as was separated from MCH and nutrition.

A beginning with health insurance was made as a part of the social security system with the provision of health and medical facilities for industrial workers under the Employees' State Insurance Scheme (ESIS), and for central government employees in Delhi under the contributory health service scheme. Other schemes of similar nature

was planned to be worked out later, based on the experience gained from these two schemes.

The family planning programme for the third plan was considered by a special committee appointed by the Ministry of Health and by the Planning Commission's panel on health. This committee while discussing concerns over long-term economic development stated that the objective of stabilizing the growth of population over a reasonable period must be at the very center of planned development. In this context, the third plan laid stress on the programme of family planning, and set a trend to be followed by the subsequent plans.

FOURTH FIVE-YEAR PLAN

"The most notable lesson is that the current tempo of economic activity is insufficient to provide productive employment to all, extend the base of social services and bring about significant improvement in the living standards of people" (GOI, 1969. pp 13). This statement of the planning commission leaves no doubts about the state of Indian economy towards the end of the third plan. Heavy investments in the industrialization and mechanization of the Indian economy, was still waiting to show results. Therefore, as one of the measures to safeguard our economy and put it on a progressive track, the commission proposed to introduce safeguards against the fluctuations of agricultural production as well as the uncertainties of foreign aid in the fourth plan period. It said that, "dependence on foreign aid will be greatly reduced in the course of the fourth plan. It is planned to do away with concessional imports of food grains under PL 480 by 1971. Foreign aid net of debt charges and interest payments will be reduced to about half by the end of the fourth plan compared to the current level..." (GOI, 1969. pp14)

It further added – "these measures which seek to limit the extent of foreign aid and to avoid inflationary financing have influenced the total investment outlays proposed in the plan...Success depends essentially on the extent of internal effort made in saving and investment and on the operational efficiency and economic discipline displayed by official and non-official agencies and establishments. In this context special

attention needs to be paid to the public sector where investment is expected to reach 60 percent of the total. The original expectations of an expanding public sector yielding, in due course, substantial resources for its continued development, have not been realized" (GOI, 1969.pp 14).

The review of earlier plans shows that till the fourth plan, India was trying to develop on its own. As a newly independent nation, we set our own goals, chalked out our priorities and designed strategies to achieve the goals. We tried to mobilize internal resources to fuel the capital needs of a growing economy. *India's position vis-à-vis foreign aid for its own development as mentioned in the second plan was of least reliance. Second plan stated that a small portion of finance would come from sterling balances or foreign loans and aid, and the bulk of resources must be found within the domestic economy.* At a time when a devastated India was trying to build its economy, there was hardly any financial support in the form of international aid – nor did we plan to depend on it for our own development. In the second plan, the total expenditure of central and state government combined was estimated at Rs.8, 800 crores. Of this, we expected an external assistance of not more than Rs. 400 crores i.e. approximately 4.55 percent. The rest of Rs. 8,400 crores was to be raised from internal resources. Even though we may not have relied financially on international aid for our development, India definitely could not have remained isolated from international development paradigms. Greater stress on industrialization and economic growth, development been seen as an effect of trickle down was an example of such influences. Another influence was the understanding of social sectors being unproductive, therefore, investments in such sectors in an economy pressed for resources was seen as a luxury. Fourth plan clearly states a cut in the subsidies in food and agricultural sectors. So while earlier plans saw an integrated approach to development as being essential to building a healthy population, the fourth was the first to draw a cleavage in such an approach. It mentions that - "for the major part public outlays have to be directed not towards welfare activity but towards strengthening the economic base of the weaker units; and more finance must be made available for this purpose in the plan. There are two main ways in which this can be done. First, by strictly limiting the scope of free or subsidized services or supplies given by the state. General subsidies in relation to agricultural supplies have been

withdrawn to a large extent. It is hoped that expenditure on food subsidies will be eliminated. In a society in which highly unequal distribution of income exists, it is undesirable to make unnecessary low charges. Above a basic minimum of free services in, say, education and health, appropriate charges have to be levied; these have to be fully economic at the average level and could with the possibility of discrimination be much higher for those with the ability to pay for them (GOI, 1969. pp 19).

The underlined in the above paragraph need a critical evaluation. First, it talks about elimination of food subsidies. This in a society marked by high levels of under nutrition and inequality in distribution of income skewed in favor of rich. Second, it talks of providing basic minimum of free services in (unproductive social sectors of) health and education. Nowhere in the plan has the criterion of streamlining this "basic minimum", for who, on what basis, has been mentioned. Clearly, this must have been left to the discretion of political parties and their populist agendas, or to the expertise of the elite bureaucracy. *It further goes on to introduce the concept of user charges and targeted intervention in case of poorer sections of the society. For the purpose of this discussion, the point to be noted here is that these are the concepts which crept in Indian planning from the fourth plan itself, and therefore, were not alien concepts when structural adjustment programmes forced them to be implemented with full vengeance in the 90s.*

These however remained at the conceptual level only, and sectors like education and health were still seen as a state responsibility (GOI, 1969. pp 386). The broad objectives of the health programmes during the first three plans were (i) control or eradication of major communicable diseases, (ii) provision of curative, preventive and promotive services in rural areas through establishment of PHCs and sub-centres, and, (iii) augment the training programmes of medical and Para-medical personnel. During the fourth plan efforts were directed towards strengthening the PHC complex in the rural areas for undertaking preventive and curative health services and for control and maintenance phase of the communicable disease control and eradication programmes.

The main emphasis of the fourth plan was more on building a strong health care infrastructure, which would be capable of providing services to the masses. Water supply, nutrition and their contribution to health found no mention. In the area of employment and increasing the purchasing power of people, the plan had already clarified the inability of state due to slow economic growth.

FIFTH FIVE-YEAR PLAN

The primary objective during the fifth plan was to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups – children, pregnant women and lactating mothers. Consolidation of past gains in the various fields of health, such as communicable diseases, medical education and provision of infrastructure in the rural areas, was also given importance. The emphasis during the fifth plan was –

- Increasing the accessibility of health services to rural areas,
- Correcting the regional imbalances,
- Further development of referral services by removing deficiencies in district and sub-divisional hospitals,
- Intensification of the control ad eradication of communicable diseases especially malaria and small pox,
- Qualitative improvement in the education and training of health personnel, and
- Development of referral services by providing specialists' attention to common diseases in rural areas (GOI, 1975, pp 234).

The minimum needs programme was to receive highest priority in this plan. As a result outlays in the health sector were revised with health receiving larger share. Communicable diseases received priority. The idea of providing integrated services gained support under the minimum needs programme. Thus infrastructural improvement was stressed in order to ensure better access to services.

An integrated approach was taken for health, family planning and nutrition programmes during the fifth plan. Therefore, funds provided for family planning and nutrition programmes was planned to be utilised for meeting part of expenditure towards strengthening PHCs and sub-centres also, as it was through these establishments that integrated services was to be extended to the community.

Midway through the plan however, there was a high intervention. Emergency was declared and the social sector cuts fell heavily upon MNP and nutrition investments. A second five-year plan was formulated by the Janta Government but the damage had been irrevocable.

SIXTH FIVE-YEAR PLAN

The sixth plan did a thorough review of the health status and planning in India since independence. While acknowledging the significant achievements of the health care system, it did not ignore the shortcomings from which it suffered. It mentioned that – "there has been pre-occupation with the promotion of curative and clinical services through city based hospitals which have by and large catered to certain sections of the urban populations. The infrastructure of sub-centres, primary health centres and rural hospitals built up in the rural areas touches only a fraction of rural population. The concept of health in its totality with preventive and promotive health care services in addition to the curative is still to be made operational" (GOI, 1980).

Investment on health was seen as investment on man and on improving the quality of life, by this plan. Thus, it recognized health in its totality and as a part of the strategy of human resource development. India adopted the policy of 'Health for all by 2000 A.D.' enunciated in Alma-Ata declaration in 1978. Sixth plan was a process of evolving an alternative strategy for FPP where infrastructure and strengthening MCH became important. Therefore, the policy guideline to be followed up to 2000 AD was based on the recommendations of the working group on health. It was as follows:

- Emphasis was to be shifted from development of city based curative services and super-specialties to tackling rural health problems. It was planned to build a rural health care system based on a combination of preventive, promotive and curative health care services, with village as a base.
- Rural health care infrastructure was to consist of primary health centres each serving a population of 30,000 and sub-centres each serving a population of 5,000. These norms were relaxed in hilly and tribal areas.

- Treatment of basic specialties was provided at community health centres at the block level for a population of one lakh with a 30 bedded hospital attached and a system of referral to district hospital/medical college hospitals was to be introduced.
- Coordination of various programmes under education, water supply and sanitation, control of communicable diseases, family planning, maternal and child health care, nutrition and school health implemented by different departments/agencies, was planned for optimal results.
- Planning to train adequate medical and Para-medical manpower for their orientation towards rural health care.
- Community participation and people's involvement in tackling their health problems was to be encouraged so that they could be entitled to supervise and manage their own health programmes eventually.

This was one plan after the Bhore committee to have talked of a larger system involving problems of poverty, illiteracy, malnutrition, poor purchasing power, poor water supply, sanitation and housing to be the root causes of health problems. It went beyond mere recognition of these issues and addressed them in the planning process. It talked of separate plans to address each of these issues, and also of intersectoral coordination and collaboration for achievement of optimum results. This is where the sixth plan differed from Bhore committee report. Even though the report had a similar understanding of health issues, its much-celebrated long and short-term goals remained limited to development of institutional care delivery system. Had it seen socio-economic changes as the solution for public health problems, why would it plan to increase only bed capacity of hospitals and dispensaries in its long-term plan? As subsequent plans were mainly structured on the recommendations of this committee, they too were skewed. With the root causes of public health problems remaining intact and the short-term solutions trying to attend to immediate demands, we did succeed in bringing down the mortality rate, but could not eliminate even a single problem. Basic and most virulent killers as diarrhoea and pneumonia still continued to take maximum toll on children even after six plans. The sixth plan realized the issues in the right perspective. It accepted that development was the best solution to all public health problems, but at the same time it maintained that poor developing

countries like India could not wait for such development to happen. And so immediate steps needed to be taken even though our long-term goal should be to address to the core of the problem.

Such a holistic understanding of the sixth plan seems to be an influence of another international health policy development i. e. the Alma-Ata declaration in 1978. WHO and UNICEF convened the international conference on primary health care in Alma-Ata, in which a target of 'Health For All by 2000' was set and the participating countries signed the declaration. Primary health care was identified as the key to attaining this goal, which was seen as a part of development in the spirit of social justice. The approach included in addition to health sector, all related sectors, aspects of national, and community development and demanded the coordinated efforts of all those sectors (Alma-Ata 1978, Primary health care, WHO, 1978). What is revealing however is the fact that the sixth plan never mentions Alma-Ata even though India was among its main signatories. It also proposed greater role of NGOs and private sector in the provision of medical care.

The adoption of India's first national health policy in 1983 was also a reflection of the same ideological perspective as present in the sixth plan and Alma-Ata declaration. The document clearly proposed opening up of medical care to the private sector (GOI: 1983).

SEVENTH FIVE-YEAR PLAN

Human resources were acknowledged to be the country's most precious endowment. The success of a plan was rated on the extent to which human resources are developed in terms of education, skills, health and well-being. India, being a signatory of Alma-Ata, was therefore; committed to achieving 'Health For All by 2000 A.D.' life expectancy had gone up from 27.4 years (1941-51) to 54.71 (1985-86). IMR had gone down from 146/1000 live births during 50s to 110 in 1981. Country had 83,000 sub-centres, 11,000 primary and subsidiary health centres and 650 community health centres. Per capita expenditure had increased from Rs.1.50 in 1955-56 to Rs.27.86 in

1981-82. Plague and small pox were 'reported' to be eradicated. (India reported a plague epidemic in Surat in 1992).

The objectives, goals and strategies adopted by the seventh plan were –

- Primary health care was accepted as the main instruments of action for achieving HFA by 2000.
- In the overall health development programme, emphasis was to be laid on preventive and promotive aspects and on organizing effective and efficient health services which are comprehensive in nature, easily and widely available, freely accessible and generally affordable by the people.

The main thrust was to be on –

- Continuation of minimum needs programme (launched in the fifth plan) for the promotion of primary health measures.
- Qualitative improvements in health and family planning services.
- Serious efforts for effective co-ordination and coupling of health and health-related services and activities, nutrition, safe drinking water supply and sanitation, housing, education information and communication and social welfare. These were to be made as part of the package for achievement of the goal of health for all by 2000 A.D.
- Plan for seeking community participation and involvement in the programmes.
- Attention was to be given for comprehensive coverage of urban and school health services, control and eradication of communicable and containment of non-communicable diseases, training and education of medical and Para-medical personnel, medical research and development of Indian systems of medicine, under this plan.

The health sector outlay for seventh plan was Rs.3392.89 crores. The outlay for the family welfare programme was stepped up to Rs.3, 256 crores, which was almost at par with the provision made for all other programmes to be undertaken by the seventh plan. two clear shifts were visible, firstly, the cuts in the sixth plan investments for

FPP saw a reversal as shown above, secondly, despite the objective of providing comprehensive, available and accessible health services, seventh plan also talks of 'easily affordable health services by the people'. This implies that the initial objective of Indian planning i.e. of providing health services for all irrespective of their paying capacities, is being modified here. Not only the seventh plan, but earlier plans as the fourth plan also mention about levying user charges for essential facilities. The earlier plans though proposed to give differential treatment to different economic strata, whereas this plan seems to be considering universal application of commodification of health services. Until now provision of health care was seen more as a right of every citizen, and state was held responsible for its provision. Seventh plan marks the beginning of a change in this perspective.

It is worth noticing that till the seventh plan, state had been consciously and whole heartedly (at least on papers) trying to create an institutional infrastructure and support system to ensure maximum coverage, availability and accessibility of health services by the people. Still the mid-term appraisal report of seventh plan states that the ratio of public and private expenditure on healthcare was 1:2. The disproportionate private expenditure could be either due to absence of public sector services, poor public sector services or that the out of pocket expenditure is on public sector institutions as well where doctors are available but drugs are not. The 42nd round of NSS shows that 42 percent of the poorest go to public hospitals when severely ill. It is possible also when people harbor some kind of dissatisfaction (due to several reasons) from the public health care delivery system. The planners, instead of looking into this aspect of the problem and trying to tackle the bottlenecks, started preparing grounds for disowning the original conception of public system. This becomes extremely clear in the subsequent two five year plans. In the seventh plan, the government prepares grounds to control private health care system without suggesting strategies to strengthen the ailing public health system.

An important shift that occurs in the seventh plan is vis-à-vis India's stand in terms of international financial assistance. This was partly due to balance-of-payments crisis due to fall in export earnings and rising external debts. The mid-term appraisal stated

"The need for careful management of balance of payments during the second half of 1980s had been clearly foreseen. For one the export earnings in 1980-85 had fallen far short of the target. For another, the scope of expansion of crude oil production during the seventh plan was manifestly much more limited, while the debt servicing obligations, including repayments to the IMF were slated to rise more sharply. In effect, the balance of payments position turned out to be worse than had been initially projected.

The crux of the problem is that gains from the terms of trade, substantial though they might remain, could either bridge the shortfall in exports or meet the cost of excess imports, but not both. Thus the eventual deficit on current account will need to be brought down to a level closer to the one foreseen in the seventh plan, so that it can be financed through recourse to available flow of foreign assistance from international financial institutions, better utilization of aid in the pipeline and marginal additional reliance on conventional borrowings. This is a feasible objective, and can be attained without slowing down growth or capital development. It will involve, however, effective use of coordinated set of policy interventions" (GOI, 1988.). These macro economic pressures pushed the health sector further away from its actual objectives of total coverage by basic health and self-sufficiency.

While discussing the fourth plan, we had seen how India wanted to do away with its need for its need for international financial aid. This was not achieved, instead, by the seventh plan it can be seen how much dependent our economy had become on this source of capital. Doing away with aid component is a long lost goal, now we are so much caught in debts and other economic bottlenecks that we were considering policy interventions to ensure the flow of this aid in order to save our crippling economy. International aid was here to stay, though it still did not form any significant contributions to the financial outlay. The table 4.5 clearly shows the external assistance during the Seventh Plan Period.

