A CRITICAL REVIEW OF MODERNIZATION THEORY AND ITS APPLICATION TO HEALTH

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ZAFAR KHURSHID

CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067
1995

Centre of Social Medicine & Community Health
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY

New Delhi-110067

CERTIFICATE

Certified that the dissertation entitled "A CRITICAL REVIEW OF MODERNIZATION THEORY AND ITS APPLICATION TO HEALTH", submitted by Mr. ZAFAR KHURSHID is in partial fulfilment of requirement for the Degree of MASTER OF PHILOSOPHY of this University. This dissertation has not been submitted for any other degree of this University or any other University and is his own work.

We recommend that this dissertation be placed before the examiners for evaluation.

Prof. IMRANA QADEER
CHAIRPERSON

Dr. K.R. NAYAR
SUPERVISOR

New Delhi - 110067,
21 July, 1995.

Gram : JAYENU Tel : 667676, 667557 Ext. 259, 262, 363 Telex : 031-73167 JNU IN Fax : (011) 6865886

"DEDICATED

TO

MILLIONS

OF

PEOPLE

WHO

NEED

INDEED,

SOCIAL MEDICINE".

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There is no royal road to academic research. This work would not have seen the light of day without the people in my academic lifeworld.

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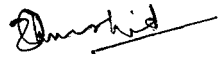

New Delhi - 110067,
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ZAFAR KHURSHID

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CHAPTER-1

INTRODUCTION

It has been widely recognised that a sustained improvement in the health status of a population can only be achieved through the combined impact of a wide range of socio-economic developments. In 1977, the World Health Assembly decided that the main social target of governments and WHO (World Health Organization) should be the attainment, by all citizens of the world by the year 2000 A.D.of a level of health that will permit them to lead a socially and economically productive life. In 1978, in the Declaration of Alma-Ata, primary health care was defined as the key, in national health strategies, to the achievement of an acceptable level of health for all and it was emphasized that health is not the concern of the health sector alone but also reguires the action of other social and economic sectors. In 1979, the World Health Assembly endorsed the Declaration of Alma-Ata and brought into sharper focus the need to coordinate a wide range of sectoral activities in order to achieve health goals. Health, therefore, has increasingly gained recognition as a social goal which has to be integrated into a strategy of social development.

By now it is clear that social development has profound repercussions on health and vice-versa. The very parochial approach to health as just of physical well-being no longer stands relevant in the present context and a new conception of health emerged within a broader framework of what WHO defines as "a state of complete physical, mental and social well being and not just absence of disease and illness".

The very relationship between health and development, however, can be placed in a network of interactions between multitude of basic services such as housing, nutrition, education, water supply, etc., apart from health services itself. Simultaneously positive health cannot be seen as a product of economic development alone, since many of the macro-indicators of development do not reveal the quality of life of the vast sections of the population. Henceforth, it is the social structure of a society which, to a great extent, determines the health status of its population. Furthermore, in the context of development and health what needs the utmost attention is the vicious-cycle of poverty and health.

In this context George Rosen rightly points out in his essay, "Historical trends and future prospects in public health," that even way back in early nineteenth century it

was established that a correlation existed between standard of living and epidemic of diseases which gave way to the state intervention in the arena of public health in rapidly industrializing Western countries (Britain, France, America and Germany). And here comes, the populist notion of 'culture of poverty' emergéd with the publication of Les Mysteres de Paris in 1843 by Eugene Sue and the Dangerous-Classes of New York in 1872 by Charles Loring Brace. Furthermore, he states:-

> "Organized public health agencies, modern style, were created to deal with the occurance of epidemics and the prevalence of endemic disease in the urban centres of the early industrial society. They developed in response to social needs within a definite context resulting from the convergence of public and private factors.....The problem of the public health was inherent in the new industrial civilization. The process that created the market economy, the factory and the modern urban centre also brought into being the health problems that made necessary new means of health protection".[1]

This brings into focus that whereas development, on the one hand, is inevitable to raise the health status of the population, On the other hand 'development', which is more or less synonymously used for the Western notion of indus-

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1. George Rosen-"Historical Trends and Future Prospects in Public Health"- in " Medical History And Medical Care" (A Symposium of Perspectives) Published for the Nuffield Provincial Hospitals Trust by the Oxford Press, London, N.Y., Toronto, 1971, p. 61.

trialization, gives birth as its by-product to various hazardous health problems, making a wider field of operation for the public health sector. Therefore, a debate comes to the fore "development for whom?" and the issue of "equitable - distribution" becomes very much prominent.

McKeown in the same fashion points out that striking improvement in the public health long preceded the application and even the development of modern medical concepts. He empirically established the fact that the improvement in public health arose from improved food supplies accompanied by control of predators through improved sanitary conditions.[2]

Therefore, it is obvious that 'health' is not a function of medical care alone, but of the overall integrated development of society - cultural, economic, educational, social and political. The health status of a society is intimately related to its value system, its philosophical and cultural traditions and its social, economic and political organisations too. Each of these aspects has a deep influence on health, which in turn, influences all these aspects. Hence, it is not possible to raise the health

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2. Thomas McKeown & C.R. Lowe-"An Introduction to Social Medicine", Blackwell Scientific Publications, Oxford, London, 1966.

status and quality of life of a people unless such efforts are integrated with the wider effort to bring about the overall transformation of a society. The objectives of integrated development are to eliminate poverty and inequality, to spread education and to enable the poor and underprivileged to assert themselves. Health development can be integrated with the larger programme of overall development in such a manner that the two become mutually self - supporting.

Since their political independence, most countries of the Third World have opted for a growth policy which is often termed as the "policy of modernization". Theories of modernization in the 1950's and 1960's, produced mainly in the developed countries, offered a blueprint to the newly independent nations to chart their course of development. Despite the fact that a large number of underdeveloped countries are agrarian or rural based in terms of population, contribution to GNP and employment, the modernization that has taken place in most cases has been urban based. This is not to say that there has been no modernization in the agricultural sector. Indeed there has been growth but the blueprints from the developed world, accepted and adapted by the indigenous ruling classes, suggested other foci. Nations were advised to move away from agriculture towards

industrialization if they wanted to develop. This modernization or industriatization was in the form of import substituting industries, most of which were situated in urban areas.

But this rise of large scale industry, by replacing labour-intensive production with energy-intensive industry, had intensified pre-existing inequities. In rural areas, big agribusiness concentrated farmland into large-holdings causing a massive exodus of landless peasants into mushrooming city slums where the environmental conditions and sanitation problems made them face hazardous health problems. So has Rosen accentuated that the problem of the public health was inherent in the new industrial civilization.

Whether it is the construction of a dam, or the Structural Adjustment Programme (SAP) on the pretext of modernization, following the 'Big is Beautiful' model of development, the brunt of its repercussion is always borne by the poorest of the poor as Ashis-Nandy states ----

> "In the name of science and development one can today demand enormous sacrifices from, and inflict immense sufferings on, the ordinary citizens".[3]

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3. Ashis Nandy-"Introduction : Science as a Reason of State" in Ashis Nandy ed. "Science, Hegemony and Violence : A Requiem for Modernity", Oxford University Press, Delhi, 1990, p.-1.

While talking of development what comes simultaneously to the mind is underdevelopment. Underdevelopment of Third World Countries encompasses multitude of factors. As one of its very prominent factor had been the development of Western industrial states which enjoy an exploitative relationship with Third World countries. In this regard, Andre Gundar Frank lucidly claims that the underdevelopment is a condition imposed on the Third World countries by the industrialised countries in order to promote their own development. He perceives economic development and underdevelopment as the opposite faces of the same coin.[4]

Therefore, we have Irvin L. Horowitz who besides external factors like that of A.G. Frank, also recognizes the internal factors. He states ----

> " ..... are all nations to be considered as autonomous units or are they to be considered as inter-related parts of a larger systematic unity. There is no escaping the fact that the magnitude of analysis is an impediments to the solution of the nature of modernization. The field of development studies became really dynamic when Functionalism entered its final phase. At the outset the problems of underdevelopment were viewed discretely as related to the inner functioning of the underdeveloped society, but later it became increasingly apparant that a Marxian element was present, that the problems of underdevelopment were increasing in

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4. Andre Gundar Frank-"Capitalism and Development in Latin America", Monthly Review Press, 1967 as quoted in Vic George: "Wealth, Poverty and Starvation : A World Perspective", St. Martin's Press, New York, 1988, p.-14.

proportion to the problems of advanced nations. This 'dialectical inter-dependence of dependent and underdevelopment' to borrow Sweezy's expression had two facets. On the one hand the wealth plundered from the underdeveloped societies became the basis of advancement of the developed societies. This was the external source of primitive accumulation of capital .....the internal source being the forcible expropriation of the masses of agricultural producers from the soils. On the other hand, pre-capital modes of production were destroyed. The perception of the problem is thus linked to the issue of social stratification at the international level".[5]

The recently adopted Structural Adjustment Programme which is being implemented in 70 Third World and East European countries on the dictate of IMF-WB combine also brings to the fore the issue of exploitative nature of stratification at the international level. Confining ourselves to the health sector, the effect of the SAP, with its slashing down of the budgetary allocation for health, is coming down devastatingly on the poor. If we take note of the current health scenario in India, we find that in the last few years, public expenditure on health has grown marginally. Compared with other developing countries and with industrial countries public expenditure on health is already very low in India. Health accounts for 2.1 percent of government expenditure in India as compared with 4.1 percent for all

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5. Irving L. Horowitz-"Qualitative and Quantitative Research Problems in Development" in M. Stanley ed. :"Social Development: Critical Perspectives", Basic Books Inc. Pub., New York, 1972.

developing countries and 12.3 percent for the industrial countries. In constant prices, the total real expenditure on health care was raised only from Rs.2,600 millions in 1989-90 to Rs.2,620 millions in 1990-91. Even, this expenditure is lop-sided. About 55 percent is spent on curative health care and medical education while the share of public health services which are more relevant to health needs of millions of people is just one-third of total expenditure. The rest is spent on the Family Welfare Programmes. In medical education, the actual emphasis is on producing the well-trained but highly specialised manpower in curative services. Thus, we have more than one doctor per nurse instead of having several nurses per doctor. Similarly, we have one doctor for about every 3300 population, while there is only one midwife per 14000 population. Furthermore, doctors are concentrated in urban areas. The rural areas, where 70 percent of our population lives, have only 30 percent of doctors and 17 percent of beds.

Medical research is also concentrated on sophisticated diseases like cancer, heart disease and neurosurgery rather than on diseases like leprosy and filariosis which are more relevant to our health needs. Thus, health care benefits are catered mainly to a small section of the rich and middle class who constitute the most vocal section of population

and monopolise the benefits from the public services. Any further cuts in the expenditure on health will have disastrous effects on the majority of poor populations because they will bear the burden. If we look meticulously on the balance sheet of health, we find ----

(1) Only 20% of our people have access to modern medicine.

(2) 84% of health care costs is paid for privately.

(3) 40% of our children suffer from malnutrition, even when the foodgrain production in India increased from 82 million tonnes in 1961 to 124 million tonnes in 1983, the per capita intake decreased from 400 gms. of cereals and 69 gms. of pulses to 392 gms. and 38 gms. respectively. Due to increasing economic burden on a majority of the people, they just cannot buy the food that is theoretically 'available'.

(4) Of the 23 million children born every year, 2.5 million die within the first year. Of the rest, one out of nine dies before the age of five and four out of ten suffer from malnutrition.

(5) 75% of all the diseases in India are due to malnutrition, contaminated water and non-immunization.

(6) Life expectency is 57 years. This is less than even that in many Third World countries like Nicaragua, Brazil, Vietnam, Burma, Peru etc.

(7) 50% of children are covered by the immunization programme. 1.3 million children die of diseases which could have been prevented by immunization.

(8) 550,000 people die of TB every year. About 900,000 people get infected by Tuberculosis every year.

(9) About half a million people are affected with leprocy, which is 1/3 of the total number of leprocy patients in the world.

(10) 70% of children are affected by some intestinal worm infestation.

(11) 1.5 million children die due to diarrhoeas every year.

This pathetic condition of health scenario in India compels us to have a cursory look on the resource allocation. We find that one of the principal reasons for this state of health of our people, lies in the wrong priorities as far as resource allocation is concerned. The following table shows progressive reduction in budgetary allocation for health in successive Five Year Plans (Not inclusive of allocation for family welfare):

TABLE[6]- 1

Budgetary Allocation for Health in Successive Five Year.

PLANS	PLAN-PERIOD	% SHARE OF HEALTH BUDGET
1st 5 year Plan	1951-56	3.32
2nd 5 Year Plan	1956-61	3.01
3rd 5 Year Plan	1961-66	2.63
Annual Plans	1966-69	2.11
4th 5 Year Plan	1969-74	2.12
5th 5 Year Plan	1974-79	1.92
6th 5 Year Plan	1980-85	1.86
7th 5 Year Plan	1985-90	1.88 (estd.)

The current trend of the share of expenditure on medical and public health in India after the implimentation of SAP, as per the analysis of Seeta Prabhu shows that in total state government expenditure for the years 1990-91 to 1994-95 has declined in seven states and remained constant in

6. Source-from-"Structural Adjustment: Who Really Pays" by Public Interest Research Group, Delhi, 1992, p.-17.

four states. Only the states of Bihar, Gujrat, Haryana, Karnataka and Orissa experienced an increase in share. With respect to intra-sectoral allocations, there was a decline in the share of public health in six states viz. Bihar, Orissa, Rajasthan, Uttar Pradesh, Punjab and West Bengal. In the states of Andhra Pradesh, Assam, Gujrat, Haryana, Karnataka and Kerala there was an increase in the share of public health whereas in Maharashtra and Madya Pradesh, there was no change in the pattern of health expenditure. [7]

Therefore, given the fact that the poor depend to a greater degree on health facilities provided by the government, a reduction in the per-capita expenditures is bound to lead to a further deterioration in the quantum as well as quality of services rendered in the public sector. The reduction in the relative share of public health is particularly alarming as several communicable diseases have shown resurgence in recent times.

Now, there is no doubt the policy formulation go in tandem with the ideology of the ruling class and obviously, at the loosing end would be the underprivileged and exploit-

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7. K. Seeta Prabhu-"World Development Report 1993, Structural Adjustment and the Health Sector in India". Paper presented at the National Conference on World Development Report, 1993 - Investing in Health on Dec. 8-9, 1994, J.N.U.

ed masses. Therefore this raises the need for a careful analysis of 'model of development' which besides economic growth certainly incorporates social welface as well. In pursuit of 'development', it becomes inevitable to dig deep into the 'modernization' theory especially in the arena of Health Services, which more often than not, had provided 'West' as the role model to be emulated by the policy planners of the Third World countries. Western medicine itself can be questioned on the ground of its rationality and scientificity, as way back in colonal period this had been imposed upon the masses who had little meaning in it- undermining their own culturally evolved health culture - and had been used more as a tool to prove their cultural hegemony.

These are the issues which bring to the fore a very exhaustive debate, some of which goes beyond the purview of this work. But an attempt has been made here to cover at length the notion of 'development' and 'modernization theory' which has provided a blueprint for the development of Third World countries since the underdevelopment of the Third World countries has became a lively issue, especially in the light of present economic trends.

In the second chapter-"Development and Modernization: Concepts and Theories - A critical Review" - the notion of development and modernization has been analysed. For Renais-

sance thinkers, it was the freedom of individuals which was the sole condition of progress. Then came the Marxists' subversive doctrine and Welfare State. But it was not till the conclusion of the Second Great War, to come out of their war ravaged economy, development model based on purely economic growth came into existence and subsequently was propagated by West. This economic growth model dominated the literature of 50's even though it ignored the issues of income-distribution and poverty. Hence, with the realization of failure of 'trickle -down' phenomenon, the notion of development further encompassed poverty alleviation and inequality reduction within its purview.

Further, modernization Theory has been taken up as one of the theories of development. Various conceptualizations about modernization has been analysed, though, most of which has relied heavily upon the model presented by the West, based on the technological and scientific development and some scholars like Yogendra Singh has considered the technological advancement as one of its determinants but not the sole one. With all its inconsistencies, the underlying connecting link within various conceptualization is economic development. However, within the purview of economic modernization, in the final conception of modernization, qualified as its primary goal is social and economic equali-

zation. Therefore, coming to a final conception of modernization, three fundamental issues incorporated are - economic modernization, equitable distribution of resources and a greater sensitivity to the qualitative dimensions of life.

In the third chapter--"Modernzation-its Emergence and Relevance in Relation to other Theories of Development" at first, the emergence of the process of modernization has been traced out in the historical context. The root of emergence of modernization is being traced in the societies of Western Europe dating back to the sixteenth century, the period they were gradually acquiring the spirit of Industrialization. In due course of time, modernization became coterminous with industrialization. The relevance of this industrialization based modernization in Third World countries has been analysed; especially in South Asian regions, despite its promising potentials in agricultural sector. The relevance of emulating West as a role model by underdeveloped countries with all their cultural differences from West, in due process of modernization has also been taken up. Then after, other theories of development have been discussed, which are - dependency theory, Marxist theory, neo-Marxist theory and structuralist theory. These all theories deal with the phenomenon of underdevelopment in Third World countries each from a particular standpoint. But

underdevelopment in Third World countries being much a complex phenomenon can at best be understood in the light of a collective multidimensional standpoint. But the relevance of modernization theory becomes more prominent in present Indian context as the essentials of this theory still influence heavily the main international developmental bodies like World Bank and International Monetary Fund - as is seen in the devastating impact of SAP (Structural-Adjustment Programme) dictated by these bodies. The main essence of SAP and its impact on Indian scenario in general and the provisions of GATT on agriculture has also been analysed in brief. Besides this the structural constraint in the 'trickle-down' phenomenon of the fruits of economic growth has been discussed in which the real beneficiary of the growth is the upper stratum of the structural set-up of the society. The same case applies in the health field with its major emphasis on curative care.

Followed by is chapter 4 - "Modernization: its Application to Health in Indian Context". Firstly, the linkages between health and development have been discussed which takes up the issue of positive impact of rise in standard of living on health as substantiated by McKeown. Though,development has on the one hand, its positive bearing on health, on the other hand this development through 'mo-

dernization' as its off shoot brings into existence various hazardous health problems, to tackle which the approach emerged is Sustainable Development. The interlinkages between health and development in international context, shows that economic development alone is an inadequate qualification for a better health status of a country. Examples are well-served by China and Sri Lanka with a comparatively positive impact of its equity-oriented growth on the health status of its people. In Indian context too, the same model applies in the comparative study of different states. This once again brings into focus an integrated approach in India to deal with various socio-economic problems for the improvement in the health-status of the people. Further, the modernization process in medical planning and its repurcussion on masses and also the trend in health service development had been analysed. The very foundation of Health Service System in India which is based on the Western 'scientific' medicine--the evolution of this Western 'scientific' medicine has been discussed at length which in fact, go hand in hand with the capitalist value system. Therefore scientificity and rationality of Western 'scientific' medicine in the Indian context with all its cultural differences from the West, has been analysed as this complying with its original essence could have well-suited for the curative

model of health services, as has been the trend in fact. Hence, further discussed are the issues of the trend of modernization in health sector which is having a bias for urban area which benefits only the upper crust of the society who in turn, are having a major say in the health policy formulations. Therefore, this trend brings to the fore the issue of equitable distribution under the purview of modernization and a preventive, rehabilitative, curative and promotive kind of health service model which could fulfil the real felt-needs of the masses.

