as part of the same project. After all, when the Congress transformed itself from a party of "secular socialism" to market liberalism (neo-liberalism), it required a cover that could give "economic reforms" launched by it, in India, a "human face." Having lost a large part of its support base in the 1990s due to these reforms, in the 2000s under the new political circumstances, the Congress invented that cover with the creation of the NAC. It exposed the lack of ideological clarity and intellectual capital within the party. So, bickering among different strands, especially under the crisis situation, was a natural culmination.

In the end, the book briefly discusses similar "credibility crisis" situations, and the then government's responses in some other countries, that are at a similar developmental stage as India. The argument brought out of the whole saga is, the "ideologies (of ruling elites) matter." The book forcefully concludes it, even though the author reaches this conclusion from a particular point of view that sympathises with ideas that have dominated the world discourse since the 1990s. The irony is that the book has come at a time when the legitimacy of those ideas is under severe challenge, as neo-liberal models have failed to live up to their promises. Consequently, an alternative understanding of democracy as well as corruption is gaining ground the world over. But the relevance of the book may survive this transformation as ideas would still, or even more, matter in the post-neo-liberal world.

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Untangling the Labyrinth of Health Inequities in India

INDRANIL MUKHOPADHYAY

> The underlying hypothesis (of the political economy of health) is that economic and political institutions and decisions that create, enforce, and perpetuate economic and social privilege and inequality are the root—or "fundamental"—causes of social inequalities in health.
>
> —Krieger N (2001)

Equity and Access: Health Care Studies in India
edited by Purendra Prasad and Amar Jesani, *India: OUP, 2019; pp xiv + 418, ₹1,195 (hardcover).*

An enquiry into the fundamental causes of social inequalities has fascinated public health researchers and policymakers around the world. The questions as to why gender-, class-, race-, and caste-based differences in health outcomes have been approached from various theoretical points of view—they have ranged from the structural to the cultural/behavioural explanations to the tendency to treat inequalities in health as an artefact. The framework put forward by the Commission on Social Determinants of Health (SDH) by the World Health Organization tries to synthesise some of these perspectives into a comprehensive framework. Prasad and Jesani (2019), in their edited volume titled *Equity and Access: Health Care Studies in India*, adopt a political economy approach to locate the changing nature of inequalities in health in India within and across social structures while critiquing the SDH framework.

Political Economy has its origin in classical economics where it was premised on the perspective that economics and politics cannot be separated. In healthcare studies, political economy draws its origin from a Marxist tradition influenced by the famous work of Friedrich Engels, *The Condition of the Working Class in England* (1845). The essence of the Marxist political economy of health is well captured by Krieger in the quotation at the begining of this text.

Despite considerable analytical potential to explain health inequalities, the application of the political economy approach is relatively rare in public health literature (Harvey 2021). Moreover, other non-Marxist theoretical traditions, including the Keynesians, neoclassical, institutional, and rational choice theories have subsequently used the term "political economy of health" in widely discrepant ways to address different sets of questions, thus leading to confusion. Further ambiguities have been created by crudely reductionist debate over "race versus class" within the Marxist tradition, even though there is a rich literature that tries to explain the relationship between capitalism and racism (Harvey 2021). Contemporary Marxist thinking on the political economy of health recognises that historically marginalised and oppressed people often face outsized material deprivation and compounded forms of discrimination and exploitation in the workplace and society writ large (Harvey 2021).

Even though Prasad and Jesani (2019) do not explicitly mention it, they have essentially adopted a contemporary Marxist approach of political economy, while also drawing from the feminist and Foucauldian critical discourses to demonstrate that social relations along the intersecting axes of race, ethnicity, sex, gender, sexuality, ability, and citizenship shape the power relations and the distribution of resources.

The book consists of 17 chapters, segregated into four broad sections, contributed by some of the leading thinkers of public health in India. The section titled "State, Market, and Health Care" demonstrates how social inequalities have been perpetuated by a series of health policy reforms. Historically, health policies in India have, as argued by the authors, served the interest of private capital and the elites—essentially reflecting on the class character of the Indian state. The section "Pharmaceuticals and Experimentation" exposes the vulnerability of the Indian state to the global policies and market in the realm of pharmaceuticals as well as biomedical and clinical research. The subsequent

section "Equity Issues in Health Care—Gender, Caste, Disability, and Violence" depicts the interplay of social institutions of patriarchy, caste and class, and the state apparatus to reproduce multiple axes of inequality. The section titled "Right to Health and Universal Health Strategies" explores the possibilities of addressing the inequalities through the frameworks of health rights and universal health coverage (UHC).