TABLE 4.5 EXTERNAL ASSISTANCE DURING THE SEVENTH PLAN PERIOD (Rs. In crores)

Financing the plan	1985-86	1986-87	1987-88
Net flow from abroad	2,720	3,580	3,674
Resources for the plan (total)	33,382	0,819	45,099

Source: Government of India, *Seventh Five Year Plan, (1985-90), Mid Term Appraisal, Planning Commission.*

EIGHTH FIVE-YEAR PLAN

In the eighth plan, the newly elected government felt an urgent need to remove the sources of discontent and unrest. This was to be done by attending to unemployment, illiteracy, ill health and decline in living conditions of the poor and vulnerable sections. Delivery of adequate health care was seen as a basic task before the nation. Inequality in access to medical care in urban and rural areas and between the rich and poor was acknowledged. The plan therefore suggested that 'in both health and education services provided by the public sector, there is a strong case, both on grounds of revenue and equity, for the better-of sections to pay adequately for the services utilised by them' (GOI, approach to eighth five-year plan. pp 35,36,37).

Analysis of the eighth plan, along with the seventh plan, shows some very important shifts.

The first is the change in the perspective of Indian planning regarding health. Until now, health was seen more or less as a matter of right (though not a fundamental right) of every citizen, and state was trusted with the responsibility of providing for it. In this approach paper, the perspective changes to health being an investment in order to get/create/build a productive workforce. The statement '...is a prerequisite for the poor to become employable productively...' signifies that ensuring health of people remains no more an end in itself, but is seen as a means to achieving (productive) ends. It is an investment to produce human capital, which could be invested to produce economically advantageous goods and services.

As for the role of state in health care, a neat background had been prepared in the seventh plan for the private sector. This gets further strengthened in subsequent plans. Privatization of health services was now here to stay.

Another important point worth noticing is that the government openly confessed its failure in developing a strong health care delivery system in India. This I see as tremendous failure. Indian planning, though, in every plan since independence, kept on repeating the need to develop a complete health system; it finally turned out to be a mere rhetoric. Finally in the health outlay, investments were mainly made in areas of curative services and in building infrastructure for its delivery. So what the planners actually planned was a strong health service system. And here in eighth plan, they admit their failure to establish even this goal. Again, this realization must not be seen as the beginning of larger, more scientifically planned efforts of our government towards building such a system. Instead, this was an addition to the creation of the background to magnify failure of state and therefore justify invasion of private sector in health care. This point shall become clearer as we discuss eighth plan in greater detail.

The eighth plan in its introduction applauded the achievements of Indian planning during the past forty years in terms of increasing and diversifying consumption basket, decreasing mortality rates and poverty, increasing life expectancy, literacy etc. it also stated that considerable development had been achieved during 1980-90. Then it went on to add – "the economy has passed through difficult circumstances during the last couple of years. The growing fiscal gap and the sudden depletion of foreign exchange resources created a situation which put severe strains on the economic system leading to drastic import curbs, high rate of inflation and recession in the industry...corrective measures have already been initiated by way of planned fiscal reforms and policy changes. The eighth plan will have to reorient some of the development paradigms, since its objective is to lay a sound foundation for higher growth and to achieve most significant goals, namely, improvement in the levels of living, health and education, and a planned growth in population" (GOI, 1992.pp 1).

About public sector the plan reads –

"The public sector was assigned a place of commanding heights in the Indian economic scene. It was expected to create the basic infrastructure for development, be a pacesetter in taking risks and nurturing entrepreneurship, take care of social needs, help the poor and the weak and create an environment of equal opportunities and social justice. The public sector also expanded considerably...in the process, it has made the people take the public sector for granted, oblivious of certain crucial factors like efficiency, productivity and competitive ability. This has eroded the public sector's own sense of responsibility and initiative...while there are several social and infrastructure sectors where only the public sector can deliver the goods, it has to be made more efficient and surplus generating. It must also give up activities, which are not essential to its role. The eighth plan has to undertake this task of reorientation...the process of planning will have to e reoriented so as to make planning largely indicative. This, in turn, will imply a somewhat changed role for the planning commission. The planning commission will have to concentrate on anticipating future trends and evolve integrated strategies for achieving the highest possible level of development in the country in keeping with internationally competitive standards" (GOI, 1992. pp 1).

About the international standards the plan mentions –

"The eighth plan is being launched at a time which marks turning point in both international and domestic economic environment. All over the world, centralized economies are disintegrating. On the other hand, economies of several regions are getting integrated under a common philosophy of growth, guided by the market forces and liberal policies. The emphasis is on autonomy and efficiency induced by competition. We cannot remain untouched by these trends...if planning has to retain its relevance, it must be willing to make appropriate mid-course corrections and adjustments. In the process, it may be necessary to shed-off some of the practices and percepts of the past which have outlived their utility and to adopt new practices and percepts, in the light of experience gained by India and by other nations" (GOI,1992.pp 2).

So we see how this plan first state the dismal performance of public sector in areas it was entrusted to perform well. It then goes on to suggest that our planning will have to reorient it in order to overhaul the public sector to make it competitive and efficient. This it said could be done by embracing the experiences from the west i.e. capitalist economies and market oriented approach. This way the plan justified the adoption of market principles in public policy formation. Such an approach stands in clear contrast by the one adopted by Indian planning over the past decades, and also in contrast to the constitutional guidelines. The aims and objectives of the past plans had been shaped according to the guidelines of the directive principles of state policy. This meant that we chose to adopt a socialist pattern of society where lines of advance were determined not by private profit but by social gains.

The fourth plan realized that each country has to develop according to its own genius and traditions. Economic and social policy has to be shaped from time to time in the light of historical circumstances (GOI, 1969. pp 3&4).

The eighth plan mentions that-"human development will be the ultimate goal of the eighth plan. It is toward this that employment generation; population control, literacy, education, health, drinking water and provision of adequate food and basic infrastructure are listed as the priorities. The provision of the basic elements, which help development of human capital, will remain the primary responsibility of the government" (GOI, 1992. pp 10). This is a great responsibility which the eighth plan put on the shoulders of a'non-efficient, cumbersome, loss-making, weak state, further weakened due to cut down in public expenditure under the new economic policy which forced the sate to recede from profit making commercial sectors to make way for markets.

With scarce resources in terms of power and capital, eighth plan suggested the following strategy to ensure public services, i.e. through creation of safety nets –

"...Creation of a social security net through employment generation, improved health care and provision of extensive education facilities throughout the country, and creation of appropriate organizations and delivery systems to ensure that the benefits

of investment in the social sectors reach the intended beneficiaries" (GOI, 1992. pp 9). In other words from full coverage, targeting the underprivileged with prescribed services became the eighth plan strategy. This primarily meant family planning through RCH.

This implies that what the government earlier planned to provide as a universal and comprehensive service would now be offered as a sop – in the name of safety net. The reason for such a step becomes clear while analyzing the ninth plan.

NINTH FIVE-YEAR PLAN

Ninth plan made no attempts to focus towards social, economic and environmental aspects contributing to health problems. It focused totally on improving the health status of population through improvement in quality of health care services based on technological interventions. As the plan reads – "during the ninth plan efforts will be further intensified to improve the health status of the population by optimizing coverage and quality of care by identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic reagents and drugs. Efforts will be directed to improve functional efficiency of the health care system through:

a) Creation of a functional, reliable health management information system, training, and development of health manpower with requisite professional competence.

b) Multi professional education to promote teamwork.

c) Skill upgradation of all categories of health personnel, as a part of structured continuing education

d) Improving operational efficiency through health services research

e) Increasing awareness of the community through health education

f) Increasing accountability and responsiveness to health needs of the people by increasing utilization of the Panchayati Raj institutions in local planning and monitoring

p) Making use of available local and community resources so that operational efficiency and quality of services improve and the services are made more responsive to user's needs" (GOI, 1997).

This plan gave the credit for improvement in health status to improvement in coverage and quality of health care and implementation of disease control programmes. However, it also acknowledged the high morbidity due to common communicable and nutrition-related diseases and also due to non-communicable diseases. Non-communicable diseases have been getting increasing attention since fourth five-year plan. Ninth plan decided to take adequate efforts to tackle this dual disease burden effectively in order to ensure sustained improvement in the health status of the population.

As strategies to improve the performance of disease control programmes during ninth plan-following steps were decided upon-

- Rectify identified defects in design and delivery
- Fill critical gaps in infrastructure and manpower
- Make service delivery responsive to user needs
- Ensure skill upgradation, supplies and referral services
- Ensure community awareness, participation and effective utilization of available services.

Here we see that our disease control programmes have gone completely technocentric and the idea is predominantly that poor health status is due to communicable and non-communicable diseases, which can be effectively controlled just by strengthening technical and equipment supported by a strong care delivery institutional set up. Ninth plan focuses heavily on strengthening the curative services, with preventive and promotive services taking a backseat. Preventive services were also in the form of technical inputs.

The ninth five-year plan stressed on reducing fertility once again. FPP now came to be known as reproductive child health (RCH) (an aftereffect of the Cairo conference). During the ninth plan the focus of FW programme was on need assessment, counseling and provision of appropriate contraceptive and good follow up services. The programme was geared up to meet the unmet needs of contraception, which was seen as prime means to improve CPR, reduce CBR and MMR. The main argument put forward in favor of the population control or family planning programme is that large population is one of the main reasons of India's poverty and slow rate of economic growth. Therefore, it is essential to contain India's population (and of the third world) in order to register any significant levels of growth.

Ninth plan was an 'honest' plan! After the sixth plan, this is the next plan where the understanding of health and factors that cause public health problems, and plan objectives & strategies were in consonance with each other. Whether that understanding and recommended strategies were epidemiologically correct and according to India's actual public health needs, is another aspect. But at least, these two plans, unlike the rest of our plans, did not give a theoretically correct and holistic understanding of issues on one hand, and suggesting completely divorced planning strategies to tackle those issues. And therefore, an analysis of these two plans (sixth and ninth), starkly brings out the magnitude of shift that occurred in our public health planning since independence.

- The sixth five-year plan we believed in the need to build comprehensive and universal health system that it aspired for. By the ninth plan, our planning became more expensive but less ambitious in terms of developing a strong health system. We narrowed our focus 'totally' to building a health service/care system only.
- Until the sixth plan, India's main concentration although was on building a health service system (as a part of a larger health system), it was more or less conceptualized as a general health system. It was supposed to support the maintenance phase of vertical health programmes, and also cater to all other health problems not covered under national disease control programmes. By the time we reach ninth plan, our focus became only the health service system and that too not as a general health system but as a technologically efficient, up-to-

date institutional structure with state of art equipment at par with any developed nation of the world. Health personnel were also to be trained to run such organizations.

- Until the sixth plan, efforts were being made to give equal attention (though not with much success) to all preventive and promotive services along with curative services. By the ninth plan curative services came to be seen as 'the most effective measure' to combat ill health, more so because of non-communicable diseases getting increasing importance as public health problems.

- Till the sixth plan, health care was seen as a state responsibility and India aspired to develop on socialist pattern, where public gains are priced over private profits. Ninth plan takes recourse to market values and hails privatization of health care as the only panacea for improvement in standards of services.

- Public health includes all the preventive, promotive, curative and rehabilitative measures. Earlier all this was states' responsibility. The ninth plan divided services. A revenue-starved state is further burdened with expenditure intensive preventive and promotive services whereas profits making curative services are taken over by private sector.

- As curative services go to private sector, coverage gets greatly reduced, poor sections get further marginalized, and out-of-pocket expenditure increases greatly, resulting into increase in health problems. But the state, though still remains a signatory of 'HFA by 2000' has no power to control these developments, and the repercussions that follow. State is forced to decrease spending in social sectors, able to provide only safety nets.

- Another major shift is in the choice of diseases to be covered under public health concerns. Earlier we identified those diseases which epidemiologically and rationally proved to be public health problems – like malaria, tuberculosis, diarrhoea, RTIs etc. but as our planning proceeded, our choice of issues became more influenced by international priorities as AIDS, non-communicable diseases as cancer etc., which are not actually a public health problem for India. Family planning is another area, which overshadows all other programmes. The amount of funds allocated to these programmes cannot be scientifically accounted for.

THE TENTH PLAN – ILLUSIONS CONTINUE

The tenth plan is also not divorced from the eighth and the ninth plans in terms of their approach to handling health issues. This plan however, very cleverly carries on the illusion created by our planners, of their being aware and sensitive to the problems of public health planning. The final report however makes no concrete efforts to do away with the earlier displaced priorities.

According to the tenth plan, health system consists of primary; secondary and tertiary care institutions, manned by medical and paramedical personnel. It also includes medical colleges, and other training institutions, systems of data collection and research. In a nutshell, health service system has finally replaced the health system in the tenth plan. Health problems are located in the non-coherent functioning of this health (service) system and so the entire document focuses on restructuring, privatizing and defining new norms for this system only. Health costs are the only concern and this document find solutions in the recommendations of the World Bank as mentioned in its 1995 and 1997 reports on financing the health sector. These recommendations are discussed later.

It talks of integrated approach to provision of health services. Its idea of integration however, remains confined only to the RCH approach to family welfare services. The remaining disease control programmes are to be dealt with separate vertical programmes. Also the concept of primary health care, which includes the primary, secondary and tertiary care connected by means of a strong referral system, has been reduced to primary level care. This primary level care is to be provided through the primary health centres, while the secondary and tertiary care systems have been privatized. Along with the privatization of the health sector, the idea of health tourism is being heavily promoted. This shows complete commercialization of the health sector where the poor is pushed out of the system due to its non-availability and affordability, and rich and international clients are given attractive packages so that the health sector becomes more financially productive and therefore less dependent on the state. The latest idea of efficiency of the health sector gives little importance to

coverage achieved with successful intervention. Such an understanding makes the exclusion of poor easier from the health system.

INTERNATIONAL INFLUENCE ON NATIONAL PROGRAMME STRATEGY – AN EXAMPLE

Taking an example of family planning programme, we can easily see how our programme strategy has been changing according to the fluctuating international paradigms. The main argument put forward in favor of the population control or family planning programme is that large population is one of the main reasons of India's poverty and slow rate of economic growth. Therefore, it is essential to contain India's population (and of the third world) in order to register any significant levels of growth.

India's family planning programme has been influenced in various ways by the US government (USAID) and other US agencies like the Population Council, the Ford Foundation, the Population Crisis Committee, the Council of Foreign Relations and the programmes sponsored by numerous universities, Church Organizations, the International Planned Parenthood Federation, and other voluntary associations. UNFPA initially attempted to sell a draft declaration to the World Population Conference at Bucharest, which had pronounced Malthusian overtones. However, when the conference proclaimed the Bucharest Declaration that 'development is the best contraceptive', the UNFPA retaliated along with other international agencies by treating the declaration as a mere scrap of paper and went on to promote many activities which went diametrically opposite to the Bucharest mandate (Banerjee, 1985).

India in its the fifth five-year plan, codified the changed perspective which saw development as the best contraceptive, and the objective of the family welfare programme was to provide certain public health facilities integrated with family planning and nutrition for vulnerable groups as children, pregnant women and lactating mothers. However, in 1975 itself failure of FPP was recognized resulting in

the view that development was being hampered by population growth. It gained strength with the imposition of emergency. Such views called for more decisive steps and suspension of normal political process facilitated the passage of the national population policy. This document acknowledged poverty to be the real culprit behind population growth, but went on to say that - "nonetheless it is clear that simply to wait for education and economic development to bring about a drop in fertility is not a solution."

The sixth plan, with its developmental approach, proposed to integrate family planning with programme aimed at meeting the basic needs. The seventh plan experienced a step rise in funding for family welfare. Government of India, in collaboration with agencies like World Bank, UNFPA and SIDA promoted contraception acceptance through CSSM and ICDS. The family planning programme got fully integrated with MCH and voluntary organizations gained a major role in FPP. These programmes were essentially attempts to implement, in a disguised form, Malthusian birth control measures, as were the area projects.

Then in 1994, International Conference of Population and Development at Cairo (ICPD) presented a plan of action, which was a major departure from this conventional thinking on population and development. It explicitly placed human beings at the center of all population and development activities.

An analysis of all five-year plans shows that although India has always realized that development is the best contraceptive, still it could not resist the temptation of choosing the short cut to limiting its size of population. Repeatedly planners have taken recourse to the idea of controlling population in order to eliminate poverty. In population control also, it is well understood that development is the best contraceptive, yet they have resorted to programmes focusing on women and are madly pushing contraceptive technology in the FPP. This inappropriate approach taken by India towards regulating fertility, once again, matches exactly with international paradigms and funding patterns of international agencies.