Though, the issues of development and modernization and their repurcussion on health need an exhaustive and intensive discussion, it has not been possible to take up all the issues within the purview of this work. But an attempt has been made to analyse the essence of modernization and its implications for health. For achieving this objective, we have relied on available conceptual and empirical materials. Despite our best efforts, there might have been some limitations. We have tried to be as objective as possible but being a critical review of existing knowledge some of the preconceived notions on the theme might have influenced the writing.

With this objective , now we start with a brief historical account of development in the second chapter.

CHAPTER-2

DEVELOPMENT & MODERNIZATION : CONCEPTS AND THEORIES - A CRITICAL REVIEW

2.1 DEVELOPMENT : A BRIEF HISTORICAL ACCOUNT

A number of conceptions has dominated the interpretation of human development. Especially during enlightenment, an essentially theological view of history gave way to a more critical mode of thinking. The idea of progress was an early result of this change in the eighteenth century social thought. Even the early social thinkers, particularly renaissance thinkers, were not averse to evaluate social change. But for them freedom of the individual was the supreme value and a movement of a society in that direction was a condition of progress. Furthermore, progress was also an ideal to be actively pursued by individuals. The Marxists' incorporation of the idea of progress and man's active intervention in the social progress provided a further sap to the paradigm of progress. However, in the domain of praxis, this was a 'subversive' doctrine insofar as it called for the replacement of a social order based on exploitation and domination by another in which the ideal of equality could be realized.

The vested interests were bound to reject a social theory which struck at the very roots of their privilege. Then came the doctrine of the welfare state, though popular a short while, was in fact an effort to reconcile the demands of the conservative vested interests in maintaining social order and to control the revolutionary potential of the dissatisfied by a two-pronged strategy : (a) allowing for free competition on the one hand , and (b) providing ameliorative measures to see that dissatisfaction is not translated into active protests. The prosperity of the society was sought to be measured in terms of economic criteria such as Net National Product, Gross Domestic Product and Per Capita Income.

After the conclusion of the Second World War, the colonial powers could not hold on to their erstwhile colonies and beginning with India and Pakistan, practically all the colonies got independence. The Western social theorists already had a model of economic growth based on capital accumulation from within wherever possible, and of one with foreign assistance (under the Marshall Plan) where domestic accumulation was not possible. The economic resurgence of West Germany and Japan were two instances where economic growth was brought about by a 'rational' utilisation of economic resources, both domestic and foreign. One of the

major objectives of the newly independent countries (popularly known as Third World) was rapid prosperity. The Western social scientists had no hesitation in recommending strategies of economic growth which had already proved successful in West Germany and Japan as the models to be emulated by the Third World. It was soon realised that the rate of growth, despite the introduction of modern technology and foreign capital, was not as high as was envisaged. It was then realised that even economic growth depends upon the 'human' factor. It was to Max Weber that attention was turned for an understanding of the factors that facilitate or inhibit growth. Max Weber had argued that the value attitudes of the Protestants were a major facilitating factor for the rise of capitalism in the Western World and that the value attitudes supported by other religions, particularly Hinduism and Confucianism, were inhibiting factors.[1] Hence, attention was withdrawn from economic growth and was oriented to modernization.

Many scholars have brought out the fact that the modernization theories proposed by the Western scholars were nothing but a rehash of the economic elthic of capitalism of

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1. Max Weber -"The Protestant Ethic and the Spirit of Capitalism" trs. by Talcott Parsons, Charles Scribner's Sons, New York, 1958.

the west. Modernization had envisaged the rule of reason in the technological, personality and the institutional domain. Despite extensive efforts, the Third World failed to fall in line with the expectations of the modernizers, not because it was incapable of doing so but chiefly because there already existed institutional structures based on alternative rationality. Therefore, the Third World has its own reservation to the imposition of formal instrumental rationality of West,the cornerstone of modernization.

2.2 DEVELOPMENT : A CONCEPTUAL ANALYSIS

Theories of development and underdevelopment can both be grouped under the two main headings.

1. Individualistic and 2. Structural.

Individualistic explanation attribute wealth and poverty primarily to the characteristics of the individual unit, whether this is a country or person. Structural explanations on the other hand, consider these conditions at both the national and international level as being primarily the result of structural factors, reflecting the balance of power between countries or groups of individuals or both.

As far as the notion of development is concerned, it is both normative and multidimensional and it shares the essential contestability of all important notions in the social

sciences. The implication of it being contestable is very much articulated in the Brandt Report that development "Never will be and never can be, defined to universal satisfaction".[2]

Value judgements are inevitable in the way it is defined, and this in turn has significant implications for the type of policies necessary for its promotion.

To begin with, it should be borne in mind that the process of development begins with man's efforts to satisfy his needs by appropriating from nature what he needs. It is obvious that the major differences between human beings and other animals is that man is immensely perfectible. He is not content with his given conditions but always seeks to improve upon them. This is especially true in his interaction with nature where he tries to alter nature to satisfy his needs. Hence, each era of human progress is characterised by an improvement in the capacity of man to appropriate from nature what he needs by improving the technology of such appropriation. And this process is also accompanied by a concurrent haterogeniety of functions and complexity of social organization. Therefore, development, incorporates

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2. Brandt Report-"North-South--A Programme for Survival". The report of the Independent commission on International Development Issues under the chairmanship of Willy Brandt, Pan Books, 1980. (as quoted in Vic-George : "Wealth, Poverty and Starvation", op. cit.)

the economic and the social structural aspects simultaneously.

While defining development, since the post-war period, three definitions have in fact dominated the literature and have had varying degrees of influence on the policies pursued by national governments and by international bodies.

The literature of the 1950's equated development with economic growth, in terms of either increases in the country's national product or more specifically in terms of rises in income per capita in country. It was a definition that seemed to make sense during a period when the efforts of most governments were inevitably directed at rebuilding their war-ravaged economies, It was the period just after the Second World War when many of the colonies in Asia and Africa were moving towards their political independence. At this juncture all the developmental theories worked with an understanding that development and economic growth were synonymous. The disciplinary inputs for an approach to development were mainly from economics.

There distinct phases canbe identified in this thinking: 1. The Classical 2. neo-Classical and 3. Keynesian.

The classical period is represented by mainly Adam Smith and David Recardo. Adam Smith was concerned with the causes of increasing productivity in relation to division of

labour and the size of the market. Recardo, on the other hand, provided an analysis of the distribution of production among the various classes in society, and of how this affects economic development.

Malthus, also contributed to the development thinking of this period while linking population growth and economic growth.

Karl Marx also belonged to this school because of his use of classical conceptual approach. However, his theory developed its own analytical frame work. For Marx, the analysis of development must begin from the process of production which contained two crucial aspects the material conditons i.e. means of production and relations of production.

The neo-classical economic theory focussed on static micro-economic relations. The main issue was how the market mechanism could distribute the resources in society.

Keynes, the well-known economist belonging to this phase considered macro economic problems more important than microeconomic relations. He argued that an increase in expenditure would lead to an increase in the level of economic activity and a decrease in unemployment. He was more concerned with the short term aim of stabilization of economy at the time of depression. Other economists during this

period also contributed to the development theory by largely considering development and economic growth as synonymous. The problem of underdevelopment was characterised as being one of shortage of capital.

Walt Rostow's model was a typical expression of this perspective giving more emphasis to economic factors. He identified the five stages in economic growth:

1. The traditional society,
2. The pre-take-off stage,
3. Take-off,
4. The road to maturity and,
5. The society of mass-consumption.[3]

For Rostow's developmental model, entrepreneurship was the most important factor. He expounded that economies can only go beyond the pre-take-off stage if they can invest over 10 percent of their national income, if they concentrate on one or two manufacturing sectors and above all, if the spirit of entrepreneurship can flourish within a Western type political and social framework. Rostow's ideas of take-off received wide support in both developing and developed countries, for they promised benefits to all con-

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3. Walt W. Rostow -"The Stages of Economic Growth", Cambridge University Press, 1962.

cerned as well as a programme to rival the Eastern European model of development, and it became the capitalist manifesto for economic development during 1960's.

The impact of early development theories on development strategies is clearly visible. The important question was that of balanced or imbalanced growth. The proponents of balanced growth, based on the issue of standard of living, investing and purchasing power, argued for complimentarity of different sectors such as industry, agriculture and infrastructure. The dominant framework was, however, unbalanced growth by suggesting that it was better to concentrate, because of scarcely available decision markers and entrepreneurial skills, on a few sectors rather than spreading them over the entire economy. Some of India's developmental strategies in agriculture remain within this model.

Another issue with regard to the neo-classical approach was international trade. They considered foreign trade as an engine of growth and favoured free trade. It was held that free trade would raise the welfare of participating countries and would finally lead to more equal international distribution of income. There were also indirect effects such as 1. availability of machinery and raw materials which would speed-up economic development. 2. It would transfer technical and administrative know-how to countries

that needed it. 3. It promotes free competition which would raise efficiency and growth.

The exponents of this approach sidelined its eventual outcome as it led to divisions between Centre which produced finished goods and Periphery contributing mainly raw materials. And subsequently this led to the underdevelopment in the periphery. It was obvious that expansion of market though free-trade would benefit only those countries which already possessed advanced technology and developed industries.

Another issue which came to the forefront is the explanation of underdevelopment. This was mainly expounded by those who adopted a structural position. It questioned the theory of equilibrium while maintaining that within underdeveloped economies, there existed two sectors--one industrial and the other agricultural. The agricultural sector serves as a labour reserve for the industrial sector. The latter is thus capable of exponsion due to this hidden capital reserve until the labour surplus in the agricultural sector is used up. It was also argued that as a result of the growth model, regional diseqilibrium will grow leading to impoverishment of those areas. The dependency relationship of underdeveloped countries on the developed ones was also pointed out by critiques of growth models. They argued

that persistent poverty of underdeveloped countries is a reflection of this inequitable relationships.

Therefore, it is seen that the dominant theory of development was based on growth models with emphasis on capital formation. It was contended that this emphasis on economic growth either ignored issues of income-distribution and poverty or, at least assumed that as the economy of a country expanded everyone would benefit more or less alike i.e. the fruits of economic growth would "trickle-down" from the top to the middle income groups as well as down to the poor.

Henceforth, with the realization that this "trickle-down" effect was not usually taking place, a second definition of development emerged to replace the first one. As it was in fact, quite common for a country's national income to grow quite substantially without benefitting the poor sections of the country as much as the rich. Absolute poverty could remain unaltered and even rise at times of substantial economic growth. Out of this realization, development came to be defined in terms of poverty alleviation and inequality reduction. Economic growth was still important but, for development to take place, it had to be accompanied by the achievement of these specified social objectives. Development now became a synonym for social improvement and could

only be measured by the extent to which the social objectives were achieved. Seer's approach to the definition and measurement of development both highlighted and established this new mood---

> "The questions to ask about a country's development are: What has been happening to poverty? What has been happening to unemployment? What has been happening to inequality? If all three of these have become less severe then beyond doubt this has been a period of development for the country concerned. If one or two of these central problems have been growing worse, especially if all three have, it would be strange to call the result 'development' even if per capita income has soared".[4]

Various names were given to this new approach to development - redistribution with growth, anti-poverty approach,the basic needs approach and so on - and they were all taken up as guidelines for the development policies of the international agencies in the 1970's. They were characterised by high idealism and a gross underestimation of the political obstacles to their implementation.

The third definition of development which came simultaneously with the second one, but went beyond it to include not only 'basic-needs' but emotional, spiritual and politi-

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4. D. Seers-"What are We Trying to Measure?" The Journal Development Studies, vol. 8, No.3, 1972 (as quoted in Vic George : "Wealth, Poverty and Starvation" op. cit., p.-3.)

cal needs as well. Within a Marxist paradigm Rodney sees development at the level of the individual as 'increased skill and capacity, greater freedom, creativity, self-discipline, responsibility and material well-being'.[5] From a structuralist perspective Todaro writes that the notion of development incorporates three core values : First-- life sustenance i.e. the satisfaction of basic psychological needs; Second--self esteem; and Third--freedom from the social servitudes of men to nature, ignorance, other men, misery, institutions and dogmatic beliefs.[6]

The very broad nature of this third difinition makes the notion of development very appealing but also very vague and hence not amenable to any social scientific measurement. Therefore, both the policy makers and social scientists have adopted the second definition.

In nutshell, "Development, therefore, refers to the multidimensional process whereby societies improve their living standards, reduce inequalities and abolish poverty among their members".

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5. W. Rodney-"How Europe Underdeveloped Africa". Bogle L'Overture Publications, 1972, p.-9.

6. M.P. Todaro-"Economics for a Developing World", Longman, New York and London, 1977.

A conceptual analysis of 'Development' would lead us logically to some of the prepostulated notions of modernization theory.

2.3 MODERNIZATION THEORY

Modernization theory as one of the theories of development emerged just after the Second World War, though its intellectual origins can be traced back to the writings of Herbert Spencer, Emile Durkheim and Max Weber in the nineteenth and early twentieth centuries. Modernization theorists perceived development as an evolutionary process going through various stages and transforming all societies from traditional to 'modern'. Like all evolutionary theories, modernization theory maintained that each successive stage is not only different but superior to the one preceding it. Development is a cumulative improvement process, and this becomes abundantly clear when compared either historically or contemporarily societies at the two extreme stages of development.[7]

More precisely, Wilbert Moore writes, modernization means 'a "total" transformation of a traditional or pre-

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7. Vic George-"Wealth, Poverty and Starvation : A World Perspective". St. Martin's Press, New York, 1988, p.-5.

modern society into the types of technology and associated social organisation that characterise the "advanced", economically prosperous and relatively politically stable nations of the Western World'.[8] This means, modernization implied changes in the technological, economic, political and social systems of developing nations so that they become increasingly like the Western European and North American countries.

The modernization theorists used Weber's work, to answer the question of driving forces behind the modernization process. Weber's basic agrument was that the development of capitalism in Western Europe was due not only to the existence of the appropriate economic conditions but also to the existence of the appropriate value system i.e. the Protestant Ethics which emphasised the values of hard work, savings and entrepreneurship.[9]

Some modernization theorists tried to combine economic and attitudinal factors, others highlighted attitudes and values only but, above all, they all considered changes in attitudes and values as the most important prerequisite to the development process in the Third World. But

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8. W. Moore-"Social Change". Prentice Hall, 1963, p.-89.

9. Max Weber-"The Protestant Ethic and the Spirit of Capitalism", translated by Talcott Parsons, op. cit.

ironically,these changes in the attitudes and values of the Third World countries had more often than not, been imposed one and had been sought on the line of Western Values.

Therefore, it becomes obvious that implicit in the modernization paradigm are two important assumptions. First, that a set of countries had already accomplished the task of development and had become modern. There problems thenceforward, could only be 'post-modern' relating to an era of 'beyond high mass consumption.' The countries outside this set (of the Third World) had to go through the process of development. Second, that the former held before the latter the models of social structures, technologies and life styles on which they could fashion their development. The history of modernization, it was contended, had provided evidence of "the process of change towards those types of social, economic and political systems that have developed in Western Europe and North America from the seventeenth to nineteenth centuries". [10]

In nutshell, the modernization approach tried to include health care and education, political factors, attitudes and institution of society etc.. Underdevelopment, therefore, came to be visualised in an evolutionary perspec-

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10. S.N. Eisenstadt-"Modernization, Protest and Change". N.J. Englewood Cliffs, 1966 p.-1.

tive, attributing it to traditionalism, negative attitudes etc.. The emphasis of the new developmental model shifted to changing these barriers to the same growth model. Development implied changing of these barriers by means of an imitative process, in which the less developed countries gradually assumed the qualities of the industrialised nations. This issue still stands relevant in Indian context as the way this framework has influenced health services development in the country.

Before we deal with the other aspects of modernization process and its application to health it is desirable to have a conceptual clarification of the very concept of 'Modernization'.

2.4 MODERNIZATION : A CONCEPTUAL ANALYSIS

The term 'modernization' is aimed at capturing quantitative and qualitative changes, both in the dimension of scientific knowledge and societal institutions, that have been taking place with increasing rapidity particularly since the sixteenth century. Since then an infinite number of terms are either being replaced by 'modernization' or are being fitted into the matrix of this concept.

This therefore, has given rise to the impression that there is a lack of consistency in the 'concepts' of modern-

ization, and that the implications of the term are vast and varied. Thus Horowitz states that --

> "... there is an obvious lack of logical consistency and uniformity of connotation in this concept".

Furthermore he thinks that:

> "'modernization' lacks the merit of being a concept and every attempt to define the concept in terms of an operational set of variables results in the introduction of new ideas which have relatively little to do with the original concept".[11]

Modernization, in fact from time to time has been analysed by social scientists according to their own orientation and perspective. The economists perceive modernization in terms of application of technologies to control nature's resources in order to bring about a marked increase in the growth of output per head of population. The sociologists and social anthropologists have been primarily concerned with the process of differentiation within social structures along with the individual and collective features of disorganization as a result of modernization. Political scientists discern the capacity of the government to involve change, respond to the social demands for change,

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11. Irving L. Horowitz-"Three Worlds of Underdevelopment : Theory and Practice of International Stratification". 1st ed., Oxford University Press, New York, 1972.

and cope with the conflict process. Psychologists study the impulse of modernization as an element of personal virtue or motivated interest in the welfare of the 'generalized other fellow'. Finally, the historians explain the 'actual development' in terms of causal relationship.

Notwithstanding these inconsistencies review of some of the major "conceptualization" reveals an underlying unanimity in what may be termed as 'modernization'. Coming to the analysis of conceptualizations -

The most common referent of modernization are the capitalist societies of the West. As Netti and Robertson point out - ''modernity' is seen to represent a single final state of affairs....found in the West'.[12]

Another very popular conception of modernization is its equation with industrialization - and this too primarily in its Western European and American version. As Moore states --

> " ....One could scarcely dispute the centrality of economic performance in the definition and indicators of modernization, for it stands both as an autonomous goal distributively and collectively and as an essential means for implementing educational, political and

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12. J.P. Netti-"International Systems and the Modernization of Societies". Farber and Farber, London, 1968.

recreational goal".[13]

It should be borne in mind that the process of modernization is not analysable exclusively in economic terms. But in most societies, especially the Third World countries, improving material standards of living has been the major objective. Thus, there is a tendency to view modernization as synonymous with economic development.