Bourgeoisie State and the Medico–Industrial Complex

Ritu Priya in her essay, "State, Community, and Primary Health Care," enquires into the reasons of failure of the mainstream health system to incorporate the essence of comprehensive primary healthcare in health programmes and policies in India. The author synthesises three strands of understanding—the liberal democratic analysis, the dialectic materialist analysis, and the politics of knowledge framework to explain the relationship between state, community, and the design of primary healthcare approach that was adopted. She argues that the elitist nature of the ruling class and the characteristics of the Indian state, which are not adequately democratic and welfarist, have led to the tendencies of over-medicalisation of healthcare under capitalism and the establishment of cultural hegemony of Western medicine. Priya brings out Foucault's examination of the links between state power and modern scientific knowledge to explain how state policies are dictated by the market forces, while voices, knowledge, and perspectives of the people get marginalised.

Priya observes that even the most progressive discourses on health, like the Alma-Ata Declaration, which proposes an alternative bottom-up approach to primary health, propose to have the role of communities and traditional practitioners as "trusted informal influencers of community health behaviour" while falling short of acknowledging the contribution of their own knowledge and skills (p 38). She brings in the framework of knowledge politics to point out the contradictions between the logic of big capital and integration of traditional medicine into the state-led provisioning of healthcare. A radical reorientation and democratisation of health policy cannot be completed without due recognition of the organic link between folk medicine, textual indigenous systems, and peoples' perceptions.

Rama Baru in her essay, "Medical–Industrial Complex: Trends in Corporatization of Health Services," delves into the root causes of consolidation of capital in healthcare. She explores the entrenched networks of power relations, the rise of business lobby and their influence on policy, and the role of state as an active agent to promote the market to explain the genesis of medico–industrial complex. Baru analyses the cases of Pratap Reddy and the Apollo Hospitals to demonstrate how the state played a critical role in providing all the subsidies and tax concessions for importing high-end medical equipment to establish the business of super-specialty care during the 1980s.

She points out that the healthcare industry is going through a rapid transition—growing partnerships between hospital chains and insurance companies, the dynamic nature of relationship between individual practitioners, small nursing homes, and corporate chains, along with the changing landscape of foreign investments due to the penetration of hot money into the healthcare system. She further argues that the nexus between politicians, real estate, liquor industry, and religious bodies are shaping the health policy and practices on the ground.

Elitist Roots of Medical Education

The lack of access to healthcare is structurally linked to the mismatch between medical education system and the healthcare needs of people. The tendencies of super-specialisation and lower priorities for primary care are intrinsically linked to the hegemony of Western medical education system on the one hand, and the expansion of private medical care and education system on the other. Neha Madhiwalla in her essay, "Social Roots of Medical Education," explores how the dominance of Western medicine system was established through the expansion of Western medical education in India and the role played by the metropolitan elites. She argues that the first generation of medical graduates were from the presidency towns, mostly Westernised middle class, who patronised colonial medical education. They settled down to practice where they trained, leading to the concentration of medical practitioners in cities, catering to the needs of the urban middle class while remaining largely oblivious to the primary care needs of the rural population. The practitioners of Western medicine, though few in number and marginal to the provision of primary care, had the political power to maintain the monopoly over the healthcare system.

Several authors have pointed out that the orientation of medical education largely remains disconnected from the healthcare needs of the population. The orientation of medical education has been geared towards super-specialisation and a greater dependence on high-end technologies and equipments. The growth of private medical education has perpetuated the urban elitist bias. The expansion of public-funded medical education system has largely remained limited. Thus, the potential role of reservation in bringing out greater inclusion and positive transformation to create an alternative to the commodified metropolitan model of medicine remains unfulfilled. Madhiwala argues that the institutional culture of medical education and practice is geared towards super-specialisation because the informal leadership of the profession continues to rest with the private practitioners located in the metro cities. Along with Madhiwala, Baru and Zacharia also make the same point in their respective pieces. The growth of private medical education as a lucrative business has fed on the willingness of the middle class to make large investments in professional education. Both Madhiwala and Zacharia argue that the expansion of private medical education remains the main driver of the interstate and rural–urban inequalities in the availability of medical professionals. It needs to be noted that the tendency

towards super-specialisation is intrinsically linked to the need of the market to discriminate its product from others to garner monopoly power and hence is essentially exclusionary in nature.