Our review of plans reveals how the planning process has undermined tackling poverty and attending to conditions like poor water supply and sanitation, housing, food security, illiteracy, unemployment etc. associated with it, which ultimately lead to disease and death. Instead we tried to build a health care system as a substitute, and have yet to be successful at that. Even in the health care system, instead of providing an integrated comprehensive health care, we focused on vertical programmes targeting certain diseases. Above all, international donors and advisors who have increased the pace of their intervention in Indian planning process heavily influence these shifts. The next chapter analyses planning priorities and the choice of diseases for control and eradication. It explores hoe rational the planning process is and how much of the priorities are based on epidemiological research. It also examines in detail the adopted and implemented sectoral adjustment programme, introduced by IMF and the World Bank.

Chapter-IV

INTERNATIONAL AID AND PLANNING PRIORITIES-AFOCUS ON HEALTH

In this chapter we discuss the role of international aid on planning priorities, with special focus on health. International aid has never made any significant contribution to the total budget outlay of India. According to the information provided by the ministry of finance and company affairs, international assistance has never exceeded more than 8-9 percent of the budget outlay. But still it exercises great power in influencing planning priorities, as every drop is considered important. To provide an overview, we give the percent share of loans and grants of the entire public sector outlay over the five-year plans. The actual amounts are given in annexure I.

Table 5.1 Percent share of loan and grant in public sector outlay.

S.No.	Five-Year Plan	Government Loan	Non-Government Loan	Grant	Total
1	First plan	5.87	0.00	3.39	9.26
2	Second plan	24.71	1.73	3.35	29.79
3	Third plan	32.33	0.00	1.25	33.58
4	Fourth plan	19.75	0.15	0.96	26.31
5	Fifth plan	11.74	0.58	2.25	14.57
6	Sixth plan	8.94	0.42	1.83	11.18
7	Seventh plan	47.92	2.83	6.49	57.24
8	Eighth plan	10.01	1.94	1.01	13.06
9	Ninth plan	6.04	1.65	0.60	-
10	Total	11.07	-	1.10	12.17

Source: GOI External assistance, 2001-2002.

Table 5.1 shows that the amount of government loans has been more or less inconsistent over the years but non-government loans are on a rise. However, the amount of grants has seen a decline over the years except for the seventh five-year plan when both government loan as well as grant saw a steep rise. Comparing the increase in loan and grant element during the seventh plan however, shows that both increased about five times their previous amounts. It must be remembered that loan has to be repaid with certain interest whereas grants carry no such liabilities. Main areas funded by grants are the social sectors, which includes health, and therefore of our interest. However, with the increasing commercialization of the health sector, lately health sector funding has gradually shifted from grants to loans. This point shall be discussed in greater detail later in the chapter.

International aid in the health sector was received as a part of social sector aid. Therefore, there is a problem in qualifying as to how much aid has been received by

health sector over successive five year plans. Due to poor documentation, such data can still not be found even after health sector being given an independent authority in early 80s. A review of details of all the loans sanctioned by all the donors to India over the five year plans reveals that very little international funding has been received by the health sector as international aid. Sporadic projects on water supply and sanitation and population projects are however present starting from fourth five-year plan. before that, international aid has been received as food aid under PL480 I and then later under PL 480 II and III.

Starting from food aid and population projects, the next areas to receive international attention was malaria control and integrated child development scheme (ICDS). As mentioned earlier, poor documentation has resulted in lack of adequate and precise data on international aid in the health sector. No government department viz. ministry of finance and company affairs, ministry of health and family welfare and controller of aid accounts and audit, has documented and preserved financial aid data nor do they easily part with it. However, as the areas being funded prior to 80s were less and the quantum of aid in the health sector was less. For the purpose of this study, analysis of post 80s international aid in health sector post 80s has been done. However the researcher has not been able to find exact data even for these years also. This study has tried to use data from the annual reports of ministry of health and family welfare (MOHFW), parliament proceedings and records provided by MOHFW. Based on these separate tables for each donor agency and/or country showing the programmes funded and the amount of assistance received (wherever available) has been drafted, which is followed by an analysis of such assistance.

ASSISTANCE FROM WHO

WHO provides policy guidelines for national programme planning. Its main form of assistance is technical expertise for proper implementation of national programmes. An analysis of table 5.2 and 5.3 shows that WHO funding has been decreasing in the area of health towards late 80s or the end of the seventh five-year plan. However, its funding for areas covered under the family welfare programme has risen drastically from the eighth plan. In other words, WHO has shifted its focus towards family welfare services. It has provided aid in the form of technical, managerial support and

training. Such support leaves very little opportunity for the recipient country to utilize aid according to its own needs.

TABLE 5.2 ASSISTANCE FOR HEALTH (in USD)

S No.	Year	Programmes funded	Amount	Percent
1	1980-81		4,091,450	2.46
2	1981-82	• Health services development	7,103,150	4.28
3	1982-83	• Family health	9,552,400	5.75
4	1983-84	• Mental health		
5	1984-85	• Communicable diseases control	9,920,048.5	5.97
6	1985-86	• Non-communicable diseases	15,180,700	9.14
7	1986-87	prevention and control	1,074,510.0	0.65
8	1987-88	• Health manpower development	5,703,916.5	3.43
9	1988-89	• Health information, research	12,092,600	7.28
10	1989-90	and development		
11	1990-91	• Environmental health	1,38,10,100	8.31
12	1991-92		1,52,87,800	9.20
13	1992-93	Mainly family welfare programmes	13,950,417	8.40
14	1993-94	• MCH	3,238,458	1.95
15	1994-95	• Family welfare and research	15,992,100	9.63
16	1995-96	• FW/PHC in urban areas		
17	1996-97	• Expanded programme of	12,776,000	7.69
18	1997-98	immunization		
19	1998-99	• Control of diarrheal diseases	13,502,000	8.13
20	1999-00	• Acute respiratory infection		
21	2000-01	• IEC	12,838,000	7.73
22	2001-02	• Guinea worm eradication		
23	Total		16,61,13,650	100

Source: GOI, Annual Reports, Ministry of Health and Family Welfare

Also, the areas funded, like communicable and non-communicable disease programmes, environmental health, manpower training and development etc. all contribute towards strengthening only the care delivery system. Crucial areas, as

chalked out by the five-year plans, like water supply and sanitation, food security, housing etc. do not receive any attention.

TABLE 5.3 ASSISTANCE FOR FAMILY WELFARE (in USD)

S No.	Year	Programmes funded	Amount	Percent
1	1980-94	MCH + research under human reproduction program.	9,998,900	51.37
2	1994-95	ARI, IEC, PHC, promotion of FW services & research, RCH, FE services in urban areas, EPI, CDD	3,639,000	18.70
3	1995-96		3,540,515	18.19
4	1996-97	Rural health services, safe motherhood and newborn care, family health services, women's health services, research on new contraceptive technology, IEC, UIP, ARI, CDD.	2,285,450	11.74
5	1997-98			
6	1998-99			
7	1999-00			
8	2000-01			
9	2001-02			
10	Total		1,94,63,865	100

Source: GOI, Annual Reports, Ministry of Health and Family Welfare

Health problems identified as major killers for infant and child mortality by Indian data and planning - like diarrhoea, and pneumonia etc. receive very little aid. As per the latest available data from sample registration survey of registrar general of India, for 1998, the major causes of child mortality and the number of deaths against each of them are as under: -

Pneumonia 4,84,456

Anemia 2,29,479

Diarrhea 1,60,635

Typhoid 1,30,035

Influenza 96,891

Dysentery 79,042

Among all the international agencies providing aid, none except WHO has ever funded any programme for these diseases. Not that these diseases require sophisticated intervention. Infact, only if India could follow the recommendations of

the first health committee i.e. Bhore committee, this would not be the situation even after successful completion of seven five-year plans. The Bhore committee had recommended – "in drawing up a health plan certain primary conditions essential for healthful living must in the first place be ensured. Suitable housing, sanitary surroundings and a safe drinking water supply are pre requisites of a healthy life. The provision of adequate health protection to all covering both its curative and preventive aspects, irrespective of their ability to pay for it, the improvement of nutritional standards qualitatively and quantitatively..." (GOI, 1946.).

Even after fifty years of planning, supported by international goodwill, we failed to adhere to these recommendations. The result can be seen in the data. This data on child mortality, surprisingly, does not mention any of the diseases covered under the universal Programme of Immunization. The six diseases covered under UIP programme have been promulgated to be the major killers by organizations like WHO, and frantically supported by other international agencies like UNICEF etc. which hold prominence in shaping international health priorities.

Table 5.2 and 5.3 show aggregate funding for all the areas/programmes supported by WHO. This does not show how much funding/importance each of these programmes received from the organizations. The next table gives us some idea regarding this domain. (WHO support is often along with other organizations such as UNDP).

TABLE 5.4 ASSISTANCE ALLOCATED BY WHO/UNDP (in USD)

S No.	Programmes	Year					
		1980		1981		Total	
		Regular budget	Other sources	Regular budget	Other sources	Regular budget	Other sources
1	General programme development and management	100,250		1,100,250		1,200,500	
2	Research promotion and development	431,100		341,200		722,300	
3	Health services development	609,700		566,990		1,176,600	
4	Family health	312,950		284,250		597,200	
5	Mental health	72,600		38,200		110,800	
6	Prophylactic, diagnostic and therapeutic substance	65,100		74,100		139,200	
7	Communicable disease prevention and control	1,045,250	3,445,000	1,028,550	3,605,000	2,073,800	7,050,000
8	Non-communicable disease prevention and control	173,100		176,100		349,200	
9	Promotion of environmental health	446,200	292,000	484,200		930,100	292,000
10	Health manpower development	314,100		310,000		624,100	
11	Health information	84,100		94,100		178,500	
12	Amount (Total)	3,654,450	3,737,000	3,498,150	3,605,000	7,152,600	7,342,000

Source: GOI, Annual Reports, Ministry of Health and Family Welfare

TABLE 5.5 WHO COUNTRY BUDGET ASSISTANCE (in USD)

S No.	Programmes	Year	
		1993-94	1995-96
1	IND/PHC/00- organization of health care system based on PHC	3,73,796	3,69,414
2	IND/MCH/003- maternal and child health care	4,02,560	2,1,186
3	IND/MCH/004- promotion of family welfare services and research	6,66,393	5,65,319
4	IND/MCH/005- FW/PHC services in urban areas	7,53,254	11,70,020
5	IND/EPI/001- expanded programme of immunization	4,84,920	4,18,538
6	IND/CDD/001- control of diarrhoeal diseases	1,14,370	42,083
7	IND/ARI/001- acute respiratory infection	1,15,090	1,61,431

8	IND/HEH/002- information, education and communication	1,35,600	6,02,524
9	Undergoing reallocation	192,475	
10	Total	3,238,458	3,540,515

Source: GOI, Annual Reports, Ministry of Health and Family Welfare

TABLE 5.6 WHO COUNTRY BUDGET ASSISTANCE (1996-1997) (in USD)

S No.	Programmes	Amount
1	IND/DHC/001 strengthening of rural health services	2,17,900
2	IND/RPH/001 safe motherhood and new born care	2,03,230
3	IND/RPH/002 family health service	6,23,720
4	IND/WHD/001 women's health service	5,50,000
5	IND/HRP/001 research on new contraceptive technologies	35000
6	IND/INF/001 information, education and communication	2,59,000
7	IND/UIP/011 immunization	2,59,100
8	IND/CDR/001 acute respiratory infection control	87,500
9	IND/CDR/002 diarrhoeal diseases control	50,000
10	Total	2,285,450

Source: GOI, Annual Reports, Ministry of Health and Family Welfare

Tables 5.4, 5.5 and 5.6 show certain contrasts in WHO funding over the years. In early 80s, communicable diseases control, health services development, basic health infrastructure received approximately 90 percent of total budget share. In the 90s, the entire WHO focus shifted to various aspects of family welfare program only. The total share of various parts of family welfare programme in the 90s remained around 70 percent or more. Control of diarrhoeal diseases, ARIs, IEC and improvement of health infrastructure were adjusted in the remaining 30 percent (or less) of the country budget.

Such trends have had lasting impact on Indian planning which shows similar trend in its plan outlays over the years. The result is that even today we are struggling to provide basic civic amenities to over 60 percent of our population. It must be remembered that it was WHO and UNICEF, which in 1978 convened a conference at Alma-Ata, which in its declaration came up with the idea of comprehensive primary health care approach. This approach towards 'HFA by 2000', saw building up of a strong health system (which includes health service system) as the only way to ensure

health of a population. Underdevelopment was seen as the crux of the problem and so it was this area, which needed to be attended to. Health was seen in a holistic manner. But superimposing the details of CPHC approach over the pattern of funding of WHO, hardly any similarity can be seen. WHO has never funded or given policy suggestions towards building any health system in India. It has funded programs of little public health credence for India, has not provided adequate support to problems of actual public health concern, pushed towards making the public health planning more technocentric and thus has contributed towards shifting priorities from issues which required greater attention according to Indian needs, towards issues of dubious global concerns.

The most recent example of this shift is WHO initiative to set up a Macroeconomic Commission on Health. This commission pushes for global investments in health to tackle poverty as poverty is considered as an outcome of ill health. Thus it leaves out all structural issues and in the name of humanism puts its weight on expanding technology market by choosing what kind of global investment ought to be made. The 8 billion US $ global fund is the first step towards this new enterprise (WHO, 2001).

ASSISTANCE FROM UNICEF

The main programmes assisted by UNICEF from 1980-85 were PHC programme, MCH, ANM training, national malaria eradication programme, tuberculosis programme, leprosy control programme, blindness control, rural and urban health services, immunization, control of diarrhoeal diseases, goitre and sexually transmitted diseases. The draft master plan of UNICEF provided a funding worth US $ 28.50million for the years1980-83.

The main areas of funding in 1985-90 were universal immunization programme (UIP), nutrition, food supplement and school health project. The aggregate funding for these programmes in this duration was approximately US $ 50 million, of which UIP alone received US $ 26,91,764.70 mainly in the form of cold chain equipment and transport. These programmes are now the main focus of UNICEF assistance.

UNICEF has been funding the MCH programme, EPI, has provided funds for multi purpose worker (MPW) training and for training of PHC doctors over the years. From 1993 onwards, UNICEF has been funding the Child Survival and Safe Motherhood programme (CSSM), along with the World Bank.

UNICEF funding also shows almost similar trends as that of WHO, in terms of decreasing funding in health and increasing funding in the areas of family welfare. The shift in funding priorities for UNICEF also is towards the end of 80s and early 90s. UNICEF funding has also been mainly in the form of equipment and expertise. Such aid is classified as technical assistance – a kind of assistance where the recipient country can exercise no choice in distribution of procured aid according to its country's needs. This shift in focus can be seen from communicable disease control programme to MCH and more so on UIP. In other words, India could not procure funding for the priorities set by various expert committees over the years, and were also realized by our five-year plans. Instead, the dichotomy between our realization of problems in plans, and the strategies adopted to combat these problems, seems to have a relation with the pattern of international funding. This point becomes even clearer in the later analysis of other funding agencies.

In our health plans, we seem to have set our priorities according to the dictat of the international organizations, as reflected in their funding patterns. The programmes/issues they have concentrated were not the key public health problem for India.

UNICEF'S AID AND CHILD HEALTH: MUCH ADO FOR NOTHING

The main thrust of UNICEF in India has been immunization programme. Therefore, I shall concentrate on this programme here. As shown by data in earlier pages, none of the diseases covered under UIP form the major reasons for child mortality, in India. Yet the diseases viz. diphtheria, pertusis, tetanus, polio, measles and childhood TB (this is now rare) have been labeled as the six killer diseases.

WHO started the Expanded Programme of Immunization (EPI) in 1974, but it started in India in 1978. It was a part of GOBI i.e. growth monitoring, oral rehydration, breast-feeding and immunization. In 1985, it became universal programme of

immunization, which was a time bound, vertical programme. In the seventh five-year plan, 55 percent of investment for communicable diseases was for immunization. Such was the importance given to UIP, which was to finish in 1990. As Banerjee puts it – "even a very broad analysis of the process of policy and programme formulation and implementation of the immunization programme (EPI/UIP) reveals that the apical organizations of international public health have shown scant regard for some of the fundamental principles of public health practice. They have dared to launch a global/universal immunization programme without caring to have a reasonably reliable epidemiological baseline. They have tended to 'homogenize' the situation; even the 100 or so poor countries have widely varying parameters. When there is no epidemiological baseline, how is it possible to assess the epidemiological impact of the programme?...no data have been produced to demonstrate the degree of effectiveness of the vaccines under the ecological/epidemiological conditions prevailing in the different countries. No evidence has been produced to justify why the level of 'herd immunity' has been fixed at 85 percent" (Banerjee, 1999).