Yogendra Singh whereas, considers modernization as a form of cultural response, involving attributes, which are basically universalistic and evolutionary. These attributes are pan-humanistic, trans-ethnic and non-ideological. Modernization, therefore, may in this respect be treated as a kind of 'cultural-universality'. Furthermore, Yogendra Singh stresses the view that modernization symbolises a rational attitude towards issues and their evaluation from a universalistic point of view. What is essential to modernization is the commitment to a scientific worldview, that is, the internalization of humanistic and philosophical viewpoint of science on contemporary problems. The volume of techno-

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13. W. Moore-"Modernization as Rationalization: Process and Restraints", in Manning Nash ed. "Essays on Economic Development and Cultural Changes in Honour of B.F. Hoselitz". University of Chicago Press, Chicago, 1977, p.-33.

logical advancement in itself is not the sole determinent.[14]

Cyril E. Black views the core process of modernization as rationalization. This is the awareness of the possibility to seek a rational explanation of physical and social phenomenon which is presumed to be law-governed.[15]

At the same time many scholars are of the view that the starting point of any definition of modernization is not the character of society, but the character of its individuals. This is so because they consider certain modern attributes as a necessary pre-condition for modernization. Thus Inkles and Smith point out --

> ".... a nation is not modern until its people are modern.... we doubt that its economy could be highly productive, or its political or administrative institutions highly effective unless the people who work in the economy and staff the institutions have attained some degree of modernity".[16]

Another issue involved in the concept of modernization comes from D.P. Mukherji who defines modernization not as

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14. Yogendra Singh-"Modernization of Indian Tradition (A Systematic Study of Social Change)". Rawat Publications, Jaipur, 1986, pp.-61.

15. Cyril E. Black-"The Dymanics of Modernization : A Study in Comparative History". Harper and Row, New York, 1966, p.-9-13.

16. A. Inkles and D.H. Smith - "Becoming Modern: Individual Change in Six Developing Countries". Harvard University Press, Cambridge, 1974 pp.-9 & 313.

growth but as 'the broader process of the unfolding of human potentialities'. Here basically, Mukherji does not specify a set of goals for modernization to achieve. Rather he sees modernization as a continuous process, developing and exhibiting the inherent potentialities of man, encapsulating the technological and scientific dimension within a more quantitative framework. As it is the latent force that automatically comes to the surface in the continous process of man's development.

Gerald M. Meir identifies the 'ideals of modernization' as rise in productivity, social and economic equalization, modern knowledge, improved institutions and attitudes and a rational co-ordinated system of policy measures that can remove the history of undesirable conditions in the social systems that have perpetuated a state of underdevelopment. Most students of development, he points out, would undoubtedly qualify the primary goal by requiring that the absolute number of people below a minimum level of real income should diminish and at the same time that real per capita income rises.[17]

Though most of the conceptualisations here emphasize single factors in development, Manning Nash presents a

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17. G.M. Meir-"Leading Issues in Economic Development". 2nd ed., Oxford University Press, 1964 pp.-6-7.

multi-dimensional view which sees modernity as a social, phychological, and cultural framework and modernization as a process for the institutionalization of such a framework.[18]

No doubt, these accounts highlight some of the major conceptualisation of modernization. Apparantly the frames of reference are inconsistent and the model projected shows a lack of consistency. But there is an underlying connecting link with in them which can be systematically traced out and that would lead us to the formulation of a singular concept.

The earlier mentioned conceptualisation of modernization with its reference to West (which is marked by its notion of capitalism, technological and scientific growth, private enterprises and uncontrolled play of market forces along with political and social freedom), with its equation with industrialization (in its Western European and American version), with its meaning to improve the material standards of living - in all, there is a clear indication of the centrality of economic growth .. primarily technological growth and industrialization.

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18. Manning Nash-"Modernization : Cultural Meanings - The Widening Gap Between the Intellectuals and the Process", in Manning Nash ed.-op. cit.

Therefore, in its conception this central concern with economic growth is not negated. As is evident, countries of the Third World are progressively channeling their energies in the direction of greater technical expertise and industrial growth.

Hereby, we find a fundamental issue either explicitly stated or implicit within the scope of every conceptualisation ..... i.e. that of economic modernization through technological and scientific growth. Therefore, a unification in the conceptual scheme which emerges, is the concept of modernization being equated with economic modernization (which of course, is not the sole determinant). However, within the purview of economic modernization the primary goal of modernization may be qualified as social and economic equalization. Besides the emergence of this issue, another significant aspect which emerges in formulating the concept of modernization is - a consideration of the qualitative dimension of life involving democracy, uncontrolled play of market forces along with political and social freedom.

Thus, three fundamental issues emerge in a final conception of modernization - economic modernization (i.e. technological and scientific development), equitable distribution of resources and finally a hope for greater sensitiv-

ity to the qualitative dimension of life (involving economic, political and social freedom). These three issues are primary in almost every society, with emphasis on each of the issues varying in different societies.

After having dealt with the various theories of modernization and drawn a unilinear concept, it becomes necessary to trace out the origin of the very process of modernization in the global context and see the rationality behind its emergence and its relevance in the Indian context. Therefore, we take up these issues in the third chapter.

CHAPTER-3

MODERNIZATION - ITS EMERGENCE AND RELEVANCE IN RELATION TO OTHER THEORIES OF DEVELOPMENT

3.1 Modernization - Emergence and Relevance

The term 'modernization' bears specific reference to the societies of Western Europe dating back to the sixteenth century, which was the period when they were gradually acquiring the spirit of industrialisation. And therefore, in due course of time, modernization became coteriminous with industrialisation. But the initial impetus towards modernization which started in Europe could, however, not be sustained due to a variety of political and social factors, and the resurgence of the industrial spirit instead passed over to England. The Industrial Revolution started in England in late eighteenth century led to subsequent spin-offs for the resurgence of the industrial spirit in Europe. The Industrial Revolution in England and subsequently in Europe, led in turn to need to find markets as well as abundant new material sources for the industrial machine. The voyages of discovery and the process of colonization gained momentum within this spirit of industrialization in Western Europe. In this process India too got into the trap of British colonizers. Once came in touch with their

British colonial masters, Indian Bourgeoisie started westernizing their life-style under the pretext of 'modernization'. Henceforth, the very process of modernization was being blended with the process of Westernization.

The First World War in many ways was a culmination of great power rivalries between the European Nation States in its due process of colonization. But with the shattering effects of the Second World War which manifested the profound dissatisfaction with the social and economic stagnation of inter-war years, there developed an urgent need to breathe new economic life into the shattered wilderness of Europe's extensive war-zones. This marked the renewed advent of industrialization and commercialization. The process thus, found its fundamental expression in England in particular and in Europe in general, with its techno-economic and socio-political transformations. Thus, the concept as such was enthnocentric, limited as it was to the rise of capitalism.

Daniel Lerner writes in this context that--

> "The sharp rise of xenophobia in public emotion has made it hard for intellectuals to establish the crucial but subtle point that the Western genesis of their modern perspectives is so to speak, an historical accident; that thought ways, once acquired, develop an autonomous status; that the appropriate criteria for

evaluating modernizm, are not its precedents but its consequences".[1]

In the context of inevitability of modernization in Third World countries, though there is a wide gap in the modernization of different societies, it seems evident that they are moving towards a similar 'industrial state' and have similar goals in this sphere, despite the persistence of cultural differences and moral values. Since their liberation from colonial rules, most of the Third World countries in the economic sphere have been facing the dilemma of concentrating either on industrial sector or agricultural sector.

Gunnar Myrdal makes a significant point in this context when he states that most societies in South Asia give exclusive attention to the rapid growth of modern techniques in imitation of Western growth patterns. This growth pattern he says, is not very relevant to the situation in South Asia. The most serious consequence of this is that agriculture becomes a symptom of underdevelopment that must make way for an efficient factory system. Myrdal makes an important point further mentioning that though the dynamic ele-

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1. Daniel Lerner- "The Passing of Traditional Society", The Free Press of Glencoe, London, 1964, p.-408.

ment in Western Europe was manufacturing, it never possessed the kind of agricultural potential that many countries of South Asia have. This situation becomes clear when problems of economic backwardness are thought in terms of a vicious circle or in terms of 'circular-causation' as Myrdal points. The general situation can be seen in terms of a chain of interlinking factors which serve to preserve the status quo of low-production. It may be the case that attempts to extract more production from the agricultural sector by turning the 'terms of trade' between agriculture and industry in favour of the latter are self-defeating because it weakens the motive for the peasant to grow cash crop so that the marketed surplus of agriculture shrinks.[2]

This was true a case in India, despite all its promising potentials in the agricultural sector, the terms of trade was turned in favour of industrial sector which is conspicuous in the growing trend of Five Year Plans outlays in both the sectors.

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2. Gunnar Myrdal-"Asian Drama: An Inquiry into the Poverty of Nations" (An abridgement by Seth S. King of the Twentieth Century Fund Study), The Penguin Press, London, 1972.

TABLE[3] - 2

PATTERN OF PLAN OUTLAY IN THE PUBLIC SECTOR (% DISTRIBUTION)

Head of Outlay	First Plan	Second Plan	Third Plan	Annual Plan (1966-69)	Fourth Plan	Fifth Plan	Sixth Plan	Seventh Plan	Outlay Annual Plan (1990-91)
Agriculture & Community Development	14.8	11.7	12.7	16.7	14.7	12.3	13.7[a]	14.3[a]	14.1
Organised Industry & Minerals	2.8	20.1	20.1	22.8	18.2	22.8	13.6[b]	12.0[b]	11.5

Taking up the issue of the relevance of 'modernization' in Third World countries, it is to James O'Connell who in his approach takes a conventional stand while rationalizing this very process of 'borrowed-modernization'. He is very

3. Source - Ministry of Finace, Indian Economic Statistics: Public Finance, December, 1988, Economy Survey, 1990-91.
   a. Figures include outlay on rural development and special area programme.
   b. The overall decline in public sector outlay on organised industry and minerals is because of the broadening of classification of power sector. It is thus not strictly comparable with the preceding plan-period outlays.

straightforward in his conviction when he states --

> "....it is worthwhile to point out that the changes taking place at present in many non-Western societies are part of modernization. Inspite of the superficial assumption of various Western appearances, they do not mean the Westernization of these societies. They involve no more than making use of some Western forms and inventions which it is easier to take over at present than to spend precious time in working out a new amidst the many pressing issues that are having to be resolved".[4]

It is to James O'Connell who earlier incorporates 'creative rationality' under the purview of modernization in order to describe the mental attitude that develops in the very process. And here the criterion of 'creative rationality' in his assumption of modernization put a question mark on the rationale behind his 'borrowed' modernization. It should be borne in mind that the emergence of modernization in the West has a specific cultural context which in no way may be similar to the non-Western societies. Once this 'modernization' is being imposed upon the non-Western societies (or to say Third World countries), it lacks the cultural ethos of the people of those countries who have got little meaning in it. And this no doubt creates a xenophobic psyche in them. And thus, the protagonists of this kind

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4. James O'Connell-"The Concept of Modernization" in Cyril E. Black ed. "Comparative Modernization: A Reader" The Free Press, New York, 1976, p.-22.

of 'modernization' come out with the 'victim-blaming' approach. Health system in India too had not been an exception, as we will discuss in the next chapter. And it is therefore, the critics of the 'modernization' theory came down vehemently, besides it being vague and unsystematic (what we have already discussed in 2nd chapter), that it is biased in favour of stability and order for the benefit of an affluent minority at the expense of the majority of citizens.

Besides this, it is quite likely that features, found in the West today do not provide the framework within which growth of those societies originally occurred, but were later consequences of technological forces. Thus the requisites for 'being' modern differ from those required to 'become' modern. What was needed for a modernization syndrome of the nineteenth century may no longer be required in a technologically and more important ideologically different twentieth century.

Whereas, Cyril E.Black categorically mentions that the essence of the Western interpretation of history is that in the course of the modern era, the West-European and English-speaking peoples have developed the political, economic and social institutions that are the best adapted to the modern

way of life and that are of universal validity.[5]

This ethnocentric viewpoint of the West, Black counters with an instance what he further quotes--

> "An extreme instance of the Westernizing view is reflected in a debate among Chinese intellectuals in the nineteenth century as to whether China could have railroads without christianity - inasmuch as the countries that had developed railroads were all christian. The answer as we now know, is that railroads can be built and operated without christianity (or democracy) but not without certain other characteristics that are essential to modern industry: knowledge of science and technology, the ability to mobilize extensive resources for specific ends and habits of work markedly different from those that normally prevail in agrarian societies. There are certain characteristics that must be present if a society is to take advantage of the advancement of knowledge for human welfare, but these characteristics do not necessarily embrace all of the institutional means employed by the West".[6]

The criticism of the Westernizing approach to history which has emanated both from other societies that have come under Western influence, has focussed on the distinction between the characteristics of modern societies that are truely universal - and those that are simply contemporary versions of the different institutional heritages of individual advanced societies. In the non-Western societies, which have come under Western influence, the question which

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5. Cyril E. Black-in "Introduction" to his ed. "Comparative Modernization:A Reader". The Free Press, New York, 1976, p.-2.

6. Cyril E. Black - Ibid., pp.-3-4.

has occupied the prominent place in the debate, is whether they must abandon their cultural heritage in order to gain the advantages of modern knowledge or whether they can adapt their institutional heritage to the requirements of modernisation.

No doubt, the initial impact of the advanced Western societies has been so profound that other societies have frequently been inclined to borrow their institutions wholesale, and to abandon their own. More often than not, such borrowings have not been successful and, thoughtful observers have come to the conclusion that the adaptation of native traditional institutions to new functions is more effective in the long run than the borrowing of Western institutions in a more or less unaltered form.

Black further, makes a significant point, that one important contribution of the concept of modernization to the interpretation of human development- as compared with its interpretation in terms of liberalism, Marxism or Marxism-Leninism - is that modernization places more emphasis on the behavioural and social science and less on Western or other models; it is more concerned with process than with goals.

In the same fashion, Samuel P. Huntington analyses the much blended concept of modernization and Westernization.

He States--

> "...In particular, there is a failure to distinguish between what is modern and what is western. The one thing which modernization theory has not produced is a model of Western society - meaning late twentieth century Western European and North American society - which could be compared with, or even contrasted with, the model of modern society. Implicitly, the two are assumed to be virtually identical. Modern society has been Western society writ abstractly and polysyllabically. But to a non-modern, non-Western society, the process of modernization and Westernization may appear to be very different indeed. This difficulty has been glossed over because the modern, non-Western box in the four-way breakdown of modern--non-modern and Western--non-Western societies has at least until the present, been empty. Presumably, however, Japan is either in or about to enter that box, and it is consequently not surprising that a Japanese scholar should take the lead in raising squarely the issue of how much of modernity is Western and how much of Western society is modern. How do two societies, one of which is non-Western, resemble each other as compared to two Western societies, one of which is non-modern?"[7]

Here Samuel P. Huntington demarcates a line between Westernization and modernization and points out the notion of universality embeded in the process of modernization.

Further, there is Dean C. Tipps, who analyses that the dichotomous tradition emplied in the modernization theories ('Modern' vis a vis 'Tradition') had been the product of an essentially ethnocentric world-view. He categorically makes

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7. Samuel P. Huntington -"The Change to Change: Modernization, Development and Politics." in Cyril E. Black ed.- op. cit. p.-36.

a point with his statement that as the modernization theorists began to adapt for their own purposes the dichotomous approach as it was developed by social evolutionists during the late nineteenth century, they did feel constrained to make certain changes. As not only were blatantly ethnocentric terms such as 'civilized' and 'barbarism' clearly unacceptable, but the explicit racism of the biological school of evolutionary theory had to be laid to rest. However, such changes were in many respects merely cosmetic. Though the language was changed and racial theories were discarded, modernization theorists have continued to be motivated by what Mazrui has termed 'the self-confidence of ethnocentric achievement'.[8]

Thus, though the terminology of contemporary modernization theory has been cleared up some to give a more neutral impression - it speaks of 'modernity' rather than 'civilization', 'tradition' rather than 'barbarism'-it continues to evaluate the progress of nations, like its nineteenth century forebears, by their proximity to the institutions and values of Western and particularly Anglo-American societies.

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8. Ali A. Mazrui -"From Social Darwinism To currrent Theories of Modernization". World Politics, 21(1), pp. 69-83, 1963. (As quoted in Dean C.Tipps - "Modernization Theory and the Comparative Study of Societies : A Critical Perspective" in C.E. Black ed.-op. cit.)

Regarding the emergence of modernization theory, Dean C. Tipps states that both the values and the cognitions embodied in modernization theory have been highly reflexive of the social and historical conditions under which they have been developed. The idea of modernization is primarily an American idea, developed by American social scientists in the period after the Second World War and reaching the height of its popularity in the middle year of 1960s. Two features of this period stand out: a widespread attitude of complacency toward American society, and the expansion of American political, military and economic interests throughout the world. American society tended to be viewed as fundamentally consensual, combining an unmatched economic prosperity and political stability within a democratic framework. Such social problems as might exist, moreover, were treated not as endemic but rather as aberration which could be resolved by normal political processes within existing institutions. After two decades of turmoil, the postwar tranquility of prosperity and stability seemed no mean accomplishment. The future of modern society now seemed assured; only that of the 'developing areas' appeared problematic. Such an atmosphere of complacency and self-satisfaction could only encourage the assumption among social scientists that 'modernity' was indeed an unmixed

blessing and that the institutions and values of American society, at least as they existed in their more idealized manifestations, represents an appropriate model to be emulated by others, less fortunate societies.

Furthermore, he points out that these attitudes themselves were occasioned only by a new concern with the role of the United States in the international sphere. While the imperial societies of Western Europe were confronted with reconstruction at home and decolonization abroad, the United States emerged from the Second World War at the height of its industrial and military strength. It also emerged from the war with a peculiar conception of world politics as a struggle between GOOD or EVIL; if Hitler was the embodiment of evil during the war, the Statlin and Mao became its embodiment in the post-war era. Spurred on by this belief, by the encouragement of its European Allies, and by its expanding economic interests abroad, the United States assumed leadership of the 'forces of freedom' involving itself not only in the international but also the domestic affairs of scores of nations in its efforts to save the world from the menace of the communist conspipracy and to secure a stable world order on terms favourable to its own political and economic interests. As decolonization proceeded in the face of emerging nationalist and revolutionary

movements in the Third World, the acquiescence of Third World societies to these interests, became increasingly problematic. As a result, these societies soon began to assume a significant place in the consciousness of American political elites both inside and outside the government as an arena of Cold War conflict. The rapid expansion of research by social scientists on Third World societies was in many respects a by-product of this new concern, as government agencies and private foundation encouraged and facilitated such research in order to expand the flow of information concerning these societies in the United States and especially in official circles.

And therefore, in this whole process of cultural hegemony, they by virtue of their ethnocentric theories of 'modernization' were able to provide an implicit justification for asymmetrical power relationships between 'modern' and 'traditional' societies, since whatever their other effects, they, the unfortunate people, may be pointed to as advancing the cause of 'modernization'.[9]

Furthermore, Dean C. Tipps makes a point when he argues the fact that such an argument was in fact commonly offered

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9. L.I. Rudolph and S.H. Rudolph- "The Modernity of Tradition: Political Development in India", University of Chicago Press, Chicago, 1967.

to justify European colonialism. Further, he states that the idea of 'modernization' has proven congenial to American policy-makers, so much so in fact that 'development' and 'modernization' came to be viewed as long-range solutions to the threats of instability and communism in the Third World, despite all its indifference to the entire issue of economic and political imperialism. In nutshell, the limited cultural horizons of the modernization theory tend to involve a subtle form of 'cultural-imperialism' an imperialism of values which superimposes American or more broadly, Western choices upon other societies, as in the tendency to subordinate all other considerations to the technical requirements of economic development.

Whereas, A.R. Desai comes out with the argument that the scholars studying the modernization process basically generalise on the basis of their study of capitalists societies, be they highly industrialised neo-capitalist societies of the West or that section of underdeveloped societies which has taken the capitalist path of development after independence. These scholars have, in his view, been attempting to elaborate universal laws in this limited field of study. The group of societies which have taken the non-capitalist path after the October Revolution in Russia are either considered as deformations and abnormalities not

worthy of examination or analysis, or are very superficially referred to, or brushed aside with a few superficial observations. This objective neglect, arising out of a conscious or sub-conscious pro-Western bias and even reluctance to include in their consideration such countries as Mainland China, North Korea, North-Vietnam, Cuba... which were colonial or semi-colonial underdeveloped countries like other underdeveloped countries, is significant and deserves to be noted. These countries have also been modernizing themselves on a qualitatively different principle of social organization based on public ownership of the means of production and production geared to the objective of the satisfaction of the assessed needs of the people rather than to the profits of the private owners of the means of production, and elaborating a qualitatively distinct principle of social stratification and distribution of wealth. Desai argues that, to neglect a scientific analysis of the modernization process of these countries, which are also endeavouring to proceed from an underdeveloped to developed state, and compare their achievements and limitations with those of similar endeavours to modernize on capitalist lines by other groups of underdeveloped countries, is a grave deficiency depriving scholars of a rich field of investiga-

tions of vital significance. Therefore, he states--

> "It is high time that scholars frankly recognize that modernization processes are manifesting themselves along two lines. As Peter Worsley rightly pointed out, there is nothing like modernization per se, there is either modernization on capitalist lines or on socialist lines, with all their respective implications. Modernization on capitalist lines....takes place on the axis of private property in the means of production and the capitalist class as the main driving force of this modernization. Modernization on non-capitalist lines takes place on the axis of public ownership of means of production and where capitalist and land owning classes are being eliminated as driving forces".[10]

Here Desai strikes at the very root of the popular belief, Modernization being a by-product of capitalistic states. Socialist countries which too have modernized in due course of time could also have been projected as the role model for modernization, but beforehand 'modernization', by capitalistic West, has been used as a tool to counter the threat imposed by the communist blocks. Therefore, writings on modernization has been designed in such a fashion to set forth a programme for the global expansion of Western capitalism as a means of protecting its interest from the threat of socialist revolution. There are some critics who perceive modernization as alternative to communism.

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10. A.R. Desai - "Need for Revaluation of the Concept" in A.R. Desai ed. "Essays on Modernization of Underdeveloped Societies". Thacker & Co. Ltd., Bombay, 1971.

It is to Yogendra Singh who sees the universalistic and evolutionary nature of modernization with its roots in the scientific world-view. He puts forth his view categorically--

> "...But what may be essential to modernization is the commitment to scientific world-view, the internalization of humanistic and philosophical view point of science on contemporary problems and not merely the volume of technical advancement."

Further, to him--

> "...It may be purely accidental that institutions contributing to modernity first developed in a culture other than one's own. Modernization in its essential attributes or in ideal-typical forms is a universal-cultural phenomenon. Like science, modernity is not an exclusive possession of any one ethnic or cultural group, but belong to the humanity as a whole".[11]

This view of Yogendra Singh bears the testimony that every society has the seeds of modernity embeded in its cultural soil. And thus, the rationale behind the imported-modernity can be put to a question mark.

After analysing some of the major theories of modernization we find that the main thrust in most of the theories is focussed on technological and scientific development. The bulk of the modernization theories deal with only one

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11. Yogendra Singh- "Modernization of Indian Tradition: A Systematic Study of Social Change". Rawat Publications, Jaipur, 1986, p.-61.

aspect of modernization process...i.e. economic; completely negating the humanist approach, a factor which has become more prominent today. Their limitations which become evident is the lack of emphasis and focus on the other humanist aspects emplied in the concept of modernization i.e. equitable distribution of resources and a greater sensitivity to the qualitative dimensions of life--involving economic, political and social freedom (as we have discussed in chapter-2).

Before we discuss some other aspects of development and underdevelopment, it would be worthy to note that the very process of modernization can be seen in the light of two approaches--Interactional approach vis a vis Myrdal's Institutional approach. According to the former, modernization entails marked changes in institutions, but these changes are dependent on changes in psychological strata. Changes in either level is causative with respect to changes in its opposite. The value of such an analysis at both the social and psychological levels is succinctly brought out when viewing the causative role of failure in development. The social and psychological approaches present different pictures. Where the sociologist would say only that the expected change has not taken place, the psychologist may see the person as having acquired a new dimension in his aware-

ness of his environment. For them, it is possible that failure resulting in curiosity and frustration may eventually lead to highly successful change.

Now coming to the development and underdevelopment of the Third World countries, it is to Myrdal who analyses not only the economic, but also the social institutions, political atmosphere, cultural heritage and demographic and ideological trends. The non-economic factors, he points, are decisive especially in underdeveloped societies. Unlike in Western societies, where the social matrix is permissive of economic modernization, the problem of modernization in South Asia, including India, calls for induced changes in the social and institutional structure which do not respond spontaneously to policies restricted to the economic sphere. Despite the fact, the modernization in India and other South Asian societies, is likely to be attended by acute, social, spiritual and political conflicts, nevertheless, Myrdal is in favour of a direct attack on the frontier...without which economic revolution may stop. Since the main resistance to change stems from attitudes and institutions, and a plan is fundamentally a political programme, Myrdal is convinced

that any attempt to modernize should be focussed here.[12]

In the approach to modernization as put forward by Myrdal we find that besides focussing on the significance of institutions, he does not examine the question of how they can be changed or how their influence can be neutralised if it is so pernicious. Although, Myrdal's implication of the necessity of revolutionary changes in effect, he does not chart the road to social revolution.

Therefore, the focal point of theories supporting non-economic factors in growth is the proposition that the major problem facing such societies, is the necessity to develop an institutional structure which is capable of continuously absorbing the various social changes which are inherent in the process of modernization.

3.2 OTHER THEORIES OF DEVELOPMENT

There are some other theories as well, beside modernization theory, which hold their relevance in the whole debate of development and underdevelopment of the Third World countries which has acquired a prominent shape in the present day global context. These are--i) Classical Marxist theory, ii) Dependency theory, iii) The neo-Marxist theory

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12. Gunnar Myrdal- "Asian Drama:An Inquiry into the Poverty of Nations" (An abridgement by Seth S. King of the Twentieth Century Fund Study), The Penguin Press, London, 1972.

and iv) The Structuralist theory. Though each of these theories attempts to explain inequalities between groups of countries, at the same time, they can also be used to explain inequalities within countries and particularly betwen different regions of the same country. Though each theory has its own limitations and have problem of overgeneralization, for no two countries are alike in all respects, nor can all First and Third World countries be treated as two homogeneous groups. Moreover, the opposite approach of treating every country as totally unique and rejecting all forms of theoretical generalization would equally be unproductive.

Now giving a cursory look on these theories:

i) **DEPENDENCY THEORY**

Dependency theorists have strong affinities with Marxism but most of them are not Marxists because their theoretical framework for development and underdevelopment is not based primarily on the production system of societies. Though the dependency school includes a large number of well-known social scientists, the work of Andre Gundar Frank, Wallerstein and Cardose represent the three main strands of thought within the dependency school.

The dependency theory was for a long time associated mainly with the work of A.G. Frank, though its origin are to be found in the Marxist writings of Baron in the late 1950s and in the structuralist writings of a group of Latin American economists working with United Nations Economic Commission for Latin America (ECLA) in Santiago in the early 1960s.

Baron's work was the first major break among contemporary Marxists from the orthodox Marxists view on economic development in the Third World. Unlike Marx, who saw all countries going through a series of stages until they reach the socialist stage, Baron saw Third World countries as being stuck in their present stage of underdevelopment as a result of their structural exploitation by the industrialised countries. The Third World provided the rich countries both with the raw materials and export markets at very favourable trade terms. There is no possibility for economic development in the Third World for, as Baron states--

> "economic development in underdeveloped countries is profoundly inimical to the dominant interests in the advanced capitalist countries".[13]

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13. P. Baron - "The Political Economy of Growth" Monthly Review Press, 1957, (as quoted in the Vic George op.cit.,p.-14).

A similar, though not as pessimistic view was adopted by ECLA economists, led by Prebisch, who contended that the international trade perpetuated and even strengthened the advantages of the First over the Third World. Unlike Baron, however, who argued that the only way forwarded for Third World countries was through a political solution that changed their dependent status, the ECLA economists argued for deliberate economic policies that fostered 'import-substitution industrialization' i.e. state economic policies that favoured national industrialization and thus, reduced the import of manufactured goods from industrial countries.

Whereas, Frank's formulation of dependency theory is based on the historical experience of Latin America and particularly of Brazil and Chile, though it has been used to cover all Third World countries. Frank argues that the underdevelopment is a condition imposed on the Third World by the industrialised countries in order to promote their own development. Thus underdevelopment in one group of countries is the result of development in another. He explicitly points out--

> "Economic development and underdevelopment are the opposite faces of the same coins. Both are the necessary result and contemporary manifestation of internal contradictions in the world capitalist system."[14]

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14. Andre G. Frank - "Capitalism and Development in Latin America", Monthly Review Press, 1967, (as quoted in Vic George op. cit.,p.-14).

Frank contends that the process of active underdevelopment began during the period of mercantile expansion of European countries in the sixteenth century, it was reinforced during the long period of colonialism and it has continued during the period of political independence by Third World countries, down to the present day. It is a structural situation through which developed and underdeveloped countries are inextricably linked in an unequal and exploitative relationship. It involves a triple form of related exploitation - economic, political and cultural - as a result of which Third World countries are mere 'satellites' serving the interests of the 'metropolis' i.e. countries in the capitalist industrialized world. This unequal and exploitative chain goes well beyond the international level into the internal system of stratification of every dependent country. The national metropolis exploits the regional towns, which in turn exploit the local centres and they in turn exploit the impoverished rural population. At any one time, the picture of the world consists of, according to Frank, a whole chain of 'metropolises' and 'satellites' which runs from world metropolis down to the hacienda or rural merchant who are 'satellites' of the local commercial metropolitan centre but who in their turn have peasants as 'satellites'. Each in chain extracts profits from the

'satellite' below it, keep some for itself and passes the rest upward untill it reaches the primary metropolis of the industrial country. These chain relationships are more than economic- they are also political and cultural - and they may vary slightly from one case to another though such differences 'do not obviate their essential similarity in that all of them, to one degree or another, rest on the exploitation of the satellite by the metropolis'.[15]

In conclusion, according to A.G. Frank the 'satellite-status' (industrial backwardness) is a consequence of the modernization process and not simply of lethargy or backwardness. It is his position that no peripheral country that has been firmly tied to the metropolis as a satellite through incorporation into the world capitalist system has ever achieved the rank of an economically modernized country, except by finally abandoning the capitalist system itself. A significant part of Gundar Frank's monistic thesis is that underdeveloped societies have managed spurts of modernization only during war or depression in the metropolitan centres which temporarily weakened their domination.

Another scholar whose work represents a very substantial extension of dependency theory is Wallerstein. In his

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15. Andre Gundar Frank - Ibid., as quoted in Vic George- op. cit.,p.-15.

'world-system' theory, the main focus of analysis becomes the world system rather the individual countries.

Wallerstein divides countries within the world system into three sub-systems, beginning with the inner ring of core countries and stretching out to the periphery with a small group of countries forming an intermediate tier which he calls the semi-periphery. It is possible for a small number of countries to move from the periphery to the semi-periphery and even to the core group of countries, though the later is extremely difficult and rare.

The concept of dependency refers to two related processes: first, the dependency of Third World countries on the few advanced industrial societies and second, the consequent conditioning of internal political forces so that, according to Frank, they are of very little significance or, according to Wallerstein, they are irrelevant to development. Whereas, another dependency theorist Cardeso, unlike Wallerstein and Frank, insists that the political forces within the country can be an important variable in its development.

Though Marxists have their reservation about Frank's reliance on trade relationships rather than on production relationships for explaining exploitation and they basically didn't comply with the use of pyramidal spatial relationships instead of class relationships to account for

underdevelopment, but they do not reject the essence of his argument. Other critics too do not challenge the essence of the dependency argument rather they merely assert that the dependency theory overemphasises the uniformities and underestimates the complexities of the structural pattern of exploitation.

In conclusion, the dependency theory provided a much needed corrective to the Western oriented modernization theory of development. Its central premise that development and underdevelopment are both largely the result of the same process- the exploitation of Third World countries over several centuries - is largely correct and holds its relevance in this present day unipolar global context.

ii) **MARXIST THEORY**

Though Marx and Engels wrote very little that referred explicitly to the underdevelopment of Third World countries, but in their scanty references to underdevelopment, they envisaged rather predicted that all countries, irrespective of their state of industrialization, would sooner or later be transformed into capitalist and eventually into socialist societies. Their five stages of evolutionary model through which according to them all countries would travel are - from slavery to feudalism, capitalism, socialism and finally communism.

The main driving force for social change in this evolutionary development is always the conflict engendered in the mode of production in the country's economic structure. It is the intensity of conflict within the economic structure of society that always determines in the end of onward march from one stage to the next.

Under capitalism, the conflict is between the two main contending classes in the economic structure, capital and labour- and it is this class conflict that will eventually lead to the peaceful or violent overthrow of the capitalist system and usher in a socialist society. Despite its destructive and dehumanising effects, capitalism has an overall progressive effect as the progenitor of socialism.

For Marx and Engels, this overall progressive role of capitalism was as applicable in Third World countries as in Europe. They claimed that the growth of capitalism in Europe will compel all nations, on pain of extinction, to adopt the bourgeois mode of production. Marx, further saw colonial industrialization as a very potent force for destroying peasant tradition and religious practices, for creating a modern railway system, for spreading literacy, for increasing economic growth and above all, for creating the necessary industrial conditions for the growth and politicization of an industrial working class. In one of

his dispatches to the New York Daily Tribune, Marx worte--

> "England has to fulfil a double mission in India: one destructive the other regenerating - the assimilation of old Asiatic society, and the laying of the material foundations of Western society in Asia".

In nutshell, Marx saw colonialism as both a negative and a positive force for development. It destroyed customs, beliefs, social relationships and the like, but it created the right conditions for industrialization and hence for economic and political change. Underdevelopment, therefore, is the result of insufficient rather than excessive colonial penetration as the dependency theory claims.

Marx's views on economic development had been criticised on the ground of being overoptimistic, even in politically independent underdeveloped countries. Again Marx's generalization about all societies passing through same stages has no evidence to sustain the claim. Besides, Marxist view of development underplays the importance of internal political factors, their theory of development also cannot explain the mounting international debt of so many Third World countries; nor the continuing famines and impoverishment of so many millions of people.

iii) **NEO-MARXIST THEORY**

Neo-Marxist explanation in the debate of development and underdevelopment has been an attempt to carve out a theoretical position that steers clear of both generalised overoptimism and overpessimism for Third World countries.

Neo-Marxists complied with the Marxists in terms of the evolution of the society(i.e. from feudalism to capitalism), but they did take note of upper class in Third World countries as not constituting a unitary one, like there is no unitary exploited class. Their basic contention was that the fragmentation of the upper class is being matched by a similar fragmentation of the oppositional class. For orthodox Marxists,the industrial proletariat was the legitimate oppositional class and were the vanguard of the socialist revolution. However, from Lenin onwards, the neo- Marxists had a tendency to upgrade the peasantry as the revolutionary class and to downgrade the industrial proletariat because of its partial incorporation into the capitalist system, earning it the description 'the aristocracy of labour'. And it was to Mao in China and Guevara in Latin America who relied heavily on the peasantry for their revolutionary activities.

Neo-Marxists contended that if neither the dominant nor the dominated class is unitary and if their composition varies from one Third World country to another, then the

nature of the state and the possibilities for socialist change are matters for detailed analysis of the economic and political situation prevailing in individual countries. It also has implications for the degree to which any one Third World country is dominated by the advanced industrial countries and by international capital, as they do accept that international capital both exploits Third World countries in a variety of ways and also distorts the development of class relations.

The strength of the neo-Marxist position lies in its emphasis on empirical studies within the theoretical framework of the mode of production. Avoiding unwarranted generalisations, it tries to show how the internal class dynamics of a country affect the nature of its development process. Though its excessive emphasis on the notion of class, overlooks the relevance of ethnicity, tribe, religion and such like groupings which to the politics of Third World countries is very significant and they cannot be subsumed under the notion of class without the latter losing its usefulness.

iv) **STRUCTURALIST THEORY**

Structuralist theory have been influenced by dependency and Marxist writings. This views underdevelopment in terms

of international and domestic power relationships, institutional and structural economic rigidities and the resulting proliferation of dual economics and dual societies both within and among nations. This also tends to emphasize external and internal 'institutional' constraints on economic development. Over the years there has been a shift of emphasis within this school of thought from a predominantly economic to a political economy approach.

Most of the writers in this group accept the importance of historical factors, particularly the period of colonization, as crucial in the understanding of the development and underdevelopment of nations. It is in this context Griffin writes--

> "Underdevelopment as it is encountered in Spanish America and elsewhere is a product of history. It is not the primeval condition of man, nor is it merely a way of describing the economic status of a 'traditional society'. Underdevelopment is a part of a process: indeed, it is part of the same process which produced development. Thus an interpretation of underdevelopment must begin with a study of past".[16]

Structuralist, at the same time, also contend that political independence has not brought to an end the direct and indirect economic domination of Third World countries by the advanced industrial societies. Trade relationships

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16. K. Griffin- "Underdevelopment in Spanish America" Allen and Unwin, London 1969, p.-49.

between the two sets of countries have continued to be disadvantageous to the Third World. Myrdal writes in this context-

> "Contrary to what the equilibrium theory of international trade would seem to suggest, the play of the market forces does not work toward equality in the remunerations to factors of production and, consequently incomes. If left to take its own course, economic development is a process of circular and cumulative causation which tends to award its favour to those who are already well-endowed and even to thwart the efforts of those who happen to live in regions that are lagging behind".[17]

Regarding the distribution of power within the Third World countries, structuralists, in general, agree that too much power is in the hands of small economic and political elites and that too little power is exercised by the mass of impoverished people. And therefore, Griffin points out that poverty can be eradicated only by changing the structure of those societies and not merely by minor reforms or by simply increasing the economic growth.

Furthermore, for structuralists incorporate land reform as pivotal to the improvement in Third World countries. Thus Myrdal argues that almost all the difficulties that have to overcome in order to apply more advanced forms of

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17. G. Myrdal-"Development and Underdevelopment", Fiftieth Anniversary Commemoration Lectures, National Bank of Egypt, 1956, p.-47.

technology in agriculture have a 'root-cause' in the system of unequal land ownership. Without such a reform, Myrdal insists that there is a little basis for a hope that all the other institutional reforms such as community development, agricultural extension and credit co-operation will not continue to become perverted to serve the interests of the better-offs.