In 1990, as the targets had not been achieved, UIP was extended until 2000. If we can state anything on the killing efficiency of these six diseases, it can only be that they can cause mortality only in cases coupled with severe malnutrition. They are not fatal in solitude. Infact, 80-90 percent of deaths under five age group are caused by diarrhoea and pneumonia – causes that our health programmes have yet to properly attend to. Causes peculiar to infancy are another major cause of death.

UIP does not attend to the actual cause of mortality i.e. malnutrition, instead, it defends the technology which is easily available to us. They have vaccines for those six diseases, so we are forced to administer them to our children and earmark 55 percent of our budget (for communicable diseases), for reasons not of immediate public health concern for India. It seems that death was not the reason to initiate UIP, but it was availability of vaccines. If UIP we must implement, I think a better way would be to incorporate it with the general health system (which has yet to be developed and strengthened) rather than making it a vertical programme. It does not deserve so much money in a resource-starved situation of health sector. Infact, if we look at the issue in this way – with the main reason, viz. malnutrition, remaining intact, even if we can guard our children from these six diseases, they either die of the

major killers as diarrhea and malnutrition or grow up with poor health to form a vulnerable workforce. Is this situation any better?

ASSISTANCE FROM DANIDA

Danida has been assisting the national programme for control of blindness (NPCB), in three phases, since 1980. It has also provided assistance in the construction of National Institute of Health and Family Welfare (NIHFW), Central Drug Research Institute (CDRI), for leprosy programme (1984-94) and tuberculosis programme (1992 onwards).

TABLE 5.7 ASSISTANCE FOR HEALTH (Rs. in Crores)

S No.	Year	Programmes funded	Amount	Percent
1	1980-85	• NPCB • Construction of NIHFW • Construction of CDRI	8.50 for NPCB 18. Million DKr for NIHFW.	0.08 98.77
2	1985-94	• NPCB • Leprosy programme	44.81	0.43
3	1994-97	NPCB phase II	Not mentioned	
4	1997-02	• NPCB phase III • RNTCP	42.58 31.95	0.41 0.31
5	Total		10387.84	100

18. Million DKr = Rs. 102.6 million according to 2001-02 exchange rates (1 DKr.=Rs.5.7).
Source: GOI, Annual Reports, Ministry of Health and Family Welfare

TABLE 5.8 ASSISTANCE FOR FAMILY WELFARE (Rs. in crores)

S No.	Year	Programmes funded	Amount	Percent
1	1980-89	Area development project in Madhya Pradesh and Tamil Nadu.	31.70	41.43
2	1989-95	Area development project phase II in Madhya Pradesh and Tamil Nadu.	44.81	58.57
3	Total		76.51	100

Source: GOI, Annual Reports, Ministry of Health and Family Welfare

Tables 5.7 and 5.8 show DANIDA funding for health and family welfare programmes. DANIDA has been fairly consistent with its funding pattern over the years, with blindness control and area development projects being the central focus. The objective of the area development projects was to reduce fertility, maternal mortality rate and child mortality by means of expansion of the health care system. The organization has supported the NPCB mainly by providing drugs and equipment i.e. as technical assistance. An analysis of the type of aid given and areas funded shows that DANIDA funding has also been towards development of a curative service, thus making our public health approach more technocentric.

ASSISTANCE FROM NORAD AND SIDA

NORAD funding has been mainly for family welfare programme, in the post-partum project. Financial details of its funding are not available. Other assistance provided by NORAD is in leprosy eradication programme and cancer research in the form of technical cooperation. The amount of funding has also been too less to make any significant contribution to the budget outlay for these programmes.

SIDA assistance has been mainly for malaria control (NMEP), leprosy control (NLCP), national tuberculosis programme (NTP) and lately the revised national tuberculosis control programme (RNTCP). Besides these it has also supplied vitamin A capsules in initial 80s and supported the MCH programme. The details about the aggregate amount of funding are not available, however certain disjointed data had been given in the annual reports of the MOHFW.

In between 1980-82, Rs.117 lakhs were received for NTP, Rs. 58 lakhs for NLCP, Rs. 39.14 lakhs for vitamin A capsules, and Rs. 16 lakhs for NMEP. From 1984-89, Rs. 125 lakhs for NTP, Multi Drug Therapy (MDT) worth 90 Million Swedish Kroners for NLCP, were received. Data for the following years are not mentioned. SIDA funding has also been mainly as technical assistance, in the form of drugs and equipment, for the above-mentioned programmes. Such a support, as mentioned earlier, only encourages the shift towards making the programmes more technologically oriented. We keep finding solutions to our health problems in the available technology, whereas the real problems remain unattended.

ASSISTANCE FROM ODA (U.K.)

ODA funding has been mainly in the area of women reproductive health research, cancer research, upgradation of health institutes and area development projects. However, there is no specific pattern of funding which emerges, with programme priorities shifting almost each financial year. ODA support has been as technical cooperation, supply of equipment and exchange of experts.

TABLE 5.9 ASSISTANCE FOR HEALTH

S No.	Year	Programmes funded
1	1980-81	Not mentioned.
2	1981-82	Cancer research, Jalma institute, PGIMER, NMEP, FW, coronary heart disease project, sterilization facilities.
3	1982-83	Gujarat cancer research institute, central Jalma institute, NMEP.
4	1983-89	Cancer research, NLCP, NMEP, Kala Azar, Monoclonal Antibodies, Viral Hepatitis, TB research, medical education technology (AIIMS), operational research on management of mosquito vectors, PGIMER, Central Jalma Institute.
5	1989-90	Medical education research, hepatitis, immunology of TB, cancer research.
6	1990-02	Medical education research, human pappilovirus infection and cervical cancer, haemoglobinopathy control, rotavirus infection control, chlamydial laboratory, Andhra Pradesh school research project.

Source: GOI, Annual Reports, Ministry of Health and Family Welfare

ODA funding as seen in table 5.9 in the area of health has been towards assisting big institutions for their technological upgradation and general upkeep. Its funding being more in favour of non-communicable diseases (NCDs) and big institutions, its focus has hardly ever been towards rural health system development or towards the marginalized groups.

TABLE 5.10 ASSISTANCE FOR FAMILY WELFARE (Rs. in Crores)

S No.	Year	Programmes funded	Amount	Percent
1	1980-89	Area development project in orissa	29.54	27.63
2	1989-90	No funding, phase II under preparation.		
3	1992-96	Area development project in orissa, concluded in 1996.	77.37	72.37
4	Total		106.91	100

Source: GOI, Annual Reports, Ministry of Health and Family Welfare

Table 5.10 shows ODA funding in family welfare. It had concentrated mainly on promotion of family welfare through infrastructure development for adequate provision of services in Orissa. ODA has funded important areas, though once again, their importance as public health concern for India can be easily questioned. It has funded cancer research and other research projects related to female reproductive tract infections, all of these have yet to be proved to be public health concerns of such magnitude. Such research can only lead to somehow proving these issues to be worthy of government support/attention, and thus making way for technology to come to rescue. This shall help create a new market for the pharmaceutical companies and other technical products required to overcome these diseases. Such developments are hardly required by a country like India, which still needs to work on its basic health infrastructure to deal with composite health problems which are getting increasingly complicated over the years due to various reasons, one of them being – vectors and pathogens developing resistance to technologies.

ASSISTANCE FROM USAID

Initially, the main thrust of US assistance to India was on projects that were designed to strengthen key institution and transfer of resources for infrastructure programmes in agriculture and social forestry. Since mid 1980, the priority has been diversified to include science and technology dimension focusing specifically on the commercialization of technology. Health and family welfare is also one of the priority areas" (Ministry of Finance and Company Affairs. External assistance 2001-2002, New Delhi.).

USAID is one of the major donors to India. While many institutions have stopped funding in the health sector whereas others have joined off late, USAID funding has continued over a long stretch of time. Earlier food aid used to be major type of

assistance provided by the organization, which has now diversified into many other funding priorities in the area of health and family welfare. Food aid was given under the Public Law 480 (PL 480) and here we give a brief account of its assistance under this law.

PL 480 Title I

Under PL 480 Title I, the US had been providing 'concessional sales' of food commodities to India. The commodities include rice, wheat and edible oil. The total value of such food aid, extended over the years 1956 and 1978 was of the order of $ 4.8 billion. Since 1978 there has been no Title I assistance.

PL 480 Title II

Under Title II, the US has been donating agricultural commodities as outright grant. The commodities are processed food and wheat products. The commodities are used in school's mid-day meals, pre-school child feeding, nutrition programmes, and oil seed grower cooperative development. The supplies are received through voluntary agencies such as CARE (Cooperative for American Relief Everywhere) and CRS (Catholic Relief Services).

Under PL 480 Title II programme commodity assistance of US $ 96.859 million including freight has been disbursed by USAID during US FY 2000 (October 99-September 2000).

PL 480 Title III

Under Title III, the USAID extended a grant of US $ 48 million worth of assistance in the form of edible oil over two years US FY 1992 and 1993. The assistance was entirely in grant form" (External Assistance 2001-2002).

Title I of the Agricultural Trade Development and Assistance Act of 1954, as amended, (Public Law 480, 83rd Congress) provides for U.S. government financing of sales of U.S. agricultural commodities to developing countries and private entities (hereafter called "participants") on concessional credit terms. Sales are made by private business firms on a bid basis in response to Invitations for Bids or IFB's issued in the United States by the participant. Sales are made at 'competitive U.S. market prices'. The agreement's concessionality results from its extended credit periods and low rates of interest charged for the financing. A developing country shall be considered eligible for P.L. 480 Title I financing if it has a shortage of foreign exchange earnings and has difficulty meeting all of its food needs through commercial

channels. In accordance with the cargo preference provisions of the Merchant Marine Act, 1936, as amended, at least 75 percent of the gross tonnage of commodities exported under Title I, P.L. 480, must be shipped on privately owned U.S. flag commercial vessels.

Besides 'benefiting' undernourished people overseas, P.L. 480 programs also support American agriculture. Strengthening the economies and agricultural infrastructures of developing countries also means helping to create potential expanded markets for U.S. agricultural products. Several of the leading importers of U.S. agricultural products, such as Egypt and Thailand, are former recipients of food assistance. Food aid positively affects almost every state in the union, with benefits not only to farmers but also to food processors, packers, transporters, railroads, stevedores, ocean carriers and others. In FY 1999, $957 million was traded in Title II food assistance.

India had become self sufficient in terms of food grain production with the success of the green revolution. Still it has been receiving PL 480 assistance, which is meant to support those countries which are unable to produce enough for self-consumption and incapable to procure food grains at competitive market prices. Since 1978 onwards, after gaining self-sufficiency in food production, India has been receiving food aid as grants under PL 480 title II and III. At the same time, millions of tones of food-grains are rotting in the Indian godowns, creating further problems for the small farmers. This in turn forces the farmers to shift towards cash cropping. These cash crops usually serve as raw materials that are exported to developed countries for further processing into finished goods. These details only go on to endorse the view that food aid is more a tool of exercising control over the recipient country's economy rather than a genuine help to the poor or the undernourished.

Table 5.11 gives an account of the utilization position of US assistance during the last five financial years. It shows that US assistance has been declining over the years. This is because of the political pressure working within the United States to cut the overall share of international aid as a part of US GDP. Such pressure has initiated a move to examine the effectiveness of aid in meeting developmental goals it is supposed to achieve. This in turn has resulted in increased conditionalities on recipient countries. Though India has seen decline in investments by USAID over the

years, but recently the trend has taken a reverse with an increase in overall US assistance in the health sector in the current year.

TABLE 5.11 UTILIZATION POSITION OF US ASSISTANCE DURING THE LAST FIVE FINANCIAL YEARS (in US $ million)

S No.	Year	Grant through budget	Grant as technical assistance	Grant on account as food aid @	Total grant
1	1997-98	14.592	21.214	95.587	131.393
2	1998-99	14.846	13.898	94.870	123.614
3	1999-00	14.390	11.810	90.000	116.200
4	1900-01	16.634	10.320	96.600	125.554
5	1901-02	14.04	14.770	72.000	102.810

@ Food aid is given through US NGOs like CARE and CRS

Source: Ministry of Finance and Company Affairs. External assistance 2001-2002, New Delhi.

The important projects which have been funded by USAID as a direct grant through budget are Innovation in family planning services (IFPS) in UP with a total grant of $ 225 million, AIDS prevention and control (APAC) in Tamil Nadu with a total grant of $ 10 million, and AVERT (relating to HIV/AIDS) in Maharashtra with a total grant of $ 41.5 million. USAID has also provided grant as technical assistance in various projects as Technical assistance and support project (TASP) with a total grant of $ 21 million, Energy management and consultation (EMCAT) with a total grant of $ 27 million,, and Energy conservation and commercialization (ECO) with a total grant of $ 25 million.

ASSISTANCE FOR HEALTH

USAID had funded private voluntary organizations for health (PVOH) in two phases. US $ 120 million supported the first phase of the project. The second phase of PVOH ended in 1997with total investment of US $ 10 million. During this period it also funded family planning and nutrition services, established clinical epidemiological units in two medical colleges in 1986-87 and also provided fellowships. It also supported biological research project to improve rural health care. This project continued until 1992. US $ 13.1 million was given by USAID against an Indian contribution of US $ 7 million. The AIDS prevention project was started in Tamil

Nadu in 1995 with an assistance of US $ 10 million. The duration of the project was 1995-2002.

ASSISTANCE FOR FAMILY WELFARE

USAID supported area development projects in Maharashtra, Gujarat, Punjab, Haryana and Himachal Pradesh. Contraceptive marketing project, UIP and ORT have also been assisted. Initially the funding from USAID was less but from 1990-91 the funding increased manifold, and so increased the coverage of these programmes. It provided US $ 325 million for a period of ten years. Of this US $ 325 million, US $ 225 million was earmarked for state/specific act and the rest US $ 100 million was to be spent on equipment, services and training. Innovation in family planning services in U.P. (IFPS), population simulation project have also received funding. PVOH phase II received another UD $ 10 million in 1994-95, whereas US $ 3.3 million have been received for strengthening the research capacity of population research centres.

US economic assistance to India started in 1951 and till 31 March 2002, the total aid (including health sector aid) has been around US $ 13.4 Billion. The aid mainly comprises development assistance, food and technical assistance. US assistance is mainly administered through USAID.

USAID and family welfare programme: misplaced priorities

One of the major areas of funding of USAID has been family planning. Increasingly large proportions of funds have been allocated to push forward the family welfare (more so family planning) programme. The centrally sponsored and 100 percent centrally funded family welfare programme provides additional infrastructure, manpower and consumables needed for improving health status of women (and children) and to meet all the felt needs for fertility regulation. Reduction in the population growth rate is the priority objective of the family welfare programme. Just to give an idea of the importance attached to the family welfare programme in India, by the international community – of the total external aid received from 1980 to 2000, 69 percent has been only for the family welfare activities and 31 percent for the medical and public health activities.

India has also been responding with equal fervor to such international stimulations. Analyzing the funding for family welfare programme over the years makes the situation very clear.

TABLE 5.12 SHARE OF CDCP AND FAMILY WELFARE IN HEALTH SECTOR BUDGETS (Rs. In Lakhs)

S No.	Year	Communicable diseases	Family welfare
1	1951-56	903 (64.5%)	70 (0.5%)
2	1956-61	1460 (64.9%)	30 (1.3%)
3	1961-66	1500 (60.2%)	270 (10.8%)
4	1966-69	939 (41.6%)	829 (36.7%)
5	1969-74	4335 (37.5%)	3150 (27.3%)
6	1974-79	7962 (34.1%)	5160 (22.1%)
7	1980-85	18211 (27.0%)	10100 (15.0%)
8	1985-90	33988 (25.8%)	32562 (24.7%)
9	1992-97	75759 (30.5%)	65000 (26.0%)

% = Percentage of total expenditure on health sector.
CDCP = communicable diseases control programme.
Source: GOI, Annual Reports, Ministry of Health and Family Welfare

Table 5.13 Estimates for the ninth five-year plan

	1997-98		1998-99		1999-2000		2000-01	
	BE	RE	BE	RE	BE	RE	BE	RE
Health (including ISM&H)	955	918	1195	981	1195	1062	1378	
Family welfare	1829	1829	2489	2253	2920	3120	3520	

BE = budget estimates, RE = revised estimates.