The structuralists at the same time, stress the positive aspects of education, not only interms of technical-skills but also as a medium of change in attitudes towards health issues, the position of women and so on. For them, it is structure rather than culture which is determinant variable in the understanding of poverty and in the policies that are necessary for its abolition. Structuralist take their stand in a reluctant and vague optimistic manner on the living standards of poor in Third World countries, what they perceive will improve gradually, haltingly and unevenly. Rather they have a stronger feeling of pessimism for the immediate prospects of developing countries. In matter of future prospects of Third World countries, it has been argued that there is an interacting relationship between high rates of economic growth and lesser inequalities in society. One one hand high rates of economic growth make reduction of inequalities politically more feasible; and on

the other hand, a more equal distribution of resources within a country is a positive factor for high rates of national economic growth. Thus the interests of the poor and of poor nations are best served by policies that promote both greater equality and greater economic growth.

While comparing the structuralists with neo-Marxists the both agree that the dominance of advanced industrial societies is of crucial importance to the prospects of development in the Third World countries. But they disagree on the degree to which the industrial group of countries dominates and exploits the later. While comparing the structuralists with Marxists who rely heavily on class analysis, structuralist perspectives accept the importance of race, religion and such factors in addition to class. However, Marxists analyses do not discount the importance of non-class factors but they try, against all odds at times, to see them within a class framework. Whereas, structuralist perspectives do not deny the possibility of a relationship between class and other factors, but they do not make class the dominant factor at all times. But they both agree that inequality is a central component of both, the world system and the stratification system of individual countries, with the result that reductions of inequality are difficult, though not impossible.

Moreover, these all theories (Modernization theory, Dependency theory, Marxists theory, Neo-Marxists theory and Structuralist theory) deal with the phenomenon of underdevelopment in Third World countries from a particular standpoint. The underdevelopment in Third World countries is such a complex phenomenon that taking any particular standpoint would not be appropriate to the cause. Though with all its limitations each theoretical perspective contributes in volumes to the explanation of underdevelopment in Third World countries. But we have stuck ourselves primarily to the modernization theory, as in Indian context, it still holds its relevance and the essentials of this theory still influence heavily the work of the main international bodies of development--the World Bank and the International Monetary Fund (IMF) in particular. The policies adopted by the IMF in relation to the problems encountered by the Third World countries in meeting their debt repayments, what is termed as Structural Adjustment Programme(SAP), constitute an even more extreme form of the modernization theory. Thus the problem of Third World countries and the solutions proposed- reducing public expenditure, holding down wage rises and the like- have the general effect of protecting the interests of advanced industrial societies at the expense of the Third World.

Though it is not possible to deal with the SAP at length, but it would be desirable to look into the essence of SAP and its implications on the Third World countries.

3.3 STRUCTURAL ADJUSTMENT PROGRAMME

'The Big is Beautiful' model of development, on the pretext of modernization in Third World countries, pushed in the 60s and 70s, huge loans from the North which made poor countries more dependent on the global market with its ruthless ups and downs. By the start of 80s, as a result of giant development loans from Northern banks, poor countries were faced with a staggering foreign debt. Huge interest payments offset any benefits from economic growth and the Third World economics began to falter. Anticipating disaster, the banks got scared and withheld new loans. As a result, scores of countries went into a fiscal tailspin. Some announced that they simply could not pay. The Northern banks, with billions of dollars in loans to poor countries, were worried sick. And then the World Bank and International Monetary Fund came to the rescue. They gave 'bail-out' loans to allow poor countries to keep servicing their debts, and to promote economic recovery.

Thus it is the 1980s which will be remembered as the decade of global impoverishment linked to IMF and World

Bank's infamous medicine : 'The Structural Adjustment-Programme'. These programmes are being implemented in over 70 Third World and East - European countries, with devastating results. The IMF-World Bank sponsored Structural Adjustment Programmes have two phases . The short term macro - economic stabilization phase is followed up by the implementation of a necessary structural reforms phase In the early 1980s, IMF stabilization programmes focused on a narrow range of policies aimed at reducing account deficits. As the debt crisis deepened and it became obvious that the stabilization programmes were not working, the U.S. Treasury secretary, Mr. James Baker came up with a strategy to solve the debt crisis. This was called as 'Baker-Plan'. Under this plan, the World Bank was asked to impose more comprehensive conditions on the debtor countries in 1985. These conditions are known as - "Structural Adjustments". In 1986, the IMF set up its Structural Adjustment facility. By the end of 1990, majority of the countries that had received conditional loans from the IMF also received Structural Adjustment loans with harsh conditionalities from the World Bank.

3.4 THE STABILISATION PROGRAMME[18]

This programme consists of following 'fixed menu'--

1. Devaluation of the currency,
2. Curtailment of government expenditure in view of reducing the budget deficit including the dismissal of public employees and drastic cuts in social sector programmes.
3. Market liberalization within the national economy implying the elimination of subsidies and price-controls.
4. Compression of real earnings through the deindexation of wages and liberalisation of the labour market. Whereas wages are as much as 40 times lower than in the advanced capitalist countries, domestic commodity prices are pushed to their world market level.

THE SAP[19]

The implementation of stabilisation programme has been followed by the implementation of 'necessary' structural reforms. Adjustment measures were designed to 'stream-line' poor country economics, and to bind them into international

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18. "Structural Adjustment : Who Really Pays?", by Public Interest Research Group, Delhi, 1992.

19. David Werner-"The Life and Death of Primary Health Care or the Mc Donaldization of Alma Ata"-(paper presented at the National Conference on World Development Report 1993-Investing in Health on Dec. 8-9, 1994, J.N.U., New Delhi).

trade accords that favour big business and 'free-market' interests in the North. Structural Adjustment Programme has usually included the following measures :

1. Cutback in public spending,
2. Privatization of government enterprises,
3. Freezing of wages and freeing of prices,
4. Increased taxation, especially sales taxes,
5. Increase of production - including food-for export rather than local consumption.

As so often happens, these heavy - handed 'austerity' strategies is hitting the poor hardest. Budgets for health, education and food assistance have been ruthlessly slashed, while bloated military expenditure have been left untouched. Likewise, public hospitals and health centres are being turned over to the private sector, putting their costs out of reach of the poor. Falling wages, higher prices, food scarcity and increased unemployment due to governemnt lay-offs, all is jointly pushing low income families into worsening poverty.

The overall results of adjustment have been hotly debated. In some middle income countries, it appears to have helped stabilize the economics, although the human and

environmental costs remain in question. But in many of poorest countries, adjustment appears to have caused even greater economic stagnation.

In spite of overwhelming evidence, to the contrary, at first the World Bank flatly denied that Structural Adjustment has hurt the poor. More recently, the Bank has conceded that Adjustment may have caused 'temporary hardships' for low income families, but that such 'austerity' is necessary to restore economic growth. Ignoring the historical record, the Bank still seems to think that by helping the rich get richer, the benefits will somehow trickle down to the poor.But the evidence is strong, the Structural Adjustment; linked to the other conservative, neo-liberal trends in recent years, has caused far-reaching setbacks in the state of world health.

The World Bank in its public statements consistently points out that over the past 30 years, Third World health has steadily improved . However, these reports shrewdly omit or downplay the fact that in many countries improvement in health have slowed down or stopped since the beginning of the 80s. Indeed, in some countries rates of under-nutrition, tuberculosis, cholera and other indicators of deteriorating conditions have been increasing. And in a few countries, mortality rates appear to be rising.

In spite of all talk of development aid and poverty relief, in the 1990s more than $50 billion net flows each year from the poor countries to the rich. Today the income of the richest 20% of the world's inhabitants is 140 times as great as that of the poorest 20% .And the gap between rich and poor has grown 30% wider in the last 10 years.According to the UNDP, one quarter of the world's people do not get enough to eat.[20]

If we see in agricultural sector, despite all its promising potentials in India, the adverse effect of the implementation of SAP had been profound. Its undue emphasis on to earn foreign exchange through export of agricultural commodities which in turn can be availed for debt-repayment replaces our food crops for export crops. Once, about 43 percent of population is already living below the poverty line and a big section of society is suffering from starvation and hunger, this new development with market-friendly Structural Adjustment Programme would be beyond imagination. Besides this, agricultural commidities are sold on world-markets where prices are set in United States dollars under conditions of very imperfectly competition. The devaluation of a particular exporting country's (which is also a condition of SAP) currency, like Indian Rupees has no effect on

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20. David Werner-Ibid.

the (global) U.S. dollar price paid by buyers in importing countries. For such commodities no price advantage in export markets is gained by devaluation. However, the devaluation will accelerate local inflation as exporters pay more local currency for the same exports.

Adrian Fraser Questions this very notion of 'development'. He states--

> "We export what we produce and we import what we consume.
>
> There is nothing new in that ; it started with colonialism and slavery. The U.S. model we're being told to follow, now-relying solely on a free-market strategy and support for the private sector--leaves those structures in place. We don't have a private sector capable of promoting growth. So if we try to follow this model, the result will be more control from the outside, more extraction of wealth, more unemployment, and the sort of development forgets about people. Real development has to start with people".[21]

Then again we have GATT and agriculture. Earlier agriculture did not become part of the GATT negotiations because of any concern for the food-deficit-countries of the world . It was brought on to the GATT agenda because the U.S. suddenly found itself in competition with the EEC countries in the international agricultural trade. As long as the U.S. controlled a very large proportion of the market, agricul-

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21. Adrian Fraser-"Is This Development?", in "Structural Adjustment : Who Really Pays?"-op. cit., p.-48.

ture was kept out of GATT. The moment it realised that its supremacy was threatened, it started demanding that a set of rules should be evolved under GATT to protect its interests. Thus when the Uruguay Round negotiations began in 1986, agriculture came on to the GATT agenda. Once the government accedes to the GATT on agriculture a new era of the colonization of Indian agriculture starts. The colonizers would be foreign companies who would control the production and distribution of food grains seeds. The Indian farmers themselves would not be able to multiply the purchased seeds. If they buy milch cattle of an improved breed, the progeny of the cattle will belong not to the farmers but to the foreign company that originally sold them the cattle. Others measures implied in the GATT are meant to make our agriculture dependent and vulnerable to U.S. and European Economic Community (EEC) food trade policies. In case India accedes to the demands on Intellectual Property Rights (IPR) made by developed countries led by the U.S., it would lead to increase in seed prices, lack of adaptation of imported technologies and total dependence on transitional corporations, while preventing the large scale diffusion of the new plants and seeds in India. This would be nothing but forced globalization of Indian agriculture.

Hence, when considering these issues of political economy of 'development' and 'modernization'; it is appalling when Manning Nash writes that underdeveloped societies by the fact of being underdeveloped are incapable of modernization without the assistance from the modernized siocieties (i.e. the capitalist societies of the West). Further, the modernized societies have an altruistic attitude towards the underdeveloped societies.

Resuming the topic on agriculture, in the past 40 years, the thrust in Indian agriculture have been towards subsidisation of inputs, extension of markets and marketing facilities, provision of support or remunerative prices for products, and strengthening the banking systems. Besides, a number of legislations and regulations were introduced to protect the small and marginal farmers, and agricultural labourers. However, these legislations have remained on papers and the benefits of the measures have been taken away by the big farmers and landlords. In India, we have an unequal concentration of land ownership. The following data shows the distribution of operational holdings.

TABLE[22]-3

DISTRIBUTION OF OPERATIONAL HOLDINGS

Size of Holdings (in Hectares)	% Share in Numerical Terms 1985-86	% Share in Area Terms 1985-86
Marginal (below)	58.0	13.1
Small (1 - 2)	18.2	15.5
Semi-Medium (2-4)	13.6	22.2
Medium (4-10)	8.2	28.7
Large (10 and above)	2.0	20.5

The above table clearly shows the disparity in land holdings. Over 76 percent of the households with holdings upto one and two hectares own only 28 percent land and 10 percent of households owning 10 hectares of land own 50 percent of land.

Therefore, keeping in view this structure, the number of schemes launched from time to time for rural development in India since Independence--have though brought considerable change in the agro-economic scene of rural-India, yet the fruits of development have been shared unequally. Briefly commenting, that despite a rhetoric of equality,

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22. Public Interest Research Group - op. cit., p.-31.

governement land and tenure reforms, taxation policy and development expenditure--these were not effectively applied to such ends. The elites managed to disturb the distribution programme to reap the rural development and agricultural extension efforts. Various studies have shown that it was the privileged and not the under-privileged section of the rural society which usurped the lion share of the benefits (S. Tripathy[23], S. Jetley[24], Mehta Report[25], T.M. Dak[26] etc.) and therefore, as a result, the rural elite has become economicaly more powerful and politically more assertive and 'terms of trade' have moved decidedly in favour of richer farmers.

Therefore, the structural set-up of a society, as an internal factor, is a major impediment in the 'trickle-down' of the development fruits. And again it is to the structure of a society which has a determining influence on the health

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23. S. Tripathy-"Development for Rural Poor"-Rawat Publications, Jaipur, 1987.

24. S. Jetley-"Modernizing Indian Peasants: A Study of Six Villages in Eastern U.P."-Asian Educational Services India, New Delhi, 1977.

25. Ashok Mehta (Report)-" Panchayati Raj : Review and Evaluation Report of the Committee of Panchayati Raj Institutions". Government of India, Ministry of Agriculture and Irrigation, 1978.

26. T.M. Dak-"Social Inequalities and Rural Development"-National Publishing House, New Delhi, 1982.

status of its population. David Werner clearly mentions that--

> " The health of people - as individuals, as communities and as an endangered species on this fragile planet - is determined less by health services than by the relative fairness of social-structures".[27]

The analysis of the relevance of 'modernization' and all pros and cons of 'development' model, enables us to review its application in Health Sector in Indian context in the following chapter.

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27. David Werner-"The Life and Death of Primary Health Care". op. cit.

CHAPTER - 4

MODERNIZATION - ITS APPLICATION TO HEALTH IN INDIAN CONTEXT

Till now we have discussed the complexity and multidimensionality implied in the conceptualization of 'modernization' and 'development' and its relevance in general. Now before delving further into the trend of 'modernization' in the development of health service system in India which obviously has a bias in favour of urban against rural, a bias in favour of privileged against the underprivileged section of society, it would be desirable to recapitulate the linkages between health and development.

4.1 THE LINKAGES BETWEEN HEALTH AND DEVELOPMENT

The approach to development planning has been to create healthy individuals to participate effectively in the process of development. Productive manpower was considered as essential for socio-economic development and if people were to be productive, they must enjoy a satisfactory level of health. In other words, people were considered in terms of their economic value and the cost involved in raising their value. In fact, this approach did not realise that would not be health supportive.

Now looking at some of the reasons for improvement in health in a historical context -

In fact, there have been many studies which went into the question of how improvements in health took place. There is one view which considered such improvements on the basis of an understanding of the structure and function of the body and the disease process which affect it. This view was responsible for the establishment of and emphasis on curative care, building hospitals, developing new technologies etc.

This view had been challenged especially by medical historians based on experiences of advanced countries. Based on historical data, they suggested that improvements in health has occured more due to non-medical factors such as limitations of family size, increase in food supplies and a healthier physical environment. (Rosen, G.[1] & McKeown[2])

In the 19th century, there were five diseases or groups of diseases which contributed to the reduction in death-rate

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1. George Rosen-"Historical Trends and Future Prospects in Public Health" in "Medical History and Medical Care : A Symposium of Perspectives". Nuffield Provincial Hospitals, Oxford University Press, London, N.Y., Toronto, 1971.

2. Thomas McKeown-"Medicine in Modern Society". George, Allen and Unwin, London, 1985.

-- these were tuberculosis (45 percent), typhus, typhoid and continued fever (22 percent), scarlet fever (19 percent), cholera, dysentary and diarrhoea (8 percent) and small-pox (6 percent). The possibility of reduction in mortality independent of human intervention appears to be around one fifth of the total improvement in the case of tuberculosis which was the major killer during this period. This reduction in mortality was essentially attributed to environmental changes. These environmental changes were--1. Changes associated with a rising standard of living.

2. Hygienic measures such as safe water, sewage disposal etc. due to the work of sanitary reforms. The decline of mortality in the typhus-typhoid and cholera was largely due to the second change. In the case of tuberculosis, standard of living had been considered responsible for the decline. The effect of therapy or any medical intervention was restricted to small-pox. In the 20th century there have been further advances in the standard of living and control of physical environment along with introduction of effective therapy and social services.

Historical data shows that major improvement in mortality in Europe and North America occurred before the massive investments in health services. Economic development and social changes seem to have done more for health than the

intervention of modern curative medicine. It has to be recognized that the spread of health services has been accompanied by major extensions in other social programmes, cash benefits to help the poor, programmes for the weaker section for better housings, extension of education and a whole range of social support programmes.

Therefore, these issues have a strong bearing on the nature of health planning. It becomes an issue of economic and social planning, and not just of medical planning alone. The linkages between health and development is interactional. While healthy idividuals do contribute to economic development, this do not necessarily contribute to an overall social development and therefore the well-being of the individual. This especially so in an underdeveloped country characterised by illiteracy, unemployment, caste-class divisions, low women's status etc.[3]

It is therefore to the structural constraints of the Indian society which is the major impediment in the 'trickle-down' phenomemon of the fruits of economic development. The Indian society which is well characterised as a society with its own highly evolved set of social and institutional values and traditions, its high degree of culturally and

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3. K.R. Nair-"Health and Development" (yet unpublished), CSMCH, J.N.U., New Delhi, 1994.

religiously sanctioned social inequalities, the concomitant economic inequalities and the further inequalities developed as a result of the process of 'modernization' itself; the trend that we find in the present context, is biased in favour of stability and order for the benefit of an affluent minority at the expense of the majority. Health service system in India has not been an exception and therefore, modernization in Health has had the same bias. Hence, inequality in the health service system is a clear-cut reflection of the unequal structural set-up of a society. David Werner accentuates is this context that 'the health of people is determined less by health services than by the relative fairness of social-structure'. Hence, the inequality fostering trend of modernization brings into focus the unilinear concept of modernization, what we have drawn in the 2nd chapter which ecompasses besides economic development, equitable distribution and qualitative dimension of life (economic, political and social freedom) as well.

Though on the one hand, the determining influence of the social development on the health status of the people is well-established, on the other hand the development through modernization which has created various public health issues can't be downplayed. And therfore, Ashis Nandy comes down

critically and states --

> "In the name of science and development one can today demand enormous sacrifices from and inflict immense sufferings on, the ordinary citizens".[4]

4.2 HEALTH PROBLEMS AS AN OFF-SHOOT OF DEVELOPMENT.

In addition to an understanding of the positive impact of development on health, this becomes inevitable to consider the negative fall-outs due to the process of development itself. These occur largely through indirect channels, especially the changes affected in the environment due to development.

Industrialization is considered to be the essential feature of development through modernization, which in the process of contributing to material well-being of the nation also create negative consequences for health. These negative consequences mainly arise out of pollutions created during production or released to the environment. In the former case, it is the worker at work place who faces the adverse effects. Diseases caused by chemicals have been observed after high exposure in the work place. Examples are - different chronic lung diseases (silicosis, asbastosis, byssi-

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4. Ashis Nandy - (ed.) "Science, Hegemony and Violence : A Requiem for Modernity". Oxford University Press, Delhi, 1990.

nosis), kidney diseases (cadmium and mereury), diseases of central nervous system (organic solvents, lead, mercury, magnese) and malignant diseases of different organs (asbestos, arsenic, nickel, aromatic amines, benzene).

In the later case, the adverse impact normally occurs due to pollutants released to the external environment - water, soil and air. The Kalu river which runs through two of Bombay's industrial suburbs receives liquid effluents containing heavy metals from over 150 industrial units. This causes high levels of mercury and lead in the water near the villages. The villagers are increasingly exposed as the heavy metals enter the food-chain. The Ganga water pollution is largely due to the effluents from the industries located along the entire stretch of the river apart from the waste generated due to uncontrolled urbanization. Industrial accidents such as Bhopal gas tragedy which caused thousands of deaths and over 50,000 injuries is another fall out of industrial development. George Rosen had been very much perceptive when he claimed that 'the problem of the public health was inherent in the new industrial civilization'.[5]

Whereas in the agricultural sector which is another component of development, the negative fall out occur mainly

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5. George Rosen - op. cit.

from the use of pesticides in intensive agriculture. This has resulted in the contamination of acquatic resources. Residues of several pesticides have been detected in drinking water. Besides having the potential to cause chronic adverse effects on human health, the presence of pesticides in water sources also lead to resistance in vectors of water-related diseases. Exposure to chemicals and pesticides poisioning are most common among farm workers.

Besides this, major irrigation schemes for supporting agricultural development also lead to serious health problems. Irrigation development has often been associated with an increased incidence of vector-borne and water-related diseases. The major vector-borne diseases include schistosomiasis, malaria, Japnese encephalitis etc. Apart from these, increased levels of salinity, flouride etc. have also been detected due to new irrigation schemes. These problems are found in many areas in India where major irrigation schemes have been implemented.

Therefore, a new approach emerged called Sustainable Development, to grapple with these problems mainly occurring as a result of over exploitation of resources, depletion and degradation of environment due to uncontrolled and lop-sided development. Sustainable Development means--meeting the needs of the present without compromising the ability of

future generations to meet their own needs. Two concerns are vital - 1. Development to meet people's basic needs; and 2. ecological sustainability so that natural resources are not depleted or damaged. Meeting the needs of the present and future world population for food, water and energy without depleting resource base or creating adverse effects on health can be achieved only if the present pattern of development can be modified substantially.

In international context, the complexity of health development inter-linkages can well be understood in comparisions between developed and developing countries. However, even within developing countries there are exceptions such as China and Sri Lanka. These countries, despite their underdevelopment, have also achieved higher levels of health.

Though, income alone is an inadequate indicator of development, for comparisions, however, it has been often used because it is more easily measured than other aspects of development. A comparison of health indicators with economic indicators, with respect to different demographic regions shows that the countries or group of countries whose inhabitants enjoy the highest life expectancy tend to be those with the highest income per person. The following table shows the pattern--

TABLE[6] - 4

ECONOMIC INDICATORS AND PROGRESS IN HEALTH BY DEMOGRAPHIC REGIONS, 1990.

REGION	INCOME PER CAPITA (DOLLARS)	CHILD-MORTALITY	LIFE EXPECTANCY AT BIRTH
Sub-Saharah Africa	510	175	52
India	360	127	58
China	370	43	69
Other Asia and Islands	1320	97	62
Latin America and the Carribeans	2190	60	70
Middle East	1720	111	61
Former Socialist Countries of Europe	2850	22	72
Market Economies	19900	11	76

The limitation of equating the wealth of a society with its health can be seen when many exceptions among the countries or group of countries are being considered. The following table-5 of some selected developing countries brings

6. Source - World Development Report, 1993, World Bank, L.2.

out this discrepency. This shows the many countries where high life expectancy at birth has been achieved without a high per capita income and also several countries with high per capita income but a relatively low life expectancy.

TABLE[7] - 5

SOME SELECTED DEVELOPING COUNTRIES SHOWING LIFE EXPECTANCY AT BIRTH AND GDP PER CAPITA INCOME.

COUNTRY	LIFE EXPECTANCY AT BIRTH, 1990	RANK	GDP PER-CAPITA 1985-88	RANK
Hong Kong	77.3	1	14,010	3
Dominica	76.0	2	3,020	41
Israel	75.9	3	10,860	5
Cuba	75.4	4	2,500	52
Costa-Rica	74.9	6	4,320	26
Behrain	71.0	18	9,490	8
Sri Lanka	70.9	20	2,120	60
Qatar	69.2	36	11,800	4
Oman	65.9	51	9,290	11
Saudi Arabia	64.5	59	9,350	9
Libya	61.8	69	7,250	12
Myanmar	61.3	72	660	115
India	59.1	77	870	101
Pakistan	57.7	78	1,790	71
Nepal	52.2	97	770	104

7. Source - WHO. Report of the WHO Commission on Health and Environment, 1993, pp.-17-19.

Although the income per capita in China is only 370 dollars as compared to 360 dollars in India, the child mortality is only 43 while the life expectancy at birth is 69 as against 127 and 58 respectively in India. This shows that democratization, redistribution of resources, satisfaction of basic needs and health services based on simple technologies play a much greater role in health.

Sri Lanka is another positive model of overall development leading to better health status of the population. Self-sufficiency in rice and several other items of food has been a development objective of the highest priority in that country. The major beneficiary of the development programme has been the rice-growing peasantry. This programme helped to reduce regional disparities and inequalities among the classes. The efforts to increase productivity and transform the peasant economy was part of larger national programme in which satisfaction of basic needs received highest priority. A most important element was the programme for universal free education, an effective food-rationing system, and an emphasis on rural housing. The public transport system and a network of roads improved the accessibility of even remotest villages. The rate of economic growth in Sri Lanka has been between 4-4.5 percent per year over the three decades of 1950-1980. Although the rate of economic growth has been

higher than for most other low-income countries, it has not been adequate enough to provide sufficient employment for the growing work-force. Unemployment reached 24% in 1975, one of the highest rates among the developing countries. The Sri Lanka model shows that equity-oriented growth have implications for the.quality of life and health of the people.

Whereas in Indian context, the health status of the population in India as a whole presents a dismal picture, as in table-4 we see the Indian situation marked by the low per- capita income, high child mortality and low life expectancy at birth. These are the typical features of underdevelopment. Within this macro-situation, there are a few exceptions similar to what we have seen in the international-context. However, when development is viewed as an integrated and interdependent process between social and economic components, much of the analytical confusion with regard to inter-state differences could be cleared. In this view, the provision of health care is also considered as an integral aspect of socio-economic development.

The state of Kerala has drawn the attention of academicians and policy makers including a number of international agencies because from a narrow interpretation of development based exclusively on per-capita income, it was a paradox.

However, contrary to popular belief, Kerala is found to be more advanced than all other states in overall socio-economic development.[8] The current explanations attribute Kerala's achievements in health to discrete variables such as Women's status, literacy, health services utilization etc. Overall development in other sectors like communication, transportation, reliable source of power supply, literacy etc. is a precondition for effective organization and utilization of health services. It is not possible to apportion the credit for health status improvement between various aspects of development which are highly interdependent and inter-correlated.

Gujarat and Haryana present a different picture. Although the State Domestic Product (SDP) is very high, their ranking in terms of infant mortality rate is very low. Tamil Nadu with a low SDP performs better than the above two states. Table-6 shows a clear picture of disparities among the states.

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8. K.V. Narayana-"Regional Variation in Health Status - An Exploration into the Relative Role of Health Services and Socio-Economic Development in India". Ph.D. Thesis, CSMCH, J.N.U., New Delhi, 1991.

TABLE[9] - 6

DATA ON SOME SELECTED STATES REGARDING VARIOUS ASPECTS OF DEVELOPMENT AND HEALTH (1981, except Assam, 1971).

STATES	% OF POPULATION BELOW POVERTY LINE 1983-84 [ASSAM 70-71]	STATE DOMESTIC PRODUCT	IMR [RURAL]	PHCs PER 100 VILLAGES	% OF LITERACY	MEAN AGE AT MARRIAGE	BANK PER SQ. KM.	LENGTH OF SURFACE ROAD PER 100 SQ. KM.	% of VILLAGES ELECTRIFIED	NO. OF MANU. UNIT PER 1000 POPULATION
Assam	35.30	570	114	0.47	25.20	18.21	0.18	5.30	2.90	0.83
Bihar	51.35	958	124	0.87	17.17	17.08	1.52	14.72	31.80	0.87
Gujrat	33.10	2150	123	1.39	36.20	19.62	1.23	17.11	68.50	2.38
Haryana	15.90	2447	108	1.30	30.33	18.22	1.92	41.30	100.00	2.72
Punjab	10.87	2842	88	1.05	35.21	21.12	3.28	64.45	100.00	2.75
Rajasthan	36.63	1220	118	0.67	17.99	17.20	0.50	9.05	45.40	2.26
M.P.	50.30	1237	152	0.67	21.22	17.19	0.53	10.92	35.80	1.25
T.N.	44.08	1413	104	2.42	38.56	20.25	2.44	64.05	99.10	2.47
U.P.	46.48	1212	157	0.82	23.06	18.35	4.47	17.81	37.60	1.95
West-Bengal	43.84	1586	98	0.91	33.12	19.40	2.69	19.55	37.50	2.12
Kerala	51.80	1540	60	13.54	69.11	21.87	6.16	49.96	100.00	5.08

Thus, even within India we have diverse situations which do not warrant the application of any uniform model. They also rule out the possibility of piece-meal solutions to any socio-economic probnlem. Improvement in the health status of the people,.requires an integrated approach to deal with various socio-economic problems like poverty, unemployment, illiteracy, communication, women's status and ill-health.

After a discussion on the linkages between health and social development we find that economic development alone is an inadequate explanation to take the better health status of the people for granted. Rather it is the integrated socio-economic development which could promise a rising standard of the health status of people. Therefore, keeping in view the interactional linkages between health and development, it becomes an issue of economic and social planning and not just of medical planning alone. But the overall development planning so far, as much influenced by the modernization theory has provided lip-services to the underprivileged section of society.

Now we switch over to the modernization process in medical planning and trend of health service development in India. India, as we know, being a signatory of Alma Ata Declaration (1978) is committed to attaining Health for All

by 2000 A.D. through Primary Health Care Services. Primary Health Care approach seeks to provide universal comprehensive health care services relevant to the actual needs and priorities of the communities at a low cost in the rural areas through health infrastructure i.e. sub-centres, primary health centres etc.. Upto December 1991 - 1,3,0978 sub-centres; 22,059 PHCs and 759 CHCs were functioning. The posting of health personnel in these health centres has also been done. But it should be borne in mind that availability and accessibility are two issues which influence the health behaviour of people, as is well-established in Shaila Zurbrigg's Raku's Story.[10] Besides this most of the health-centres because of lack of budgetary allocation remain disfunctional. And therefore, notwithstanding a colossal accretion in health infrastructure and health manpower, the quality of life of the rural masses has not been adequately improved. Ironically the slogan of "Health for All" by the year 2000 A.D. remains a distant dream as the century is drawing to a close.

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10. Sheila Zurbrigg-"Raku's Story : Structure of Ill Health and Source of Change", Madras, 1984.

One of the principal reasons for this state of health of the people lies in the wrong priorities as far as resource allocation is concerned. The progressive reduction in budgetary allocation for health in successive Fivr Year Plans (as shown in the table-1 in the Ist chapter) exposes the double-speak of the state government. Health accounts only 2.1 percent of government expenditure in India as compared with 4.1 percent for all developing countries and 12.3 percent for the industrial countries; And even of this 2.1 percent, about 55 percent is spent on curative health care and medical education while the share of the public health services which are more relevant to the health needs of the millions of people, is just one-third of total expenditure. This political economy of health finds its expression in the very ideology with which Western medicine emerged and what we had inherited from the colonial period.

Looking back in the distinctive features of the mode of Western cultural impact on the Indian tradition in historical as well as substantive terms, we find, historically, the distinctive element was its gradual expansion through succession and replacement of various forms of Western traditions differing in political and cultural orientation and influence. The earliest (fifteenth and sixteenth century) contact was with the Portuguese; but in orientation,

their impact was proselytizing and predatory and brought with them pre-modern values and religious prejudices. They were followed by the Dutch and the French in the 17th and 18th century. Neither the Dutch nor the French had christianization as their main objective. The Dutch were mainly interested in commerce. The French had political goals, but their influence was marginal. It was only the British who finally emerged as a dominant power in India. The Western impact on the Indian culture has, therefore, been primarily of the British.[11]

This British impact has also a profound impact on health culture of indegenous people. Health culture, what Banerji defines as - 'the ways of dealing with the various types of health problems arising as a result of interaction between a human group and its surroundings is a part of cultural coping process. This process has three major interacting components-

1. Perception of various kinds of health problems and their impact on individuals and groups.
2. Development of cultural mechanism and institutions for coping with health problems.

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11. Yogendra Singh-"Modernization of Indian Tradition : A Systematic Study of Social Change". Rawat Publications, Jaipur, 1986, p.-85.

3. Action taken by individuals and groups when they encounter health peoblems - This interacting complex is termed as health culture.[12]

There are evidences that before the advent of Britishers we had a well-flourished health-culture with the culturally evolved indigenous system of medicine. But with the imposition of Western medicine in the colonial India the indegenous system of medicine received a set-back and once caught in the whirlpool it was bound to go into the oblivion.

Western medicine which has a pre-assumption of being scientific, was imposed upon the people under the patronage of state government and therefore, this left no scope for the indigenous practices which in the West view were 'unscientific' and 'irrational'. In Indian subcontinent, in one of his studies, Kalinga Tudor Silva cites an example about people's perception and indigenous dealing with malaria even prior to the introduction of Western 'scientific' ideas concerning the disease and its control in the dry zone of Sri Lanka. More specifically, his study explores the relationship between the relevant herbal tradition and Ayurveda,

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12. Debabar Banerji-"Poverty, Class and Health Culture in India". Prachi Prakashan, New Delhi, 1982.

which is generally viewed as the system of indigenous medicine common to the South Asia Region. He also explores the people's perception about the malaria and its linkages with the mosquitos, which people understood very well, and their way of dealing with it. His study found that the relevant herbal remedies and the cultural practices often constitute an effective adaptation on the part of humans to endemic malaria.[13]

Therefore the debate on the fore, along the recent resurgence of malaria in many parts of the world and the absence of any imminent technological breakthroughs that may enable the affected tropical countries to overcome the disease in the near future, is that a considerable attention should be focused on the re-examination of the efficacy of indigenous herbal remedies and the effect of certain cultural practices.

Now we take up the evolution of Western Scientific medicine, upon which the Health Service System in most of the Third World countries were founded, and then we alanyse its scientificity and rationality.

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13. Kalinga Tudor Silva-"Ayurveda, Malaria and the Indigenous Herbal Tradition in Sri Lanka". Social Science and Medicine, Vol. 33, No. 2, 1991, p.-153-160.

4.3 THE EVOLUTION OF WESTERN SCIENTIFIC MEDICINE

In fact, it was developed capitalist nations where the perception of clinical medicine emerged with the rise of industrial capitalism and its basis was provided by the Cartesian model of the human body and the germ theory of illness. Looking back to the evolution of Western 'scientific' medicine, we find that both the theory and practice of this medicine are inextricably linked with the society within which it has evolved.

Most accounts of the development of Western medicine reflect the split between theory and practice which has characterised the social scientific approach to medicine i.e. histories of medical thought have been produced in isolation from histories of medical practices. A brief outline of the development of the theory and practice of Western 'scientific' medicine, placed in its social and economic context would depict a clearer picture.

The Western 'scientific' medicine in fact, represents only one particular medical tradition. Although this, now being the dominant mode of mediation between individuals and ill-health, this has not always been the case. Indeed, it was not until the twentieth century that most of the population were able to obtain access to medicine on anything like a regular basis. Hence, in dealing with the early period of

the development of medicine, would in fact be, dealing with something which was relevant to only a minority of the population. Most healing and care of the sick was undertaken at that time on an informal or semi-formal basis, often by women. Their knowledge of healing was largely based on tradition, and involved the use of empirically-based 'natural' remedies such as herbs, as well as religious or supernatural methods like amulets, spells or prayer. The last two centuries have, however, seen the almost eclipse of these 'unscientific' methods and their supercession by modern medicine. And with the development of this medical domination healing became something for 'experts'.

The knowledge base of what we know as Western scientific medicine had its origin in the scientific revolution of the seventeenth century. The natural science which developed during the Renaissance, transformed the Aristotelian view of the world which had dominated Western thought for 1500 years. The new science increasingly equated an understanding of the natural world with a capacity to control it - a conception which came to fruition some two centuries later in the Industrial Revolution. And in case of medicine, the 'new-scientists' of the Renaissance began for the first time to map out in detail the internal working of the human body. These early investigations were founded upon a mechanistic

view of the nature of man, and of human sickness and health--following the more general pattern of Renaissance science in analysing living things as sets of mechanical parts - as machines rather than organically integrated whole. Philosophers like Hobbes and Descartes helped to lay the philosophical and methodological ground work for this model of human beings. Descartes, for example, argued not only that the human body must be assumed to work in the same way as a machine but also that the mind and the body of a given individual could be separated into two substances - one 'corporeal' or material and the other 'incorporeal' or immaterial. By and large, medicine came to be viewed as concerned only with the former and this mechanistic model remains the basis for medical thought today.

Therefore, it was this gradual replacement of the Aristotelian paradigm with its belief in the organic unity of living things, which ultimately made possible those aspects of medicine which have been genuinely successful either in preventing or curing disease (e.g. vaccination, antiseptic, anaesthesia or antibiotics) or in providing symptom relief. Thus, with the adoption of mechanistic paradigm of this kind, scientific medicine ultimately became curative, individualistic and interventionist, objectifying patients and denying their status as social beings. Jewson

categorisation of three basic stages through which scientific medicine has passed as corresponding to three successive modes of production of medical knowledge --
1. Bedside medicine 2. Hospital Medicine and 3. Laboratory Medicine[14] provide a useful means to understand both the development of medical thought and practice and also its relationship to broader social and economic changes.

'Bedside medicine' was dominant in Western Europe from the Middle Ages until the late eighteenth century. During this period, the 'new science' had made almost no impact on medical practice and the patron/doctor relationship was a very important determinant of the content of medical treatment. Patient was being treated as a whole person and whose account of symptoms and feelings was of major concern. All disease was basically assumed to be caused by a disturbance in the balance of the organism which included both mind and body. Hence the patients' own account of their condition was assumed to be of major diagnostic significance and all aspects of the patients' life to be of importance in understanding the illness.

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14. N. Jewson-"The Disappearance of the Sick Man from Medical Cosmology, 1770-1870'. Sociology, Vol.10, No.2, 1976. pp.-225-44. and N. Jewson-"Medical Knowledge and the Patronage System in Eighteenth Century England". Sociology, Vol.8, No.3, 1974, pp.-369-85 (as quoted in Lesley Doyal and Imogen Pennell-"The Political Economy of Health". Pluto Press, London, 1979.

By the beginning of the nineteenth century, a dramatic change had begun to take place in medical world view and in medical practice what Jewson has called 'hospital-medicine'. The unhealthy cities typical of the late eighteenth and early nineteenth centuries which were an offshoot of Industrial Revolution and the concomitant process of mass urbanization, paved the way for the establishment throughout Europe of huge hospitals to house the sick. Now patients were no longer dominant in the doctor/patient relationship. The doctors themselves were becoming more organised as a profession, and the working-class patients who entered hospitals were inferior in status to the doctors who treated them. Patients were no longer individuals with their own particular set of symptoms and problems but came increasingly to be seen as 'cases' - the disease became more important than the sick person. Hospital medicine then, shifted from a belief in disease as a disturbance of the total system to what is called 'localised pathology'. The vastly increasing sophistication in descriptive anatomy and pathology which occurred at that time, did not produce a corresponding sophistication in theraphy i.e. the growing social prestige of medicine was in no way matched by its therapeutic effectiveness.