Table 5.12 clearly shows that there is a perpetual decline in investment in the most crucial public health concern i.e. control of communicable diseases, and rise in that of family welfare programme. It also shows that we were giving "equal priority" to "one programme" on one side and "all other programmes" on the other. Table 5.13, breaks down the data for each year in the ninth five-year plan. This table also shows that not

only was health plan revised negatively unlike the family welfare budget, but it was also decreased to half and then one third of the family welfare outlay over the years.
A close look at the financial assistance given in this chapter reveals that most of the funding for family welfare has come either for post-partum programme (NORAD), as contraceptives and technical assistance to develop the contraceptives indigenously, as training and sensitization of manpower for proper utilization of these contraceptives, towards contraceptive research or towards building infrastructure for family welfare programme (ADPs).

Referring to the argument put forward by S.K. Rao - "...it is not so much socio-cultural factors like caste, religion, literacy, urbanization etc. but objective socio-economic circumstances like the chances of child survival, the nature of the source of livelihood etc, which are factors determining fertility. Therefore, expenditure on family planning, which tries to work purely through the former set of variables, cannot be expected to influence fertility behavior significantly. All that it can hope for, at best, is to help people who are already motivated to limit family size to switch over from conventional and cumbersome method of contraception to the modern methods" (Rao, 1976). And this is exactly what seems to be happening in Indian context. How far such adherence to international financial dictums is going to take India is not hard to imagine!

ASSISTANCE FROM WORLD BANK

As mentioned earlier, health became an area of investment for World Bank only in the 80s. To begin with its investments were largely in developmental projects.

Assistance for health

Table 5.14 shows World Bank funding in the health sector. World Bank funding increased in the 80s and more dramatically in the 90s when India adopted the new economic policy embracing SAP, as directed by World Bank and IMF economists. World Bank funding from the very beginning was for India population projects (covered as area development projects) and also for water supply and sanitation facilities in various states. It's funding for disease control programmes came only in 90s with main emphasis being on AIDS and malaria control.

Table 5.14 Assistance for health (Rs. in Crores)

S No.	Year	Programmes funded	Amount	Percent
1	1994-95	NACP NLEP NPCB	250 302 554 For seven years.	2.17 2.62 4.81
2	1995-96	NACP, NLEP, NPCB, Andhra Pradesh health system development project West Bengal health system development project Karnataka health system development project Punjab health system development project	 608 698 546 425	 5.27 6.06 4.74 3.69
3	1996-97	In addition to earlier projects, NTP Malaria control	$ 142 million 891.04	48.68 7.73
4	1997-98	Same projects continue in this year.		
5	1998-99	Orissa added with a funding of	415.58	3.60
6	1999-00	Maharashtra added	727.00	6.31
7	2000-01	U.P. added	495	4.30
8	2001-02	Earlier projects continue + foreign travel by senior officers which cost	60 lakh	0.005
9	Total		11521.22	100

US $ 1=Rs. 39.5 according to 1996-97 exchange rates.
Source: GOI, Annual Reports, Ministry of Health and Family Welfare

Table 5.15 Details of World Bank assistance as against total external assistance received by disease control programmes for 1999-2002. (Rs. in crore)

S No.	Programme	1999-2000	2000-2001	2001-2002
1	National anti-malaria programme	120	100	100
2	National leprosy eradication programme (includes DANIDA funding also)	49.05	38	52.00
3	RNTCP	67 (89.24%)	94 (91.22%)	119 (86.86%)
4	NPCB	60 (92.31%)	65 (86.67%)	96.01 (90.5%)
5	NACP	135.50	120.50 (88.28%)	166.50(83.88%)

% = percent share of World Bank in total assistance received for the programme

Table 5.15 shows that presently World Bank commands the international funding scene for major communicable disease programmes in India. And it must not be

forgotten that none of World Bank funding comes as a grant, unlike all other funding bodies, they are loans with differing rates of interest.

World bank and Area development programmes

India receives maximum funding for this programme from the World Bank in the name of area development projects. The area development project scheme was initiated in 1973 to overcome the constraints faced by the family welfare programme such as

- Weak infrastructure
- Poor skills of health functionaries and
- Inadequate and poor quality of services mainly in low income and backward states due to resource constraints.

The ultimate objective of these projects was to bring down the birth rates through creation of facilities for integrated delivery of health, nutrition and maternal and child health and family planning services as near to homes as possible, specially in the rural areas. Demand for family planning services was sought to be created through expansion of information, education and communication activities. India Population Projects (IPP) are one of the largest schemes for research in family planning.

Table 5.16 Assistance for family welfare (Rs. in Crore)

S No.	Year	Programmes funded	Amount	Percent
1	1980-88	ADP in UP and Andhra Pradesh IPP I-IV	64.20 61.98 (approx.)	3.14 3.03
2	1988-92	IPP V in Bombay Madras	For 7 years 42.40 66.11 *	 2.07 3.23
3	1992-93	Earlier projects continue	Funding increased sharply, exact amount not specified.	
4	1993-94	Social safety net	40	1.95
5	1994-02	IPP in 12 states, CSSM, Social safety net.	1,215 557.70	59.34 27.24
6	Total		2047.39	100

*** 60 % of project cost was borne by World Bank, remaining was Indian contribution.**
ADP = Area Development Project.
Source: GOI, Annual Reports, Ministry of Health and Family Welfare

ADP was started in selected districts of Karnataka and six districts of Uttar Pradesh with financial assistance from the World Bank and Swedish International Development Agency with the ultimate objective of reducing maternal and child mortality, morbidity and birth rates. Construction of institutional buildings for service delivery and training and also of staff quarters, in addition to positioning of trained staff in the service centres received focused attention under these projects. Over the 5th to 8th plan period, this scheme was extended to cover even more districts and states, the details of which can be seen in annexure II.

Funding pattern for ADPs

"The total cost of the project is shared between the government of India and the state governments in the ratio of 90:10. The funds are provided to the state governments as grant-in-aid under the centrally sponsored family welfare programme. Reimbursement is claimed from the external donor agencies on the basis of expenditure reported by the state governments. The assistance in the case of UNFPA, DANIDA and ODA is in the form of grant amounting to 100 percent, 85 percent and 75 percent respectively of the total project cost, while the assistance in respect of World Bank projects is in the form of loan" (Ministry of Health and Family Welfare, 1996-97, pp 64).

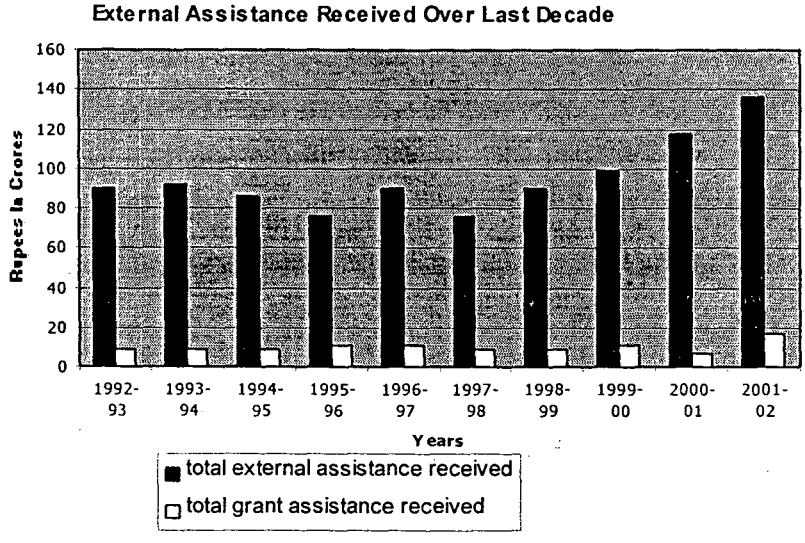
ADPs as a catalyst in increasing debt burden

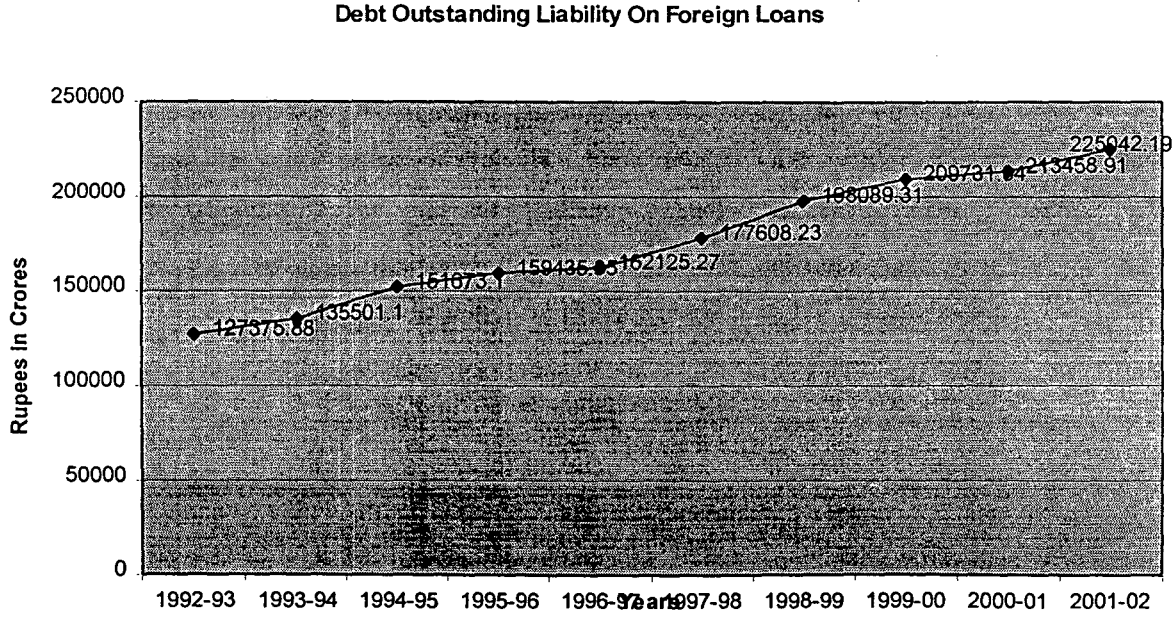
TABLE 5.17 PERCENT SHARE OF VARIOUS DONOR AGENCIES IN ASSISTANCE FOR ADPs.

S No.	Donor agency	Percent	Assistance category
Completed projects – Phase I			
1	World Bank	71.21	Loan
2	USAID	13.28	Loan + Grant
3	ODA (UK)	6.70	Loan + Grant
4	DANIDA	9.47	Loan + Grant
5	UNFPA	6.03	Grant
Completed projects – Phase II			
1	DANIDA	3.09	Loan + Grant
2	ODA	5.13	Loan + Grant
On-going Project – Phase III			
1	World Bank	81.39	Loan
2	UNFPA	7.2	Grant
3	Germany	3.15	Loan + Grant

Source: GOI, 1996-97. Annual report, MOHFW.

An analysis of table 5.17 shows that out of the total funding of Rs.502.35 Crore in phase I, only 6.03 percent (UNFPA) was a grant. 71.21 percent (World Bank funding) was totally a loan, whereas funding from other sources had varying degrees of loan and grant element. In phase II, of the total funding of Rs. 1504 Crores, only Rs. 108.5 Crores i.e. 7.2 percent (UNFPA) was as grant, eighty one percent i.e. World Bank contribution was a loan and the other funds again had varying degrees of loan element. This loan we (India) has to pay back to the donor agency with certain rate of interest charged over the principal amount. This data becomes important when seen in conjugation with India's family welfare programme approach (discussed earlier with USAID funding)





The family welfare approach adopted by India had a demographic approach to a complex problem rooted in the cause of underdevelopment. It did not address the problem of underdevelopment and unhealthy environmental and living conditions, which lead to morbidity and mortality. For such a family welfare programme, which is bound to register failures, which our planners and health committees have known, India has succumbed to such huge amounts of loans in the name of international aid. The adjoining graphs show the steep rise in the debt outstanding liability of India over the past decade, the total amount of external assistance received by India in the same period and the share of grant element within that aid received, for the same time period. The simple question which arises on the analysis of these data is - 'is international aid, in anyway, helping India overcome its health problems, or is it only contributing to aggravate its debt liabilities, pushing it closer to the debt trap.

World bank funding for AIDS control

Another major area of funding of World Bank is HIV/AIDS. Table 16 shows that World Bank is the single largest funder for AIDS programme in India. The first indigenously transmitted HIV infection was detected in India in 1986. In 1987, the department of health launched the National AIDS Control Programme (NACP). During 1987-92 phase, the NACP was operative with technical support from the DGHS and funding by the Indian government.

Opinions about AIDS as a public health concern

In 1992, the programme took a big leap, when it received huge amount of loan from the World Bank and bilateral international institutions. The institutional structure of NACP was separated from other departments of health and a separate National AIDS Control Organisation (NACO) was created. As argued in a paper by Ritupriya - "the first phase of the World Bank AIDS control project for India lasted from 1992-97. The funds were poorly utilised, largely because the state governments did not spend them. The reasons were cited to be bureaucratic hurdles causing delays in money transfers, but it is clear that many states did not see it as a priority area and others did not know how to approach the problem of HIV/AIDS. A common perception among the administrative and public health professionals was that there is too much hype about AIDS. Many also did not agree with what appeared to them to be the main

activity for AIDS control - awareness about 'safe sex'... the second phase of the World Bank project was started in 1999, after 2 years of evaluation and completion of phase I. In the phase II (1999-2004) added emphasis was given to 'management strengthening', and developing care and support for people with HIV/AIDS. The former includes 'an experiment' of the World Bank, the loan administration control initiatives, where application of a management system under diverse administrative and political conditions (as prevail in the diverse Indian states) is being tried for a large-scale programme in the social welfare sector.

The overall thrust and perspective continues to come from the international experts through the UNAIDS, an agency coordinating the AIDS related tasks of 8 international agencies (WHO, UNICEF, UNDP, UNFPA, UNIFEM, UNESCO and World Bank, with ILO recently being added on).
The public health expert opinion within the country has been diverse. In the early period of the epidemic in India, i.e. the late 1980s and early 1990s, one opinion was that this will be a devastating disease in the Indian context and so strong steps are necessary to prevent its entry and spread...the other was denial of the threat of AIDS to Indians because of cultural safeguards. A third perspective accepted HIV/AIDS as an important public health problem but one to be viewed within the overall epidemiological situation, wherein the first view could be termed as 'exaggeration'. It also said that the panic generated by this would be counterproductive and that far not be used as a tool...

The first view was closest to the dominant international perspective and was adopted as the dominant...the second was rejected outright, and the third was ignored by clubbing it together with the second as 'denial' and ridiculed as middle class hypocrisy or parochial chauvinism.

There is a fourth stream that draws from international scientific debates of thought on AIDS...and views HIV as only a figment of the scientific imagination and the whole hype and programme only a tool of the medical equipment and pharmaceutical industry to make profits as well as a mechanism of the international and national elite to ignore the existing problem of malnutrition, and infectious diseases in the developing world and addictions and other lifestyle issues in the developed world.

This view, though refutable epidemiologically, has been an important focus globally for articulation of dissent against the apparently monolithic dominant official international perspective. Unfortunately its extreme position has not allowed it credibility in public health. Its discrediting has, on the rebound, given added strength to the biomedical view and the pharmaceutical industry has won by the issue to anti-retroviral drugs taking center-stage" (Ritupriya, 2002).

As regards the status of AIDS being a public health concern for India, Dr. Banerjee argues - "introduction of AIDS as a public health problem in the country has exposed the pathetic state of public health analysis, practice and research there. It ought to have brought out new ideas, not only to more effectively cope with the problem than had been done by the other countries of the world. Instead, the authorities concerned; failed to follow even the well-established procedures for responding to such crises...the two phases of the World Bank/WHO/UNAIDS driven programme brought in a great deal of money but little new thinking. The epidemiological and management information system has been exceedingly poor; there have been active moves to doctor information by liberal sprinkling of misinformation and disinformation. Despite all the efforts, they failed conspicuously in their contention that the disease will spread rapidly and India will become the 'AIDS capital of the world'.

At the beginning, there was a case for exercising caution and for error, as the disease behavior in the country was not confidently predictable. With retrospect of even the fragments of data on the size, speed and extent of its spread, it is time to proceed with less frightening perspective of the disease and work towards alternative hypothesis for coping with it by initiating public health research. Even 14 years after the first case was discovered there are a mere 11,000 AIDS among the 10,000,000 deaths that took place in 1999. This certainly does not justify the alarmist or panic reaction against the disease that has been the hallmark of the programme all these days" (Banerjee, 2000).