It was during the same period i.e. the first half of the nineteenth century - that an interest in 'public-health' was also developed due to the devastating effects of wide-spread industrialization and urbanization. But the public health movement was not part of the mainstream of medical development, and only a few of its important activists were doctors. With the development of the germ theory of disease in the late nineteenth century, the emphasis in medical practice swung even more sharply towards the individual 'case'. This was the period of 'laboratory medicine' when doctors were able to probe even deeper into the working of human bodies, paying less and less attention to the social and economic environment within which these bodies lived their lives.

In the later half of the nineteenth century, with the final victory of the mechanistic world view the period of 'laboratory medicine' started. Now doctors were no longer simply observing the human body but were emphasising active intervention in human physiological processes. In the later half of the nineteenth century, both histology and physiology were developing extremely rapidly and the individual cell came increasingly to be seen as the central focus for understanding ill-health. This shift in emphasis produced an even more fragmented definition of sick person since it saw the

patient as made up not just of a set of organs, but of millions of cells. This cell theory and controlled clinical trials formed the basis for twentieth century developments in clinical medicine. However, at the same time, this form of 'biological-reductionism' widened still further the gap between doctor and patient. And above all, it reinforced the tendency to view the patient as an object to be manipulated - a trend which reached its apotheosis in past-war scientific medicine.

Therefore, we see between the late eighteenth century and the present day, medicine has been characterised by 'a shift from a person-oriented to an object-oriented cosmology'. Hence, complying with the mechanistic world view, ill-health now came to be defined by the 'experts' in terms of the malfunctioning of a mechanical system and treatment consists of sergical, chemical or even electrical intervention to restore the machine to normal working order. And health was defined negatively - as the absence of incapacitating and extremely verifiable pathology. This reductionist approach to define health and illness in a functional way was in fact, in consonance with the capitalist value system which defined people primarily as producers - as forces of production. It was concerned with their 'fitness' in an

instrumental sense, rather than with their hopes, fears, anxieties, pain or sufferings.[15]

That too, under capitalism, health is defined purely in an individualistic way. It is always individuals who become sick, rather than social, economic or environmental factors which cause them to be so.

This was the model of health and medicine which originated in the capitalistic world and upon which the very foundation of Western scientific medicine was laid. The driving force which is engrossed in the capitalist value system is profit-making which stands in stark opposition to the basic approach of public health. And therefore, health service system based on the Western scientific medicine could have suited only curative model and this has been so infact. Especially in a developing country like India, where the 43 percent of population are living below the poverty line, the brunt of its impact was borne by the poor and it has a direct influence on their health status.

No doubt, the emphasis on the individual origin of disease effectively obscures the social and economic causes of ill-health. Since the destruction of health is potential-

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15. L. Dayal and I. Pennell-"The Political Economy of Health". Pluto Press, London, 1979,pp.-27-36.

ly a vitally important political issue, therefore it cannot be downplayed--the medical emphasis on individual causation as one of the means of defusing this. In due course of time, the individualism inherent in the scientific medical model has taken a new and more powerful form. Ill- health is being explained in terms of individual moral failings - by blaming the victims for what has happened to them. Individuals are blamed for their own unhealthy life-styles means and moral exhortations to be healthier as well as self care and self-help are stressed as important future trends in health care.

This curative model of health care go in tandem with the capitalist value system as has been argued, in the way - the expansion of technological curative medicine has provided the basis for an expansion of an extremely profitable health care industry.

In conclusion, it was developed capitalist nations where the perception of clinical medicine emerged with the rise of industrial capitalism and its basis was provided by the Cartesian model of the human body and the germ theory of illness. Here the perception of human beings was totally individualistic and divorced one human being from another - a view that fitted well with the philosophy of classical liberalism and was compatible with the philosophy of Industrial Revolution and the rise of technology. Thus, the

curative kind of health services based on the clinical model of medicine provided momentum in the capitalist production as well. Therefore, many criticisms of medicine has taken the view that the mechanistic paradigm adopted by scientific medicine, despite many apparent successes, is in some sense 'wrong' because it individualises sickness and fails to consider the social factors which produce ill-health.

Therefore, inherent in the present context notion of medicine and health as Doyal and Pennell further point out, are three--but problematic assumptions--First, it is assumed that the determinants of health and illness are predominantly biological, so that the patterns of morbidity and mortality have little to do with the social and economic environment in which they occur. As a consequence, the solution to current health problems is seen to lie almost entirely within the framework set down by modern medicine and broader ideas of social changes are seen as largely irrelevant. Secondly, medicine is assumed to be a science. The way medicine is presented, and society's acceptance of its claim to authority and resources, rest to a considerable extent on its definition of itself as a natural science. Thus, it is assumed that it is possible to separate the doctor from his/her subject matter (the patient) in much the same way as a natural scientist is assumed to be separate from his/her

subject matter (the natural world) and medical progress is said to be based on the use of 'scientific method' which supposedly ensures certain and objective knowledge. Hence, it is usually believed that medicine, because it is 'scientific', can produce an unchallengeable and autonomous body of knowledge which is not tainted by wider social and economic considerations. Finally, underlying this common view of health care is a particular view of the relationship between medicine, health and society; namely the belief that scientific medicine provides the only viable means for mediating between people and disease. Medicine is seen as by definition 'good' - the only problem being that there is not enough of it to go round, and discussion therefore centres around how this body of scientific knowledge and technical skills can best be dispensed. There is a common belief that the problem of providing effective health care for all, like the problem of poverty, can ultimately be resolved through the natural processes of parliamentary democracy and pressure group politics. And this assumption is, of course, dependent on a broader conception of the nature of capitalism - especially on a belief in its capacity to solve social problems through economic growth.[16]

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16. L. Doyal and I. Pennell - Ibid., pp.-12-13.

After analysing the evolution of Western medicine which originated with the mechanistic world view divorcing one human being from another and inherent in it was capitalist value system which in no way could have paved the ground for public health operation - we intend to see now its advent in India. Western medicine was first introduced by the Britishers in the colonial India, when India had its own flourished health-culture with various well-established indigenous system of medicine.

Therefore, we take up the topic - "imperialism and medicine" to see the objective behind the introduction of Western medicine and its impact on the then existing health-culture.

4.4 IMPERIALISM AND MEDICINE

In India this Western 'scientific' medicine was first introduced by the Britishers in due course of their colonisation spree. In fact disease has always been a major obstacle to European Expansion - this became increasingly apparant during the seventeenth and eighteenth centuries as commercial activities intensified in many parts of the world. Long sea-voyages and the growing necessity for the large trading monopolies to post permanent staffs overseas were exposing their employees to greater hazards. The resulting high rates of mortality and morbidity among Europeans led not

only to the attachment of medical personnel to the merchant marine, but also to the gradual development of rudimentary hospital facilities at overseas trading posts by commercial organisations such as the East India Company. And these beginnings were to form the basis of the Indian Medical Service, inaugurated in 1764, which ultimately became a model for the organisation of medicine throughout the British colonial system.

The Indian Medical Service was run by the East India Company until 1885. Following the Indian Mutiny of 1857, the British government had assumed direct control over Indian affairs. The state was therefore given a strategic role-at that time unprecedented-in the determination of all aspects of social life. This made possible a gradual rationalization of health policies in accordance with the changing requirements of an imperialist economy. In fact, the medical department in the East Africa and Asian colonies had instruction firstly, to preserve the health of the European community, secondly to keep the African and Asian labour force in reasonable working condition and lastly to prevent the spread of epidemics.

David Arnold[17] whereas, comes out with the view that the spread of Western medicines has often been seen as an unqualified triumph, an emphatic justification for imperial rule. Imperialism, which is viewed as more that a set of economic, political and military phenomena, was in fact a complex ideology which had widespread intellectual, cultural and technical expressions in the era of European world supremacy. And therefore, imperialism can be understood only in their wider cultural context which had profound effects on dominant as well as on subordinate societies.

Medicine was itself seen as a primary vehicle for imperial ideas and their application, offering richly suggestive insights into the general character of European expansion. Medicine in imperialism highlighted it as an ideology as much as a practice. This particular way of viewing well illustrates the exploitative interdependence of metropole and periphery. Medicine and disease had a relationship of power and authority between ruled and rules and between colonialism constituent's parts. To the imperial mind, medicine was taken as a prime exemplar of the constructive and beneficial effects of European rule and as one of its most indisputable claims to legitimacy.

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17. David Arnold-(ed.) "Imperial Medicine and Indigenous Societies". Oxford University Press, Delhi, 1989.

Despite the fact that the initial impact of European contact itself had a disastrous demographic and social consequences for indigenous peoples and major health hazards itself was a by-product of colonialism, the proponents of Western scientific medicine came out with the victim-blaming approach. Even the epidemic diseases which had a profound devastating effect had, what some argue, been unwittingly introduced by Europeans and unleashed on societies without prior experience of their ravages and with pitifully little immunity agaisnt them. Arnold says in this regard --

> "Europeans forged new epidemiological links, either by relaying diseases (like smallpox and measles), long present in Europe or by establishing ties between parts of the world that had previously had few (if any) such connections with each other. The manner in which plague travelled from Hong Kong in 1894 to Bombay in 1896, to Cape Town in 1900 and Nairobi in 1902, and then to West Africa a decade or so later is indicative of the new facility of disease transmission opened up by modern trade, transport and imperial ties; and the pattern was repeated in even more rapid and devastating form, in the influenza pandemic of 1918-19. As well as the diseases themselves, European trade and transportation helped the spread of disease vectors, the mosquitoes, fleas and lice by which epidemics were communicated..... The way in which the 1918-19 influenza pandemic spread along these interior lines of contact and communication in Africa - through soldiers and mine workers, through markets and railway stations - was a striking demonstration of the degree of European com-

mercial and administrative penetration by the end of the First World War".[18]

To him further,

> .....in a colonial situation, where the cultural and political gulf between rulers and ruled was likely to be peculiarly acute, epidemics might variously be seen as a divine judgement on a benighted people or as a colonial malevolence unleashed against a troublesome race. The concurrence of epidemic catastrophe with European conquest deepened the bewilderment and trauma of conquest itself. The greater the white man's immunity, the greater the suspicion that he must be in some way complicit in the indigenes' misery and sickness".[19]

In the European conceptualization of indigenous society, disease had been a very potent factor. By the close of the nineteenth century European began to pride themselves on their 'scientific' understanding of disease causation and kept mocking the indigenous responses to disease what they saw as the fatalism, superstition and barbarity. Thus emerged, the discipline of 'tropical medicine' in consonance with the imperial idea of tropical world, as having a primitive and dangerous environment in contradistinction to an increasingly safe and sanitised temperate world. Hence disease became part of the African and Asian 'backwardness' just as medicine became a hallmark of the racial pride and technological assurance that underpinned the 'new imperial-

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18. David Arnold - Ibid., pp.-5-6.

19. David Arnold - Ibid., p.-7.

ism' of the late nineteenth century. Ill-health among indigenous peoples, therefore, fostered European's growing sense of their innate racial and physical superiority; and European medical attitude despite all its claim of medical objectivity, remained highly subjective, embodying the social and cultural prejudices of the age.

One of the several imperatives behind increasing Western medical intervention in colonies was out of the growing realization, which first gained recongnition in India during the course of the nineteenth century that the health of European soldiers and civilions could not be secured through measures directed at their health alone rather it was the existence of the masses of the 'sick' native population, by which the troops were surrounded, had a determining influence on their health. And therefore, it followed that the protection of European health could only be attained by measures that took Western medicine into the black towns and bustees. The other imperative was capitalism's internal contradiction between the pursuit of labour efficiency (i.e. worker's health) and the pursuit of profit which impelled European colonial regimes and the commercial and industrial-interprises that worked under them, towards greater involvement in indigenous health care.

But because of self-interested reasons for colonial concern, medical intervention was piecemeal and selective, with scant resources concentrated in areas vital to the operation of the colonial economic and administrative system. Thus, while the mine compounds, the plantations, the barracks and the main urban centres were favoured, there was a general neglect of the rural population and of the health of women and children. There was an imphasis on epidemic rather than endemic disease, and upon curative rather than preventive medicine.

Medicine was often regarded as a part of the ideology as well as the accountancy of empire. Even before the scientific breakthrough of the late nineteenth century, imperial powers were beginning to use medicine as a demonstration of their benevolent and paternalistic intentions as a way of winning support from a newly subject population, of balancing out the coercive features of colonial rule, and of establishing a wider imperial hegemony. Given the limited military and administrative resources at the disposal of the early colonial regimes, this was a potentially important weapon in the consolidation of imperial rule. But it was only in the closing years of the nineteenth century, medicine became a demonstration of the superior political , technical and military power of the West, and hence a cele-

bration of imperialism itself. It gave expression to Europe's faith in its own innate superiority, its mastery over man as well as nature. Medicine registered the imperial determination to reorder the environment and to refashion indigenous societies and economies in the light of its own precepts and priorities. Thus Western medicine came to be defined as rational, scientific and universalistic, in opposition to the presumed irrationality and superstition of indigenous medicine. The customs and beliefs of the people were treated as obstacles to be overcome, obscurantism to be brushed aside by the new scientific age. Therefore, it was the task of the medicine to uncover and counter the disease through the use of specific therapeutics and the social, cultural and economic context of disease was largely ignored.

Although, with all its claim of scientificity and rationality and state patronage to western medicine, the scenario in India had been different as far as the acceptance of the Western medicine by the indigenous people is concerned. Even after one hundred and fifty years of British rule, Western medicine was still struggling to establish itself among the people of India not perhaps due to the modern-traditional dichotomy but due to other reasons. The Western medicine could not penetrate the masses because of

the fact it had remained too closely identified with the requirements of the colonial state and so was remote from the needs of the people. In fact it had failed to make the transition from state medicine to public health. Another reason of its failure was that the mass of the population remained content with the innumerable and readily accessible practitioners of indigenous medicine - the Kaviragas, the Vaidyas and the Hakims - and either saw no reason to seek out Western -trained practitioners who were not available or were not affordable. The total scenario was as such, despite the influential patronage of the colonial state, and its own scientific claims and monopolistic aspirations, Western medicine could not get hold onto the masses and had had singularly failed to displace its indigenous rivals. Therefore, Western medicine is often seen as having had only a superficial impact on India, confined to the small enclaves of the army and the European community in India and, even as late as the 1940s and 1950s as having made little impression upon the beliefs and practices of the great majority of the Indian population.[20]

Though Western medicine met with little more than passive acceptance from the large majority of Indians whose

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20. David Arnold-"Colonizing the Body : State Medicine and Epidemic Disease in Nineteenth-Century India". Oxford University Press, Delhi, 1993, pp.-3-9.

lives it affected, it was gaining in prestige and popularity among the Western - educated middle classes. Therefore, in his concluding remakrs Arnold states --

> "Thus, the colonizing process of colonial medicine could never find their fulfilment in colonial hands alone. In the end (and that end was already foreshadowed by 1914) the future of Western medicine in india lay not with Europe's colonizers but with India's emerging elites. They had their own political programs and professional agendas to pursue, their own course to steer between "cosmopolitan" science and subaltern society. While some sought to tear down Western medicine along with the crumbling edifice of colonialism itself, many were beginning to see a more active, a more public-oriented, role for state medicine than colonialism had ever thought politically expedient or financially desirable. In the years after 1914, they were to take up Western medicine as part of their own hegemonic project".[21]

Thus during the Afro-Asian struggles for independence the position of Western medicine was ambiguous. On the one hand, some nationalists looked to a revival of indigenous medicine as part of a rediscovery of their own cultural roots and rejected the West's alien therapeutics. On the other hand, indigenous practitioners of Western medicine were often influential members of the nationalist class and colonialism was condemned for its stinginess in bestowing the benefits of Western medicine. Arnold argues that this

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21. David Arnold-Ibid., p.294.

very ambivalence was an indication of the strength of the impact imperial medicine had made upon indigenous societies.

Despite the fact, Western medicine as an imperial artifact was introduced and imposed in the nineteenth century India, which was an alien and state-oriented system of medical thought and practice presenting contrasts to Indian attitude and responses; at the dawn of independence, the model of independent India health service system was laid upon this Western medicine receiving full state patronage in the name of 'modernization' and this model in essence, had been an exact replica of the colonial India medical services. Despite all the rhetorics of Bhore committee Report[22] which envisaged a promising health service system for the rural masses, only lip-services has been discharged to meet out their felt-needs. This double-speak bears its expression in what Myrdal sees as 'Soft-State' policy. Banerji writes in this regard that during the anti-colonial struggle, to mobilise the masses, the leadership made promises to have an egalitarian system of government after independence was achieved. This mobilisation generated a process of democratisation, which was continued even after

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22. Bhore Committee Report-Health Survey and Development Committee, Govt. of India, Manager of Publications, 1946.

the country attained independence. However, this trend went against the interests of the new ruling class, which took over power from the British. This generated a counterforce in social studies. These opposing social forces led to the formation of what Gunnar Myrdal has termed as a Soft-State--egalitarian pronouncements not followed up with appropriate action. In the case of health services, in the wake of egalitarian recommendations of the National Planning Committee of the Indian National Congress (National Planning Committee 1949) and the Bhore Committee (Government of India 1946) of the pre-Independnece days, the successors government of independent India embarked on ambitious programmes for development, showing special concern for the deprived populations in rural areas. This was in the form of setting up Primary Health Centres for providing integrated health services as a part of the wider Community Development Programme, a social orientation of medical education, and special attention to programmes for protected water supply; other measures were improving nutrition, promoting the indigenous systems of medicine, the rapid extension of network of rural health services with deployment of a large number multi-purpose workers, culminating in the decision of 1977 to entrust people's health in peoples hands by providing one Community Health Worker for

every 1000 rural population.[23]

This soft state policy void of strong political will to meet the end, has resulted in a very dismal situation, what Banerji states further --

> "The existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and establishment of curative centres based on the Western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. The hospital-based, disease and cure-oreinted approach towards the establishment of medical services has provided benefits to the upper crust of society, specially, those residing in the urban areas. The prolifration of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas. Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of health care".[24]

In Colonial India, Western medicine which enjoyed full state-patronage left indigenous system of medicine caught in the whirlpool. In fact, unlike the industrial European countries, the colonial countries were plunged directly from a pre-industrial health-culture to a complex alien pattern of colonial based health-culture. The most devastating impact of colonization on the health arena was the degenera-

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23. D. Banarji-"Social Sciences and Health Service Development in India : Sociology of Formation of an Alternative Paradigm". Lok Paksh, New Delhi, 1986, pp.-12-13.