World Bank - India's new guiding star

In 1987, a World Bank policy study - Financing Health Services in Developing Countries, An Agenda for Reform, identified three main problems of health sector for

most developing countries. It argued that each of these problems was due in part to the efforts of government to cover the full costs of health care for everyone from general public revenues. The three problems were -

- Allocation: Insufficient spending on cost-effective health activities. World Bank classifies the services provided by the health (care) system into two - truly "public" health programmes including mainly the preventive and promotive aspects of health care, and curative and referral services. And according to the bank, government spending even if better allocated, would not be sufficient to fully finance for everyone a minimum package of cost-effective health activities.
- Internal inefficiency of public programmes.

  According to the report - "Non-salary recurrent expenditures for drugs, fuel, and maintenance are chronically under funded, a situation that often reduces dramatically the effectiveness of health staff...the quality of government health services is often poor; clients face unconcerned or harried personnel, shortages of drugs, and deteriorating buildings and equipments."
- Inequality in the distribution of benefits from health services. This inequity is borne out of differentials in access to both government and non-government services due to rural-urban divide in distribution of health infrastructure and poor purchasing power (in case of access to private health care system).

The four policy reforms suggested by the bank to counter the above-mentioned problems were -

a. Charge users of government health facilities. This would increase the resources available to the government health sector and allow more spending on under funded programmes.
b. Provide private insurance and other risk coverage. This would relieve the government of the high cost of curative care, while simultaneously protect the households from large financial losses.
c. Use non-government resources effectively.
d. Decentralize government health services.

In 1992, World Bank conducted a study on health sector financing in India. Another study in 1995, suggested policy and finance strategies for strengthening primary

health care services. The 1997 report was on new directions in health sector development at the state level: an operational perspective. Another World Bank document, which gives us an insight into the policy directions, is the 1993 World Development Report.

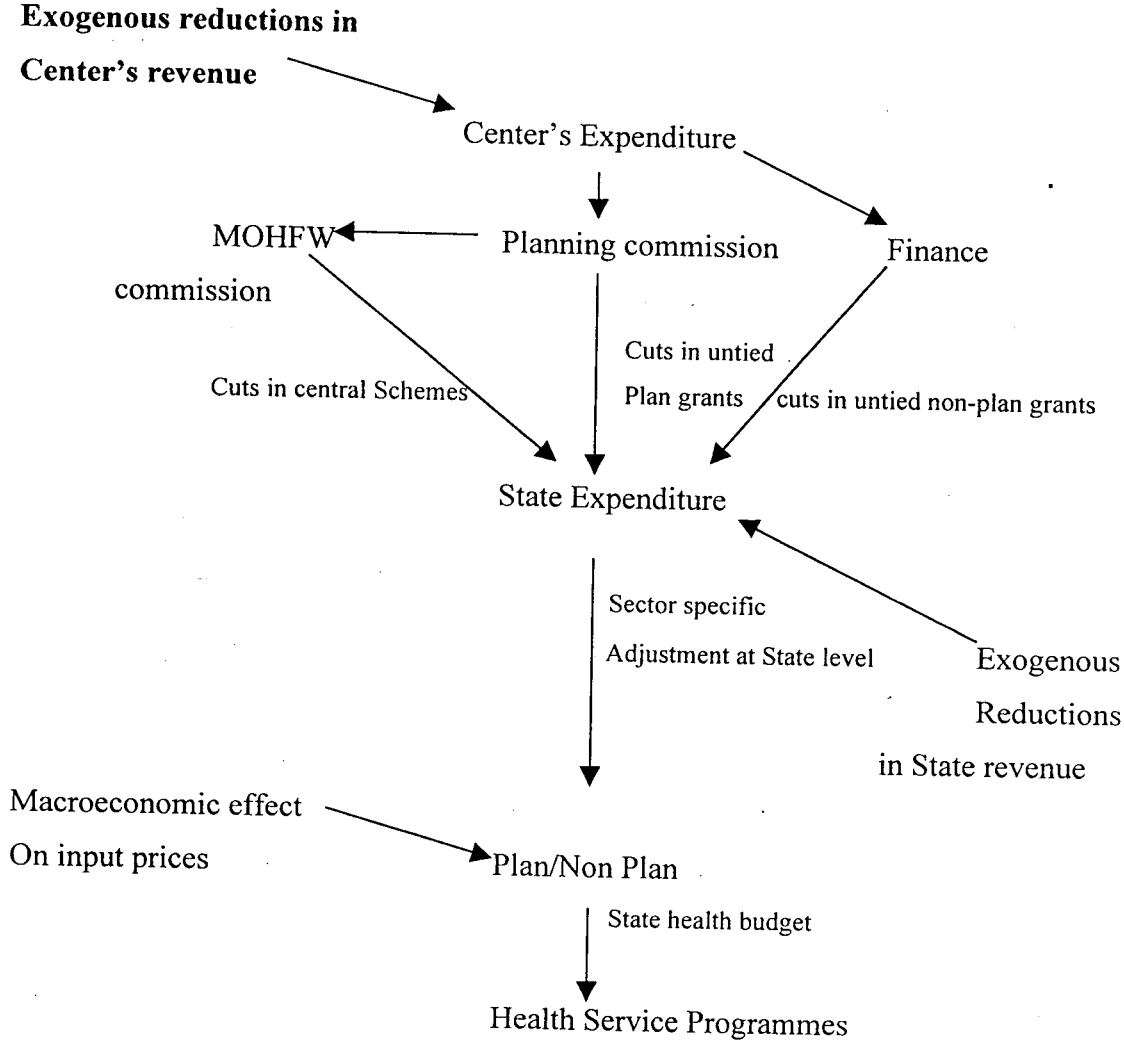
The main issues addressed by the World Bank in these reports are -

- Relationship between center and state spending, and on the ways in which central level policies can affect the sectors.
- How health financing is related to efficient and equitable provision of health services. They review patterns and trends of resource allocation and find that the present pattern of resource allocation impedes the government as it seeks to provide the greatest level of benefit for the broadest community.
- They suggest determined change in policies, especially in context of adjustment, in order to avert the low-return public expenditures from being reinforced.
- According to the World Bank, the major concern under adjustment must be reallocation of health sector expenditures to achieve greater effectiveness in solving national health problems, especially for the poor, who suffer disproportionately from poor health and high mortality. The means available to achieve this goal, according to the bank are:
    a) "Targeting communicable diseases with public spending
    b) Reinvigorating other primary health care activities that produce greatest benefits to the community and to lower income groups in order to make them more efficient; and
    c) Encouraging effective private sector health service delivery. These themes run throughout the analysis and recommendations" (World Bank, 1992. pp vii).

Contradictory perspective

An analysis of the issues addressed and recommendations suggested in Bank reports, reveals that major conceptual and administrative contradictions about India's public health concerns exists in the understanding of the World Bank. While making policy

recommendations for the welfare (health) sector, the bank seems more concerned about their feasibility in economic terms rather than larger social returns. Such policy directions go on to decide the bank's priorities while lending to India. Indian government, in turn, maintains this flow of policy directives, by making changes in its plans, in order to prevent the much-needed foreign exchange flows from drying up. The flow chart shows the route of funding for national health programmes:



Source: "India: Policy and Finance Strategies for Strengthening Primary Health Care Services." World Bank Report No.13042-IN. May 1995.

The channels through which structural adjustment affects health spending is shown in the flow chart. The exogenous reduction in the center and state's revenue is the whip used by the bilateral and multilateral donors to introduce changes in Indian health sector.

DALYs - a tool for shifting priorities

World Bank in its study reports puts forward a strong case in favor of non-communicable diseases and injury, and DALY's has been used as a tool to support such recommendations. As stated in 1997 report - "The comparison of the demographic features in the four states and their evolving burden of disease highlights the continuing need to address those diseases which contribute the most to the BOD (burden of disease), in a cost effective manner... the emphasis on addressing communicable disease should not overlook the marked difference in demographic indicators and disease burden at the regional level, state, district and block levels... the data indicate that in the case of urban areas, the emphasis should be in moving towards improving lifestyle and behavior patterns... prevention of NCDs and injury are quite cheap and should be promoted. Some curative services for NCD and injury, especially at the secondary level, are cost-effective and may be provided by the stat governments. Cost sharing should be considered for other services which are less cost effective, with exemptions for the poor" (World Bank, 1997.).

In the previous chapter the dichotomy between the annual public health needs over the years as identified by the plans, and the issues which have received attention over the years, had been presented. It revealed that we have designed our programmes more based on international funding priorities rather than our own domestic needs. How the international priorities are framed is shown here. It is policy directions framed on the basis of simplistic, misguided, technical indicators such as DALYs that decide the future of our public health priorities. DALYs as a method has been severely criticized.

"DALY is a step forward in terms of incorporation of all levels of suffering from ill health. But it as resulted in the narrowing of the definition of health and health care. It moves back from 'well being as health' to a greater disease orientation. It also takes a step back to 'experts' making social choices related to health care, and consciously attempts to pre-empt social and political processes. It gives a decontextualised, universalistic meaning to health problems, and creates a hegemony of the international technocrat. It shifts the focus from diseases that continue to be the major problems among the deprived majorities of the third world, to the problems, which are the priorities of the industrialized north and the elite sections of the third world. Its se,

so far, has been to rationalize further the selective primary health care package of medical technologies as against the primary health care approach, that had a far-sighted vision, respect for social and political process and local context, and involved intersectoral coordination... there is a danger of such tools being given greater value than they deserve, as they create illusions of an 'objective description of disease and suffering'. Such a depiction will further stall deeper analysis and understanding of the gap between health policy and people's needs and perceptions" (Ritupriya, 2001).

It is essential to mention that all these policy directives given by the World Bank have been imbibed by our National health and population policy documents, even though their suitability to Indian conditions can be questioned. While 1983 NHP held close resemblance with the Alma-Ata declaration by putting development in the centerstage, the draft NHP 2001 holds similar resemblance with the dictates of the World Bank. It fosters a very vertical, technocentric approach to health care, and holds no links that mark its continuation and further progression with the NHP 1983. This is despite the fact that NHP 2001 acknowledges that many goals set by NHP 1983 remain yet to be fulfilled. While first NHP, emphasizing development as basic to health, envisaged proper health system, the 2001 policy completely fails to recognize any such relations - as done by the World Bank also. This is where the root of the problem lies. This policy also puts financial costs in the forefront and all priorities have been decided keeping financial considerations. Excessive dependence on private sector is evident, although the policy envisages a regulation of this sector. How it plans to do so, and to what extent it shall be successful is a point to be noticed.

The analysis on Indian planning in the previous chapters brings out the fact that our understanding has also been fine tuned to match with that of the World Bank. With growth as the primary goal, it is natural that changes in the patterns of investing in health will have to be made in order to ensure maximum benefits. Wasteful expenditures (earlier known as non-productive investments) need to be identified and done away with in order to pave way for smooth economic escalations. It is for this very purpose that the bank financed the three studies in India, and put forward the health sector reform package.

ASSISTANCE FROM UNFPA

UNFPA has funded projects in Rajasthan and Bihar, with UNFPA meeting about 80 percent of the total project cost in the states.

Table 5.18 Assistance for family welfare (in USD)

S No.	Year	Programmes funded	Amount	Percent
1	1980-85	ADP in Bihar and Rajasthan National level scheme for sterilization, population education & MPW training	60 million @	28.04
2	1986-90	Phase III assistance for ADP, contraceptive production, population education, organized sector project	64 million	29.91
3	1991-	Phase IV assistance for various programmes	90 million	42.06
4	Total		214 million	100

@ UNFPA gave $ 1 for every $ 24 spent by India. From 1979 till 1981 UNFPA gave $ 23.5 million against an Indian contribution of 556.3 million.
Source: GOI, Annual Reports, Ministry of Health and Family Welfare

UNFPA funding has been mainly for family welfare as area development projects. It has played an important role in shifting Indian focus towards family planning programme. Even though its contribution has been far less than the World Bank, it is important as UNFPA is the only organization whose aid comes as 100 percent grant. UNFPA support has been mainly as supply of equipments (mainly contraceptives), training in medical technology of sterilization and education. Its focus has thus been towards technological interventions for securing family welfare, which ultimately is India's focus too, fully realizing that such approach shall not make any long-term effect. The family welfare programmes viz. ADP and population control have already been discussed in previous pages.

ASSISTANCE FROM OTHERS

SAARC

Details of SAARC assistance appears to be very fractured and short lived, as could be inferred from the data provided in the annual reports of MOHFW. It was mainly as

workshop and seminars on changing and varying priorities as tuberculosis, chest diseases and leprosy in 1985-86, health and population from 1986-90.

GERMANY

Funding from Germany first appears in the eighth plan period (1992-97) i.e. post-liberalization. It has been as soft loans for pulse polio immunization programme, rural and district health systems for various states and Rajeev Gandhi Cancer institute.

JAPAN

Japanese funding started in 1982 when it funded the central research institute for production of encephalitis vaccine. Later it has provided funds for construction and/or upgradation of SGPGI (Lucknow) and other hospitals and also for polio eradication.

DFID

DFID has funded tuberculosis, malaria and now AIDS programme in India starting from 90s.the amount of DFID funding has been very small as compared to other bilateral and multilateral aid, even though it plays an important role in influencing national prioritization of public health issues.

The decade of 90s and after witnessed many new players in international aid taking interest in India's health like France, Netherlands (ORET), Russia (with rather sporadic funding) and greater consolidation of stronghold by the veterans. Overall, today India is receiving huge amounts of international aid, but how far this international assistance is actually aiding India in building a strong, effective, accessible and affordable public health system, is a point to be given serious considerations.

Our review bring forth the dichotomy which exists between India's public health needs as realized over the years by its five year plans, but ignored while devising strategies to address those needs in favor of simpler, populist measures. It also points out the links between the issues chosen to be attended to, measures adopted, and the pattern of international funding priorities over the years.

We find that strong links exist between the nature of international funding and selection of our national priorities such as family planning and MCH, tuberculosis, malaria and AIDS, even though they did not deserve to receive that magnitude of

attention and finance they have been receiving over the years. Such measures have come at a cost. The planners have constantly been neglecting to acknowledge that fact that even in the 21st century, the analysis of Bhore committee about causes of India's poor public health, hold strong. Secondly, international funding on programme basis has tended to push verticalisation. The notion of 'efficiency' and need to save probable resources has rendered primary health care to primary level care.

Our analysis throws up another issue as well. National priorities are influenced not only by international funding, but also by prevailing international development paradigms. And since World Bank, today stands tall in the international aid scene; its opinion enjoys the strongest whip in altering the world perception of any issue, with most of the remaining funding agencies to follow. With World Bank providing the maximum amount of aid to Indian health sector (table 5.15), there is a major shift in the quality of international aid to the Indian health sector. World Bank aid is in the form of loans, soft loans for the health sector. Initially social sectors (including the health sector) received aid mainly in the form of grants. Now it has transformed to loans, which have to be repaid within a specified period, with interest. This is another reason forcing towards privatization of the health sector, as repayment of these loans requires the health sector to become a profitable business. Health sector started opening up right from the sixth plan, and by the eighth plan, which coincides with India adopting the new economic policy; health had already become a lucrative sector. This is the time when we note a sudden increase in the number of bilateral donors, increase in the amount of funding by the existing donors, World Bank pushing inexorable suggestions for restructuring and financing the Indian health sector. This also resulted in national plans accepting the technocentric thrust where technology exchange and purchase becomes central to health planning.

India has also readily adopted these policy prescriptions and the tenth plan is ironically a sad replica of the World Bank policy prescriptions, which to me seem highly unsuitable for Indian conditions.

Chapter-V

THE INDIAN EXPERIENCE OF INTERNATIONAL AID- A DISCUSSION

International development aid appeared on the global scene to aid the reconstruction of devastated Europe after the Second World War. Since then international aid has undergone tremendous change. It was forced to shift its focus from developed European nations, which no longer needed such capital (which came with strings attached), as their economies became strong enough to raise money from the international financial markets to the underdeveloped third world. This transition was not borne out of any altruistic motives of financial organisations, but was an effort to strengthen their own position in the international financial scene. Today it has become a very powerful tool of influencing planning priorities of developing nations.

We have studied international aid at two levels. Firstly, the evolution of aid, its definition, history, political economy at the global level. And secondly, it examines operational details and discourses on international aid to India's health sector and its dynamics. For the latter part, India's five-year plans are studied in relation to the health sector. The attempt is to find the shifts in the perspective over the years, and the effect it had thereof, on the planning priorities.