24. D. Banarji - Ibid., p.-14.

tion of pre-existing health cultures, some of which had attained an astonishingly high level of development for self-sufficiency in alleviation of the suffering, what Chattopadhayaya finds out in the case of Ayurveda in India.[25]

As a result, the masses of population were stranded in the choice between an alien and imposed Western medicine in which people had little meaning, and the rapidly degenerating indigenous system of medicine which they had developed earlier as a component of overall way of life. Thus was created a vaccum which was filled by faith-healers, sorcerers, magicians and other quack medical practitioners, who exploited the sufferings of the peoples for their own gains. Thus the proponents of Western medicine with all its claim for scientificity and rationality came forward with their victim-blaming approach, as Arnold writes --

> "Through their voluminous studies of medicine all illness, doctors and surgeons helped to form and give a seemingly scientific precision to abiding impression of India as a land of dirt and disease, of lethargy and superstition, of backwardness and barbarity-images which have remained so powerful even in the contemporary understanding of India - and to contrast this Orientalized india with the cool-headed rationality and science, the purposeful dynamism and the paternalistic humanitarianism of the West".[26]

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25. D. Chattopadhayaya-"Science and Society in Ancient India", Research India Publications, Calcutta, 1977, pp.4-9.

26. David Arnold-"Colonizing the Body". op. cit, p.-292.

This classical approach of victim-blaming is very much explicit in the studies of McKim Marriot[27], Morris Carstairs[28] and K.A. Hassan.[29]

McKim Marriot then a Fellow for the Ford Foundation in India, carried out his study in the village Kishan Garhi in Aligarh District of Uttar Pradesh in 1952. His analysis basically centres around the cultural problems involved in introducing what was considered to be more effective and scientific medical techniques, to a 'conservative' village.

In the same fashion Morris Carstairs then a Rockefeller Research Fellow from Cambridge University, conducted his study in 1951 and 1952 in two villages - Surajpur and Delwara - located in the extreme north of the then Udaipur State. His conviction was that to the people of rural India, sickness is as much a moral as a physical crisis and therefore, villagers holding on to 'nonrational' beliefs can scarcely be expected to change their whole cosmology simply to accord with the outlook of a Western-trained doctor.

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27. McKim Marriot-"Western Medicine in a Village of Northern India," in B.D. Paul (ed.)-"Health Culture and Community". Russell Sage Foundation, New York, 1965.

28. Morris Carstairs-"Medicine and Faith in Rural Rajasthan" in B.D. Paul (ed.)-op. cit.

29. K.A. Hassan-"Cultural Frontiers of Health in Village India". Manak-talas, Bombay, 1964.

This victim-blaming approach besides its other inherent biases, also neglects the fact--the issue of Western kind of training itself, as Todaro remarks--

> "Leading university intellectuals, trade unionists future high level government economists and other civil servants get their training in developed country institutions where they are unwittingly served an unhealthy dose of alien concepts and models camouflaged behind a smokescreen of excessive sophistication and esoteric irrelevance".[30]

During the post-war period, at the dawn of independence to india, with this assumption by the Indian government following the suit of modernization that Western scientific medicine provides the most appropriate means of coping with human disease; they reproduced a pattern of medical provision founded on Western medicine which was hospital centred, highly technological and dispensed on an individual curative basis. With this step-motherly treatment, the indigenous system of medicine which already was loosing its ground could not sustain the brunt and was bound to go into the oblivion. Therefore, this 'borrowed' modernization--emulating the West, raises the question of its relevance as discussed in the third chapter. Yogendra singh remarks that 'it may purely be accidental that institutions contributing to

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30. Michael P. Todaro-"Economic Development in the Third World", 2nd ed., Longman, New York & London, 1984.

modernity first developed in a culture other than one's own'--meaning, that every society has the seeds of modernity embeded in its cultural soil- the rationality behind this 'imported-modernity'becomes questionable.

Besides the curative model of health services, the very viability of Western medicine to deal with the problems created by the underdevelopment of health remains doubtful, as in essence it emerged with a reductionist paradigm and with a mechanistic world view, well-suited for a curative kind of health service model.There are of course, many health problems for which Western medicine can offer either effective therapy or valuable symptomatic relief. But it is realised that application of Western medical treatment under Third World condition may have extremely beneficial short-term consequences for the individual patient, it cannot reduce the high incidence of disease, nor raise the general level of health. In this regard Ivan Illich too has questioned the credibility of Western medicine. He states--

> "The medical establishment has become a major threat to health.The disabling impact of professional control over medicine has reached the proportion of an epidemic. Iatrogenesis, the name for this epidemic, comes from 'iatros' the Greek word for "physician", and 'genesis' meaning "origin". Discussion of the disease of medical progress has moved up on the agendas of medical conferences, researchers concentrate on the sick-making powers of diagnosis and therapy, and reports on paradoxical damage caused by cures for sick-

ness take up increasingly space in medical dope-sheets.The health professions are on the brink of an unprecedented housecleaning campaign".[31]

Illich name this kind of development as "iatrogenic epidemic". Furthermore,he points out that during the last generations the medical monopoly over health care has expanded without checks and has encroached on liberty of the people with regard to their bodies. Therefore, in due course society has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might become sick, and what should be done to such people. Further, Illich is of the view that the social commitment to provide all citizens with almost unlimited outputs from the medical system threatens to destroy the environmental and cultural conditions needed to people to live a life of constant autonomous healing.

Illich comes out with the conclusion that the medical and paramedical monopoly is a glaring example of the political misuse of scientific achievement to strengthen industrial rather than personal growth.

Ivan Illich's stand on 'scientific' medical profession should not mean that the physical and chemical laws governing disease mechanisms can simply be abandoned, but rather,

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31. Ivan Illich-"Limits to Medicine-Medical Nemesis: The Expropriation of Health", Marion Boyars, London, 1976.

that they must be seen to operate within a social and economic context which is constantly changing.

The curative health service system which has flourished as an 'industry' with all its sophistication and technocentricity, has made the masses of the Third World population more alienated and health for them a distant-dream. Therefore Claude Alvares states --

> "Despite all the sophisticated gadgetary, health remains a dream; in fact so expensive has modern medicine become that even the dream is fast receding in Industrialized countries".[32]

As far as the unifying principle of allopathy practice is concerned, on which India's medical development programme is based following its mechanistic world-view; it has its philosophy of treating illness by countering the indicators of illness. Thus, if high blood pressure indicates a disease, anti-hypertensive drugs are administered; if serious inflammation occurs on the body, surface anti-inflammatory medications are prescribed. Such a principle of treatment distinguishes allopathy from Indian or Chinese indigenous medical systems which rely less on external drugs and more on body's own regenerative powers, granted in principle by natural evolution to all living organisms.

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32. Claude Alvares-"Science, Colonialism and violence : A Luddite View" in Ashis Nandy (ed.)-"Science, Hegemony and Violence". op. cit. p.-99.

The most commonly used therapy in modern medicine, based on germ theory, is the use of antibiotics. But it is an established fact that the more powereful antibiotics are also more toxic to humans and can be as dangerous as a generalised infections. Penicillin, the first true antibiotic to be discovered, interferes with the cell-wall formation of certain bacteria, and bacteria cell-walls are different in important ways from human cell-walls. But, more powerful antibiotics are toxic to basic cellular processes - processes that is common in human and in bacteria.

It is however, resistance that ultimately defeats the purpose of antibiotics. By now it has been discovered that resistance to certain drugs can be transmitted directly from one bacterium to another, whether or not these were from the same genus. With such transmissions, there is a situation in which bacteria essential to life are capable of becoming pathological or disease-causing and resistant to whole range of antibiotics. Keeping this in view, there is one inference that the immune-deficiency diseases (AIDS) which have emerged in recent times are not unrelated to the increasing use of antibiotics. Disease of this kind, which involve the failure of the intricate and powerful natural defence systems that have evolved over many millions of years to

protect man and animals from disease, did not appear till after the use of antibiotics became widespread.

In this very context of negative fallouts of antibiotics Manu and Mehta quote J.A. Raeburn who has prophesied[33]---

> "In years to come, the story of antibiotics may rank as Nature's most malacious trick".

Manu and Mehta, further raise the issue of violence in modern medicine which is meted out to individuals with all its technocentricity and sophistication in order to cure them. Patient is merely seen as the battlefield where physician wrecks his vengeance on disease and death. The 'industry' of medical profession has flourished to its zenieth and now to such an extent it has hegemonised the world view that a normal individual who is at ease enters the medical laboratory and comes out as a chronic patient, though not at dis-ease but diseased.

With all these issues of negative fallouts of Western medicine and modern health service system, in some cases its value in effective therapy or valuable symptomatic relief can't be denied. What is important to realise is that while

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33. Manu L. Kothari and Lopa A. Mehta-"Violence in Modern Medicine" in Ashis Nandy (ed.)-op. cit., p.- 171.

those aspects of curative medicine which have been successful in the metropolitan countries have been predicated on the prior implementation of basic public health measures, in the Third World, curative medicine has become a substitute for public health and as a result, is inevitably much less effective. Moreover, the vast majority of people living in underdeveloped countries are currently denied access even to those curative services which would be of value to them. This arises because the priority given to curative medicine, focussed on hospital facilities has perpetuated the gross maldistribution of resources, characteristics of colonial period.[34]

Western medicine-which has inherent in it the capitalist value system according to Navarro, is in crisis as Western system of power is itself in crisis. Navarro believes that these crises are due to and reflect the crises of legitimization and capital accumulation of Western or contemporary capitalism, and that the crisis of the Western system of medicine is part and parcel of that broader crisis of contemporary capitalism. Therefore he states ---

> "....the pervasive process of industrialization, invading all spheres of our collective and personal lives, has transformed our societies into what one of indus-

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34. L. Doyal & I. Pennell-"The Political Economy of Health", op. cit.

> trialism's main theorists, Ivan Illich, has called "an engineering hell", an engineered nemesis in which feelings of powerlessness and alienation have become the main trademarks of our populations.
>
> And in the overall invasive process, medicine has not been an exception. Thus, the crisis of our Western system of medicine - reflected in its ubiquitos problems of costs, ineffectiveness and inequities- is attributed to its industrialization, by which highly technological medicine, controlled by the medical bureaucracy and technocracy, is becoming a source of harm and oppression, rather than,as it should be,a source of relief and liberation".[35]

These issues raised by Navarro has implications in the Indian context too. The sophisticated curative health centres which are mostly located in urban areas, has intensified the alienation process of already alienated underprivileged section of society. About 55 percent of budgetary allocation on health is spent on curative health care and medical education while the share of the public health services which are more relevant to the health needs of the millions of people is just one-third of total expenditure. Hence, we see that we have a watertight compartmentalization of urban health system, modelled on Western prototype vis-a-vis rural health system meant for public health; as we are having two sectors--Industrial vis-a-vis agricultural. The former in both the cases, have always got the state favour

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35. Vicente Navarro-"Crisis, Health and Medicine : A Social Critique ". Tavistock Publications, New York, London, 1986, pp.-19-20.

at the cost of latter, since the resources are limited - and that is in the name of modernization - (In case of Industrial Vs. Agricultural, we have seen the trend of resource allocation in 5 year Plans in the Table-2). As we see there is lopsided pattern in the health services with expenditure concentrated on sophisticated facilities in the towns, leaving the rural majority practically unserved- so there is an obvious bias in favour of urban against rural and hence a bias in favour of privileged against the underprivileged section of society where the affluent enjoy the health facilities similar to that of most people in developed countries.

Therefore, this inequality inherent in the health service system makes much more prominent the issue of 'equitable distribution' - drawn in our unilinear concept of modernization in the 2nd chapter, which also incorporates the issue of sensitivity to the qualitative dimensions of life.

Another issue which comes to the fore in this context is A.R. Desai's contention that modernization, which is an intrinsically universalistic phenomenon in nature and not an exclusive enterprise of capitalist Western world i.e. a by-product of industrialization; could have been fashioned on non-capitalist world too. Therefore, this pattern of mod-

ernization in health service system in India or elsewhere in the Third World country, could have guaranteed an equal opportunity of the health facilities to the population alike. With in the inequality-sustaining trend of present context of modernization, such as new economic policies and Structural Adjustment Programmes, there are perceptible changes accurring in the health sector also. This is in the form of World Development Report -1993 and the consequent policy changes in the health sector during 1994. The country has witnessed the same forces of inequality-catering 'modernization' with the gradual decline of budgetary allocations in certain subsectors of health. The Primary Health Care and "Health for All by 2000 A.D.", which could have resulted in a cohesive people-oriented promotive, preventive, curative and rehabilitative health service system remains a distant-dream and health of the masses a long drawn struggle. Moving along these lines would have created a non-capitalist answer to the issue of modernization of health care.

These policy changes have also led to further emphasis on curative hospital-based health services largely delivered through a private system and a deemphasis on public health and primary health care.

CHAPTER - 5

CONCLUSION

Health is based on the thin edge of 'being' or 'not being' and is not just mere absence of disease and global well being in order to work. It is intricately related to the social contexts and the very existence of people.

A health problem is not just a manifestation of disease conditions in uncontrollable dimensions rather it is a manifestation of certain limitations in the many ways of living of people. Limitations emanating from the economic, political, social and ecological ramifications which are complex and fragile in nature due to inter-linkages and inequalities entrenched within them.

Therefore, in the light of definition of 'health' endorsed by WHO which perceives it as 'a state of complete physical, mental and social well being and not just absence of disease and illness' - 'health' becomes a part of overall development and the linkages between health and development becomes interactional.

Hence, it is obvious that 'health' is not a function of medical care alone, but of the overall integrated development of society--cultural, economic, educational, social and

political. This is why the pattern or model of development largely influences the health status of population. We find that the recent trends in economic policies have gone back to the earlier growth models with an emphasis on free market and privatization of economy with an aim to achieve capital accumulation through exports. Along with this, however, there is also a cut on governmental resource allocation for basic services like health and education which were earlier the institutional life support system of the poor. Now they are to be considered only as a safety net. The impact of such changes have not been properly assessed although there are indications that it might worsen the condition of the underprivilaged.

Whereas, a synoptic view of the development theory and policy formulations reveals some fundamental issues which can be recapitulated as -

a. Economic development alone may not lead to better quality of life of the people.

b. Along with quantitative dimensions the qualitative dimensions of development also need to be emphasised.

c. The benefit of development do not trickle-down to the lower sections as evident from our developmental planning.

d. Redistribution of resources or distributive justice is an important aspect of development.

'Modernization' as one of the theories of development bears its relevance in the present context of developmental planning. It is more often than not emphasised that the economic growth following the 'Big is Beautiful' model put forward by the West, has to be emulated in underdeveloped countries. A review of various conceptualizations of modernization raises three fundamental issues, namely -- economic modernization, equitable distribution of resources and a greater sensitivity to the qualitative dimensions of life. But the essentials of 'modernization' theory which more or less is synonymous with the Western ideals of development still influence heavily the main international bodies like World Bank and IMF as clearly manifested in the new economic policy of liberalization imposed upon the Third World countries. In the health field and other social sectors, the responsibility of the state is deemphasised and the emphasis is on privatization of health care. Hence, once established that health is one of the basic indicators of quality of life and the basic goal of all development processes being the improvement of the quality of life--health status of people becomes the prime indicator on the measurement-scale of development. In a Third World country like India, 43

percent of population, already living below the poverty line cannot afford to keep pace with the private nursing homes. Under such conditions health status of people becomes the responsibility of the state. But the lip-services catered to the people to meet their felt-needs causes concern over the double-speak of the political leadership and exposes the lack of their political will power.

What constitute the main focus is the structural set-up of the society which is the main constraint in the trickle down phenomenon of the development processes. Economic growth, for instance, caters only to a particular section of society and at the same time sustains the status-quo. It has been established on the experiences of different countries that health status to a great deal depend on the distributive process, the degree of equity and the socio-political structures that enable people to articulate their needs and participate in social dicision making.

Since far, the approach to development planning, keeping in view the capitalist value system has been to create healthy individuals to participate effectively in the process of development. This approach in fact did not realise that this model would not be health supportive. Productive manpower was considered as essentials for socio-economic development and if people were to be productive they must

enjoy a satisfactory level of health. It means, people were considered in terms of their economic value and the cost involved in raising their value.

It is also realised that the capitalist production is itself a cause of ill-health in variety of ways - consequently any preventive medicine which has to be substantially effective, would need to interfere with the organization of the production process itself. Insofar, as curative medicine appears to deny or at least to minimise the need for such preventive measures, it serves to protect economic interests. Therefore, it is obvious that the function of medical organizations and the mode of production of health care are to a very large extent determined outside the health sector. In large part they are a reflection of the need of a capitalist system to sustain a particular set of social and economic relationships within the spheres of production and consumption.

It was colonial India, in which Western medicine was imported with all its mechanistic world view and inherent value system. And in colonial India, the medical establishment on Western medicine, as Arnold pointed out, has often been an emphatic justification for imperial rule and the Western medicine was used as an instrument to prove their curing potentials. The essence of colonial Indian medical

establishment still holds its relevance in the present context of global medical attitudes. In the Western capitalist countries, where medical profession has flourished as an 'industry', has hegemonised the world view and has encroached in our personal life as Ivan Illich puts it, in order to sustain their post colonial imperial rule. And therefore, this hegemonisation of medical world view, finds its expression in the dectates of IMF -WB on Third World countries, in the health policy formulations (through SAP etc.) which sustains the perpetual trend of 'modernizations' with its emphasis on curative model of health system and slashing down of the budgetary allocation for the public health.

The scholarship of the Third World has been forced to rediscover its own pre-colonial roots in its search for an alternative to imported Western intellectual styles and models.

In this way, therefore, 'health' becomes a political site of struggle between different medical systems and of shifting power relations between doctor and patient, within a social space that is already charged with inequalities and struggle. Official policy is mainly predicated on political choices and scanty bedgetary allocations never turn out to be enough. And the production of medicine and its practices,

like any other material activity, operates within relationships of power and privilege.

An historical analysis of health service development in India during the colonial and post-colonial periods underlines the important role of certain intrinsic socio-cultural forces which set a limit to possibilities of political action and purposive interventions to improve health services. These socio-cultural processes are embeded in the historical and ecological conditions of the country. These are - impact of Western medicine on the pre-existing health-culture, ecological consequences of colonial exploitation and plunder, limiting access of Western medicine to specific classes, using struggle for health as a component of the overall anti-colonial struggle and the post-independence changes in the power structure and their implications for health service developmenht.

Keeping in view the trend of modernization in the development of health service system in India which emphasises curative health service system, this is ironical that the diseases which are socially created i.e. whose roots are embeded in the socio-economic conditions of the people, have been tried to be tackled with the curative model of health services. For example malnutrition which is the glaring fact

of almost all the Third World countries and which simultaneously affects the immunity system of the children, highlights the underdevelopment of Third World countries. If this phenomenon of underdevelopment is seen in the light of Gundar Frank's 'Metropolis' vs. 'Satellite' theory, the vicious cycle of underdevelopment and social marketing becomes conspicuous. This is very much evident in the UIP - with its technocentric bias and reductionist approach (Banerji : 1990). What causes concern is that the established empirical linkages between disease and society are overlooked to meet conditionalities of external agencies.

In India, the diverse situation of health and development do not warrant the application of any uniform model. They in fact, rule out the possibility of piece meal solutions to any socio-economic peoblem. Improvement in the health status of the people requires an integrated approach to deal with various socio-economic problems like poverty, unemployment, illiteracy, communication, women's status and ill-health with a promotive, preventive, curative and rehabilitative model of health services. This would be an endogenous answer to the Western ideals of modernized health services system.

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