India has been receiving international aid since the first five-year plan. Ironically, when Indian economy was fragile and in greater need of international aid, it hardly received any, nor did it intend to rely on external assistance for its development. But gradually with each succesive plan the need for aid grew and so did the support from international financial agencies.

SHIFTING PATTERN OF AID

There have been two visible shifts involving the form and the type of aid that has come to India.

A) SHIFT IN NATURE OF AID – FROM GRANT TO LOANS

India has experienced this shift in nature of aid i.e. from grant to loans. Initially aid came more freely (though never as an absolute grant-in-aid, it always had some share of loans), although in meagre amounts as compared to what India receives today. Such aid matches with the general understanding that aid is free, untied and a generous help. Until the end of ninth five-year plan, the percentage of total grant element in the total external assistance received is only 9.04 percent (annexure I). The

The rest comprises of goverment and non-goverment loans which have to be repaid within a specified time period with certain rate of interest.

Annexure II shows aid receipts have been growing gradually till the sixth five-year plan and drastically thereafter. Today India has a huge debt to repay, so much so that most external assistance it receives goes for debt servicing rather than for actual development programmes.

B) SHIFT IN THE AREA OF FUNDING

If we look at international assistance since the 50s, among the government loans and grants, during the initial years of industrialization and green revolution, major portion has gone to the government thrust areas like agriculture, fertilizer and irrigation. Later, since the 70s, infrastructure, and now power sector became the focus. Today India receives huge amount of loans under Structural Adjustment Programmes. This is given with the idea to offset the negative implications of structural adjustments. SAP, as has already been discussed in chapter I, is more to save the international banking system from its crisis, than to bail out the developing countries of their balance of payment problems.

External assistance for health sector was very little in the initial planning years. Funding in the health sector during the first three plans concentrated in the area of communicable diseases like malaria, leprosy, tuberculosis, small pox etc. India also received large amounts of food aid under PL 480. In addition to thesis, funding was also received for family planning programme. However, the balance between the outlays of CDDs and FPP was maintained till mid 60s.

In order to get the much needed foreign exchange, a country accepts the terms and conditions of the donor agencies. Once it invests certain amount in a programme the entire focus shifts towards running that programme successfully so that the source of further assistance does not dry up. Most of the times such programmes are in accordance with the international priorities set by the developed world. This trend is visible across projects and sectors. We have focussed our analysis on the health sector to understand what were the implications of aid in India's failure to protect its public health interests.

The third plan was the first to witness a slight cut in outlay for CDs and sudden increase in FP investments. Since then with an exception of fifth and sixth plans, FP has been

allocated increasing amounts of funds. We have argued in chapter III that despite the awareness of a suitable strategy for fertility control, India shifter its approach to first an aggressive and coercive strategy and later to a purely technology oriented reproductive health approach. This shift clearly due to the heavy influence of international funding agencies and their priorities. The share of CDs in total health outlay has been on a decline. Among CDs malaria, tuberculosis and HIV have become the thrust areas in national programmes. These are also the programmes that now are the prime focus of international funding priorities. The entire global fund proposed by the macroeconomic commission has been built to focus on these problems.

IMPLICATIONS OF INTERNATIONAL AID FOR HEALTH SECTOR PLANNING

There exists a strong relationship between international funding priorities and national programme planning. The programmes receiving international aid ultimately gain precedence over the rest of the programmes. The public health needs of our country, as identified by the first five year plan, in terms of mitigating the impact of poverty on the living conditions of people by adopting a development approach for building a socialist society where public good is rated above personal gains, still remain even in the 21st century. Still more than 60 percent of our population is waiting for safe drinking water supply and sanitation coverage, same proportion of population remains malnourished (undernourished to be precise), housing and unemployment conditions remain grave and aggravating with each passing day. Social security measures that were accepted as essential for the welfare state infact serve the interests of international capital.

Some international agencies have aided India in achieving its health objectives whereas many have twisted its policies towards issues of more global rather than national concern. Organizations like DFID, Netherlands (ORET), DANIDA, SIDA, WHO, UNICEF have provided necessary support and guidance for careful programme implementation. Whereas others like UNFPA, ODA (UK), USAID and World Bank who have provided huge sums of finance only to serve the interests of developed capitalist economies in the name of helping the poor. Family welfare or the family planning programme has always

gained precedence over health in Indian planning. Thanks to these international donor interventions, today India has yet to conquer malnutrition and control communicable diseases. WHO, which was once behind the Alma-Ata declaration also could not resist the pressure of these giant international funding agencies. Over the years its assistance has also shifted more towards family welfare programme whose approach is highly questionable.

The manner in which these donor agencies operate in the country also gives a very confusing picture. There does not appear a planned operational strategy for interventions. Instead, the country has been divided into pieces with each organization adopting a small piece of area for intervention. The programmes for which assistance is provided is also divided into various components. Different donors take up different components of the same programme. With varying approaches and amount of funding for each component of one programme the final success of the programme becomes questionable. This also focuses on the arbitrary nature of interventions. Presence of careful planning of interventions cannot be seen. In such a scenario the agency, which provides maximum assistance, gains precedence over the others in terms of choice of programme components and areas of interventions. The very fact that they assist with large amounts of foreign exchange works as a whip to turn the policy directions in favour of their interests. World Bank is one such classic example. The bank, which till mid 80s did not believe in health sector investments, later started investing heavily in this sector. So much so that today it is the largest donor agency to India. Its interventions have helped drastically in reforming India's health sector. Not that only the World Bank is responsible for these changes, others also have contributed there share, but it is the Bank's interventions which gave thrust to the entire process. These changes are discussed in greater detain in this chapter.

A) HEALTH SERVICE SYSTEMS EPITOMISING HEALTH SYSTEMS

Since mid 80s instead of working towards building a health system covering the population, we have only focused on the health service delivery system, giving priority to preventive and promotive care on paper and curative care in reality. The initial plans at least remained aware of this dichotomy between words and deeds, the later ones, more so the eighth and ninth plan made it the order of the day. They have adopted the world bank dictum of divorcing the preventive and promotive care from

the curative component of public health, making the former the 'liability' of the public sector, while the latter is being awarded to the private sector for its 'perceived efficiency' in serving the 'clients'. This step has been taken sidelining the fact that preventive, promotive and curative aspects form the integral core of public health services and none of the components can be separated without altering the nature of health services for the population concerned. Curative care proves to be ineffective as a control mechanism in absence of effective preventive and promotive programmes, as can be empirically seen in India where communicable diseases still continue to be the major killers.

B) CHANGE IN PLANNING PERSPECTIVE

Perspective on health today has undergone a sea change from the time India started to plan for the nation. Health was a right of every citizen and a responsibility of the state. The understanding managed to survive until the sixth five-year plan. The first national health policy (1983) was designed immediately after alma-ata, which reinforced such a view. Yet these two important milestones were the first to introduce the notion of shifting responsibility from the state to the NGOs and the private sector.

Seventh plan saw a change in the perspective of health when health was seen as an investment. The idea was to invest for a healthy 'human resource' which would result in more production. This seems more to promote the idea that health is an important factor in increasing production, and that investments in health itself can improve the quality of human resource, even if the sructure of economy remains unchanged. It overlooks the fact that improvements in health are dependent on the strutural changes in the economy i.e. one which improves employment opportunities, increases purchasing power, increases accessibility to basic services etc, and inputs in health alone without structural changes will have limited impact.

This shift over the eighth and ninth plan made health as a commodity, an item of consumption. It has ceased to be a right, now individuals are most important and they are to decide the standards of health they can 'afford' to achieve. Health has moved from demand driven facility to a supply determined commodity – fiercely marketed and inflated – making it a luxury for most rather than a necessity. The increasing

intervention of the World Bank as seen in chapter V are primarily responsible for these shifts as World Bank influences WHO and forces it to shift its own perspective.

C) PRIMARY HEALTH CARE VS PRIMARY LEVEL CARE

Another impact of international aid is the illusionary structure of Primary Health Care (PHC). PHC has experienced a change from having a comprehensive health care approach to being selective primary health care, then it transformed into first level care and now only essential health care. The basic health care package is also not the one designed according to our needs but is the one suggested by the World Bank experts.

The distinctive features of PHC were that it –

- "considered developmental inputs, other than health, as necessary for health.
- Included secondary and tertiary care as elements of primary health care and
- Understood that people's health needs, participation, and affordability of care were basic to PHC.

The inability of the Alma Ata declaration to centrally locate the developmental issue on the debate on public health, in contrast to the importance given to technology and its organization, set the stage for the transformation of PHC at its inception. The concept of equity in development and self-reliance was lost and mere reorganization of health services remained the focus of PHC. This obscured the distinction between 'basic health care' and 'comprehensive primary health care'. The term PHC thus got automatically diluted into basic health care for all practical purposes". (Qadeer, I. 2003).

Eighth and ninth plans that mark total departure from the original concept of PHC was a phenomenon experienced under the influence of politics of international aid played by the World Bank. It was peculiar not only for India but for most of the developing countries. "For the south Asian countries, the 1990s have been a significant period in which the concept of PHC regressed one step closer to its extinction. The acceptance of structural adjustment policies brought along with them a new notion of reforms, very different from the reforms of the 1970s. In the health sector, it meant cutbacks in the role of the public sector, privatization, and cost recoveries. In the social arena, it

meant cutbacks on all other welfare inputs, undermining of food security systems, and increasing the burden of unemployment for the poor. 'Reforms' then, was a mere euphemism for 'adjustments'. To give these reforms a human face, a veil of a 'safety net' was drawn to protect the vulnerable, but this veil remained invisible". (Qadeer, I. 2003).

It is not surprising then that in the draft tenth plan the concern of planners has shifted to health tourism rather than PHC. The good public sector hospital are to attract foreign patients to earn foreign exchange and make profits at par with industrial productive units (GOI 2002) rather than worry about the marginalized at whose cost health tourism will be promoted.

D) FINANCIAL COSTS VERSUS PEOPLE'S NEEDS

World Bank analysis of India's poor state of public health, and recommendations given to resolve them are an indicator of its poor conceptual understanding as far as public health planning is concerned. Its cost-benefit analysis, based on purely economic standards fail to capture the social costs of its recommendations in the long-term. While the original concept of public health prioritization focuses on accommodating people's perception of their illnesses, the bank uses experts to decide priorities.

In the Bank's views, restructuring the financial allocation is the best possible way in achieving the health objectives. In case additional resources are not available, especially for preventive and promotive services, the government will need to redefine its priorities in the health sector and be much less optimistic about its objectives and goals (World Bank, 1995). The focus of public spending, according to the bank, should be in areas where private investment is negligible such as preventive health care, infectious disease control and limited disease interventions providing inpatient treatments. This might also mean reducing the current public investments in medical education; tertiary care and government subsidized insurance schemes, and allowing the private sector to play a greater role in these areas.

Such steps as recommended by the World Bank – as cutbacks in subsidies, instead of incorporating socio-economic strategies of disease control- as clean water supply,

food security, sanitation and housing – its overconfidence in the medical interventions, supporting standard essential public health package for all developing countries rather than using an epidemiological basis for disease prioritization, and pushing private sector in public health domain – only show World Bank's concern for the monetary rather than social costs. Such an approach is detrimental for the poor.

The shift in focus has been from – providing for people's needs to providing what public funds can support. Due to SAP and cut down in funding for public health services, the present focus has shifted to what can be provided at minimum cost – whether or not it has scientific basis and social relevance. A classic example is the essential public health package; introduced as a standard check for all developing countries in 1993, and followed up in India, later analyzed in 1995 and 1997 reports. The standard package includes AEPI, FPP, tobacco and other drugs, AIDS prevention and school health programmes. The only basis of this package is that it can produce substantial health gains at modest cost. Such a package is supported inspite of the fact that every report has identified respiratory and diarrhoeal diseases to account for a large proportion of childhood mortality and preventable mortality and morbidity especially among the poor. Communicable diseases are also the major killers. (World Bank, 1997)

This inadequate approach has pervaded India's health planning process that today depends entirely on the advice of the Bank, WHO and other donors. All of them including the European commission are pushing for removal of poverty and disease through technology. This increases business for them and more loans to purchase the technology for the LDCs governments that are implementing the structural adjustment policies to satisfy their donors.

E) SHIFT FROM COMPREHENSIVE TO TECHNOCENTRIC STRATEGIES

Even in the domain of curative health care system, Indian planning has mainly focused on vertical disease control programmes. They rely heavily on technological accuracy rather than efficiency in terms of coverage and cost effectiveness and efficacy. Also the choice of diseases to be attended by means of national disease control programmes has been found to be conforming more to the funding patterns of

the international agencies rather than Indian needs. It has been shown in the analysis in chapter V, how the choice of most of the national programmes actually lack any epidemiological basis. Mostly India has received funding as technical assistance in the form of drugs, equipment or expertise from international consultants. This has directed India's public health interventions towards being more technical rather than comprehensive. Faulty choice of issues to be attended and an increasingly techno centric approach, has rendered our public health investments more or less ineffective in tackling the situation which has become complex with non communicable diseases sharing the diseases burden along with the communicable diseases.

This multiple burden of disease, absence of a proper health system, investment of scarce resources in programmes of dubious epidemiological significance, unbalanced growth of the health care system having more of urban curative bias – as if these were not enough challenges for India to face – that came the World Bank prescription of sectoral adjustment programme. The only long term public health vision, India had ever invested into (on its own without any external international influence), was an infrastructure for delivering preventive, promotive and curative health care. India did build a huge infrastructure over the years. However instead of bulding upon it, it was allowed to develop an urban bias with heavy dependence on curative care packages the rural set up was transformed into a second rate system of PHC.

With the World Bank prescription, based on its only considerations of lowering the financial costs in public health interventions, the most severe impact is being felt by our efforts to build a universally accessible health care infrastructure. In order to cut down the non-plan expenditure on maintenance of the existing infrastructure, the Bank suggested of passing the secondary and tertiary care services to the private sector, whereas public sector is left with only 'primary level care' where it is prescribed to provide a basic essential package of services as designed by World Bank experts (who once again prove their ignorance about Indian needs). Primary health care, in absence of a proper referral system of secondary and tertiary care services, invariably ceases to loose its value for comprehensive public health interventions, more so when its functioning is further restricted to provision of only piecemeal reproductive health services, child care interventions, and AIDS interventions.

According to the World Bank – " Public health programmes work in three ways: they deliver specific health services to populations (for example, immunizations), they promote healthy behavior, and promote healthy environments. Governments play a leading role, and provision of information through public education is a central feature of most programmes, especially those designed to change behavior. But difficult choices have to be made about the best use of public money. The expanded programme of immunization (EPI), - is highly cost effective, at about $ 25 per DALY gained, but not all programmes offer such good value for money...six particularly cost-effective public health services in the realms of population based services (including immunization), nutrition, fertility, tobacco and other drugs, the household and external environment (including control of insect vectors of disease), and AIDS. Public health packages in developing countries should include components in most or all of these six areas." (WDR, 1993. pp 72)

The focus of 1995 and 1997 World Bank studies in India has also been to reallocate and manage health sector financing in a way to ensure maximum support to curative health care system. This is to an extent that preventive and promotive aspects of public health have been almost totally starved of any mention in these reports, and whenever they do find mention, it is with regards to some technical interventions only.

These reports give an impression that the major problems of mortality and morbidity are a result of limited resources of the health service systems. In other words, if the health care system were adequately financed, more lives would be saved. And it is to restructure the financial set up, by including public-private partnerships, that these studies had been conducted. These reports overlook the fact that a country's level health and mortality is dependent on many more important factors, and not only on its medical services. This does not mean that medical technology is not required in the realm of public health, but that it is not justified to explain a country's state of health by its medical services. It is unjustified to see the problem of malnutrition in developing countries as protein and/or iron and /or vitamin deficiency, or overnutrition leading to obesity. Malnutrition as a public health problem in a developing country cannot be anything but undernutrition and that too undernutrition

in terms of insufficient overall diet (calorie) intake, and not in fragments or micronutrient deficiency – as the World Bank perceives it to be.

The decline of mortality rates in American and European economies began much before the discovery of antibacterial drugs, which are now seen as main instruments for the success of medical intervention. Mass therapeutics and immunization programmes were questioned by the third world experiences, when they showed limited success when implemented through weak infrastructure amidst populations living under conditions of extreme deprivations. Except for the eradication of small pox, none of the other programmes could achieve the expected results. "Thus, the need to tackle poverty, which was at the root of constraints such as poor nutritional status, sanitation and the availability of drinking water, housing and transportation emerged as one of the major thrusts in public health debates...The importance of providing subsistence and welfare infrastructure along with basic health services and the critical role of people's participation, control, and self-sufficiency had been undeniable in the experience of countries such as china, Cuba, Nicaragua and Zimbabwe." (Seetaprabhu, K. and Sudarshan, R. ed.2003. pp 222)

F) PUSHING THE CASE FOR MARKET ECONOMIES

Comparing the state of health in developing countries with that of market economies (mainly developed countries), World Bank advocates that 'market economies' have better health standards. "One simple statistic gives a sense of the remaining burden of disease: about 12.4 million children under age 5 died in 1990 in the developing world. Had those children faced the mortality risks of children in the established market economies, the number of deaths would have been cut by more than 90 percent, to 1.1 million." (WDR, 1993. pp 25)

In other instance it states that "the higher the disease burden, the higher the proportion attributable to the communicable group of causes. Sub-Saharan Africa has the highest disease burden per 1000 population, and 71 percent of this is from the communicable disease group, whereas in Latin America (a medium burden region) the figure is 42 percent and in established market economies it is only 10 percent." (WDR, 1993. pp 29)

Such a comparison cannot be justified on any parameters. The high burden of disease in Sub-Saharan Africa, Latin America and other developing (and socialist) economies is due to poverty and subsequent poor health system. It has nothing to do with market economies. The established market economies have their health systems in place, with mass poverty attended to a large extent. They have good water supply and sanitation facilities, housing, clothing, food and environmental faculties, which are essential in controlling (especially communicable) diseases. McKeown has outlined the causes of low levels of mortality in European countries long back. The evidence shows that the most dramatic declines in mortality and increases in life expectancy occurred during the 20th century before medical care proved effective. And a lot of credit for such improvements goes to chadwickian sanitary reform movement and ensuring food and adequate clothing for the masses. The developed market economies have also gone through stages wherein welfare measures for the masses marked the decline in communicable diseases, while the industrial revolution and the economic growth improved living conditions. Medical interventions came at a time when communicable diseases were either on a decline or completely eradicated. Each step followed the other but did not overshadow each other. However, the World Bank in its analysis chose to ignore this gradual progression and compares what the developed world is today. It would have been closer to reality had it compared Sub-Saharan Africa today with what Britain was at the time of industrial revolution, when socio-economic conditions of the two regions were at least comparable, if not the same.

The proponents of market economies also ignore the fact that historically colonization of Asia and Africa has played a key role in destroying their agricultural economies and in transforming them into dependent and poor countries. At the same time the surpluses appropriated from these countries were involved in the production and welfare interventions of the state in the colonizing countries. LDCs today have no such advantages.

It is also critical to note that given the importance of financial capital in today's globalised world for forces that are working for expanding markets are very powerful. The private capital MNCs and developed national governments depend on expanding markets. Hence they are coming together as public private partnerships and

penetrating new areas of investments. Medical services are one such area hence health sectors of LDCs are being readjusted through health sector reforms.

G) SHIFT FROM REGULATING PRIVATE SECTOR TO REGULATING PUBLIC SECTOR

The 1995 World Bank report concluded that India had achieved significant improvements in health status of its population and developed an extensive basic health care infrastructure. It also says that the public primary health care system, especially its preventive and promotive services, is overextended in terms of its capacity to provide and maintain services at peripheral facilities; and the system is underfinanced for the range of services it is expected to provide. (World Bank, 1995.) The reason for low finances of public system has been attributed to the high non-plan expenditure (almost 80 percent of state health budgets), which goes for maintenance of the already existing infrastructure and other costs. Therefore, the bank recommended the public sector to hold back further expansion of infrastructure and utilize the money saved thereof, in the upkeep of the existing facilities and maintaining supplies in order to provide better services. Sounds convincing though, evidences point to a different reality.

No doubt health care services are quite developed in India, but a major part of health care exists not in the public sector, but in the private sector, which is essentially curative. The main objective of medical care is aiding in the achievement of health by making available basic health care services – curative, preventive and promotive – to all who need it. The services must be appropriate, adequate and rational in order to be effective besides being dynamic in nature in order to meet the changing epidemiological needs. (Jesani. 2003. pp 222)

"While in absolute terms the size of the health care sector appears to be 'good enough', its distribution is very lopsided... there is an overwhelming dominance of private sector in all categories. In fact, on examining the data from the 1961, 1971 and 1981 census, we find that there is a progressive de-ruralisation in the location of doctors. In 1961, 49.69 percent of all doctors were in rural areas, but in 1981, only 41.2 percent were located there. As a consequence, for urban areas, the doctor-population ratio (1urban doctor for 387 urban persons) is better than many of the developed countries. The ratio for rural areas (1 rural doctor for 1,611 rural persons)

is bad, but the ratio of doctors at the PHCs (1 PHC doctor for 24,938 rural persons) is the worst. Thus, the real under development is related to government service and not the whole health care sector." (Jesani. 2003.)

Once the centre is convinced of the need for change, international agencies have proved to be instrumental in fostering the interests of the pharmaceutical industries, by supporting a technocentric approach through vertical disease control programmes in the developing world. Now their fierce lobbying for private sector as the sole rescue from the vagaries of the public sector is another part of their effort to push the interests of international capital markets and the market economic structure of the developed west. So powerful is the influence of international aid that it has convinced the public sector of its own inefficiency without even introspecting the actual reasons behind such inefficiency. So convinced is our public sector of its inabilities, that it blatantly and vehemently proposes to follow the schema designed by foreign agencies for itself. The eighth plan mentions – "The public sector will have to become very selective in the coverage of activities and in making investments and should clearly define its objective principles. The following principles will have to followed:

- The public sector should make investments only in those areas where investment is of an infrastructural nature which is necessary in facilitating growth and development as a whole and where private sector participation is not likely to come forth to an adequate extent within a reasonable time perspective.

- The public sector may also withdraw from areas where no public purpose is served by its presence. The public sector should come in where the investment is essentially for preservation and augmentation of basic resources of the country, like land, forest, water and ecology, science and technology or for running key infrastructural activities. The public sector will have responsibility for meeting social needs or for regulating long term interests of the society like population control, health, education etc.

- In large parts of public sector operations where commodities or services are produced and distributed, unless it is necessary for protecting the poorest in the society, the principle of market economy should be accepted as the main operative principle. It means charging as per cost and costing with full efficiency in operations." (Government Of India(1992) Eighth five year plan)

These principles rooted in policies of donors adopted by our public sector show how international aid is creating a suitable atmosphere for the private sector to enter smoothly. Government interventions in areas profitable for the private sector is considered as disorder which renders the system inefficient. Anything which is not suitable for the markets is seen as inefficient and therefore needs to be replaced by the more efficient markets. Areas which have little scope for monetary returns, even if they create heavy externalities, as in the case of preventive and promotive services, have been left for the non-efficient government to address.

SUMMING UP

The impact of following the guidelines of international funding agencies is such that today if we attempt to search for India's vision for public health and try to analyze its strategy adopted to realize its goal – all that we find is a disjointed, mosaic of interventions which have no link with their preceding steps. Health sector has been treated with utmost negligence, to begin with, when we did not concentrate on keeping development as central and developing a strong health system, and now this sector is being used for getting further concessions from the international players for investments in rather more productive sectors.

"Not surprisingly, considering the pronounced structural anomalies, such technocentric 'categorical' or 'vertical' global programmes as those of immunization, control of AIDS, eradication of tuberculosis, poliomyelitis and leprosy that were imposed on the people of poor countries at the cost of billions of US dollars, failed to attain even the limited objectives that were set for them. In the bargain, the rudimentary infrastructure of the health services in the poor countries has further suffered from neglect because of their preoccupation with trying to implement high priority global vertical programmes. Apparently, the flaws of the 'techno-managerial' programmes that are pushed by WHO and other international agencies, such as the World Bank, have become so obvious that the government of a country like India, which had hitherto been faithfully following the line laid down in the global vertical programmes,has been impelled to make a forthright 'confession' in the final version of its national health policy of 2002 about the degree to which the health services have suffered because of these programmes. It says: over the last decade or so, the government has relied upon a 'vertical' implementation structure for its disease control programmes. Through this, the system has been able to make a substantial

dent in reducing the burden of diseases, however, such an organizational structure, which requires an independent manpower for each disease programme,is extremely expensive and difficult to sustain. Over a long range, 'vertical' structures may only be affordable which offer a reasonable possibility of elimination or eradication in a foreseeable time frame...It is a widespread perception that over the last decade and a half, the rural health staff has become a vertical structure for the implementation of family welfare activities. As a result where there is no separate vertical structure, there is no service delivery system at all." (Banerjee, 2002.)

Although India has been a recipient of international aid since independence i.e. more than half a century, yet studies regarding this external assistance have been few and far between. Another fact is that aid has never occupied a prominent place in the scheme of financing development in India. "If we treat official development assistance as aid as it is generally done, aid had been only around 0.4 percent of India's GNP during the last decade. The entire quantum of aid including non-official assistance has never been over 1 percent of the GNP. Even so, aid does play an important role in India's development. It is not quantity but quality that matters." (Cox, Aidan. et.al. 2002)

There is nothing wrong when a country invests to attract foreign resources. Such a step is necessary for growth and development. The problem arises when such development comes at the cost of millions of lives which could be saved, if only planning could had been a little bit more sensitive, sensible, pragmatic and scientifically designed and methodologically implemented. This is the problem with India. Its social stratification and class structure has ensured that the planners who dominate have upper class roots and perspectives (believing in SAP as the only path to development), and chose to sign on the dotted lines. They neglect what should have been India's priorities and accept the strategies, which would please the rich donors, and finally have landed in a gamut of contradictions, which seem difficult to resolve if the present frame of planning is to continue.

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ANNEXURES

ANNEXURE I

Total external assistance received by GOI, 1951-2001 (Rs. in Crores)

S No.	Category	Public sector outlay	Value of Agreement Concluded	Receipts	Percentage
1	First five-year plan 1951-56				
	Government loan	2069			
	Non-government loan		243.79	121.57	5.87
	Grant		0.00	0.00	0.00
	Total		137.96	70.18	3.39
			381.75	191.75	9.26
2	Second five-year plan 1956-61				
	Government loan	4800			
	Non-government loan		2409.68	1186.32	24.71
	Grant		0.00	83.24	1.73
	Total		121.46	160.64	3.35
			2531.14	1430.20	29.79
3	Third five-year plan 1961-66				
	Government loan	8577			
	Non-government loan		2666.13	2772.60	32.33
	Grant		0.00	0.00	0.00
	Total		132.58	107.15	1.25
			2798.71	2879.75	33.58
4	Yearly plan 1966-67				
	Government loan	6756 for	1426.80	1034.30	
	Non-government loan	1966-69	0.00	0.00	
	Grant		79.70	97.10	
	Total		1506.50	1131.40	
5	Yearly plan 1967-68				
	Government loan		702.00	1073.03	
	Non-government loan		0.00	61.87	
	Grant		16.80	60.70	
	Total		718.80	1195.60	
6	Yearly plan 1968-69				
	Government loan		878.40	728.64	
	Non-government loan		0.00	108.76	
	Grant		68.40	65.20	
	Total		946.80	902.60	
7	Fourth five-year plan 1969-74				
	Government loan	15902			
	Non-government loan		3976.00	3139.94	19.75
	Grant		0.00	80.96	0.51
	Total		196.20	152.80	0.96
			4172.20	4183.70	26.31
8	Fifth five-year plan 1974-78				
	Government loan	39303			
	Non-government loan		6153.90	4615.03	11.74
	Grant		0.00	226.25	0.58
	Total		1354.20	883.75	2.25
			7508.10	5725.03	14.57

9	Yearly plan 1978-79				
	Government loan		1894.60	822.76	
	Non-government loan		0.00	81.35	
	Grant		441.10	273.36	
	Total		2335.70	1177.47	
10	Yearly plan 1979-80				
	Government loan		1295.10	973.06	
	Non-government loan		0.00	75.60	
	Grant		564.40	304.53	
	Total		1859.50	1353.19	
11	Sixth five-year plan1980-85				
	Government loan	97,500			
	Non-government loan		15197.20	8713.43	8.94
	Grant		0.00	409.12	0.42
	Total		1564.10	1780.14	1.83
			16761.30	10902.69	11.18
12	Seventh five-year plan 1985-90				
	Government loan	39,649			
	Non-government loan		41325.20	18998.88	47.92
	Grant		0.00	1123.49	2.83
	Total		2739.50	2572.74	6.49
			44,064.70	22,695.11	57.24
13	Yearly plan 1990-91				
	Government loan	64717	6795.28	5638.58	8.71
	Non-government loan		806.02	531.46	0.82
	Grant		522.08	534.25	0.83
	Total		8123.38	6704.29	10.35
14	Yearly plan 1991-92				
	Government loan	72317	9785.01	9116.25	12.61
	Non-government loan		2657.25	1579.56	2.18
	Grant		1119.08	918.98	1.27
	Total		13,561.34	11,614.79	16.06
15	Eighth five-year plan 1992-97				
	Government loan	4,34,100			
	Non-government loan		49157.59	43451.57	10.01
	Grant		13016.97	8421.44	1.94
	Total		8821.56	4830.44	1.01
			70,996.12	56,703.45	13.06
16	Ninth five-year plan 1997-2002				
	Government loan	8,59,200	65011.71	51919.93	6.04
	Non-government loan		14854.67	14192.14	1.65
			9071.28	5280.29	0.6
	Total (upto march 2002)		88937.67	71392.36	
	Grand total loans		240253.30	182091.13	11.07
	Grand total grants		26950.40	18092.25	1.10
	Grand total	1644890	267203.71	200183.38	12.17

Source: GOI, 2001-2002 External Assistance, Ministry of Finance and Company Affairs.

ANNEXURE II

Details of funding for area Development Projects (ADPs)

Name of the donor agency	Name of the states covered	No. of districts	Project cost (Rs. in Crores)	Period of operation
Completed projects – Phase I				
I. World Bank				
IPP-I	karnataka	5	09.33	1973-80
	Uttar Pradesh	6	11.87	1973-80
IPP-II	Andhra Pradesh	3	31.40	1980-88
	Uttar Pradesh	6	73.33	1980-88
IPP-III	Karnataka	6	71.31	1984-92
	Kerala	4	53.36	1984-92
IPP-IV	West Bengal	4	117.12	1985-94
II. USAID	Gujarat	2	15.76	1980-86
	Haryana	3	8.75	1980-86
	Himachal Pradesh	3	14.75	1980-86
	Maharashtra	3	15.13	1980-86
	Punjab	3	12.34	1980-86
III. ODA (UK)	Orissa	5	33.67	1980-87
IV. DANIDA	Madhya Pradesh	8	26.50	1981-88
	Tamil Nadu	2	21.08	1981-88
V. UNFPA	Bihar	11	16.51	1981-87
	Rajasthan	4	13.81	1980-86
Completed projects – Phase II				
1. DANIDA	Madhya Pradesh	8	21.85	1989-95
	Tamil Nadu	2	24.77	1989-95
2. World Bank				
IPP-V	Chennai	1	89.13	1988-96
	Mumbai	1	71.45	1988-96
3. ODA	Orissa	5	77.25	1.11.89 to 31.3.96
On-going Project – Phase II				
I. World Bank				
IPP-VI	Uttar Pradesh	State wide	94.00	1990-97
	Madhya Pradesh		39.00	-do-
	Andhra Pradesh		69.66	-do-
	NIHFW		1.75	-do-

IPP-VII	Punjab	STATE WIDE	48.66	1990-91 to 31-12-97
	Haryana		42.42	-do-
	Bihar		88.18	-do-
	Gujarat		43.90	-do-
	J&K		51.54	-do-
	NIHFW		1.48	-do-
	Social Marketing		33.85	-do-
	NGOs/IEC		24.59	-do-
	Unallocated		1.10	-do-
IPP-VIII	Delhi		47.25	6.8.93-5.8.98
	Calcutta		101.64	-do-
	Hyderabad		35.15	-do-
	Bangalore		39.23	-do-
	Min. of Health & FW (MOHFW)		0.10	-do-
IPP-IX	Assam		101.22	16.6.94-june, 01
	Karnataka		114.75	-do-
	Rajasthan		108.57	-do-
	MOHFW		10.46	-do-
II. UNFPA	Rajasthan	13	34.85	1.4.89-31.3.96
	Maharashtra	5	38.36	1.4.89-31.12.96
	Himachal Pradesh	9	35.29	1.4.89-31.03.95*
III. GERMANY	Maharashtra	4	47.40	20.5.96-19.5.01

* under extension.

Source: GOI, annual reports, Ministry of Health and Family Welfare.