Zacharia uses the case of ischaemic and rheumatic heart diseases (IHDs and RHDs) to demonstrate how mindless applications of knowledge systems, structures, and practices derived from Western sociocultural contexts hinder the development of appropriate knowledge and practices in India. He argues that the orientation and emphasis of the discipline of cardiology revolve around the problem of IHDs. Private sector care for IHDs has centred on the metropolis catering largely to the richer sections. Whereas public hospitals do not have adequate specialists and neither do they invest on capital-intensive technologies, leading to considerable rural–urban and rich–poor inequities. The RHDs, even though they continue to affect a large section of the Indian population, remain neglected because in the Western world the problem declined even before cardiology became a specialty. Hence, the prevention and treatment of rheumatic fever did not receive the sustained academic and research attention required to eliminate RHDs in India.

Hypocrisies of Neo-liberal Reforms

Prasad, in his essay "Health Care Reforms: Do They Ensure Social Protection for the Labouring Poor?" argues that the growing inequalities in the access to health are a result of declining public investment in primary and secondary care, rapid growth of the private and corporate sector, and dependence on private out-of-pocket expenditure (OOPE) as a means of financing healthcare. Prasad points out that the consequences of OOPE on the labouring poor are quite severe as informal lending, distress sale of household assets, etc, are on the rise. He reviews the performance of eight central- and state-run general government revenue-funded health insurance schemes to argue that though these schemes claim to address the issue of the growing financial hardship, these reforms have been ineffective in improving access and reducing the OOPE. He points out that these schemes are essentially a form of public–private partnership where, in the name of better social protection, public resources are being used to promote the unregulated expansion of the healthcare market. Instead of reducing OOPE, these schemes have created opportunities for unethical care, unnecessary procedures, and over-medicalisation, thereby increasing inefficiency and costs. It is worth noting that the formal sector workers have earned their social security entitlements through struggles; the un-organised, non-unionised workers in the informal sector would gain health rights only as part of the general rights or in a manner in which the class interests of the capitalist system are retained and propagated.

The transformation of the Indian pharmaceutical industry into a prominent supplier of cheaper generic medicines for the developing world was an outcome of a pragmatic policy regime, which prevented exclusive monopoly rights over medicines. However, under the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement, India was obligated to amend its Patents Act and introduce a product patent by 2005. Amit Sengupta, in his essay "Globalization, Intellectual Property Rights, and Pharmaceuticals," brings out the political tussles around the Patents (Amendment) Act of 2005. He illustrates how the ruling dispensation was reluctant to build some of the key health safeguards like the compulsory licensing, parallel imports, and stricter patentability criteria into the act under the influence of the big pharma and the rich countries. However, the government had to eventually buckle down to pressure from the left in Parliament and incorporate these key amendments. The Patents Act of India, over time, became a model act and many developing countries introduced similar provisions into their acts. Sengupta demonstrates that despite having the provisions of compulsory licensing introduced within the act, the multinational pharmaceutical lobby has tried its best to prevent the use of its provisions.

Though India is regarded as the pharmacy of the Global South, as it provides access to cheaper generic medicines to millions of poor and vulnerable people in developing and developed world, a large part of the Indian population does not have adequate access to medicines and gets pushed into poverty as it has to incur heavy OOPE on medicines. Sengupta also discusses how under the new patent regime, the generic pharmaceutical industry is increasingly tying up with multinational companies (MNCs) to reach the global export market, while the policymakers, under pressure from the big pharma from the United States and European Union, are continuously promoting further liberalisation of the pharmaceutical industry. These tendencies are adversely affecting the structure and composition of the pharma industry in India. S Srinivasan and Malini Aisola, in their essay titled "Access to Pharmaceuticals: Role of State, Industry, and Market," point out that the lack of effective regulation and price control leads to the proliferation of irrational medicine production and prescription practices and corresponding escalation of costs of medicines.

Sengupta had always been vocal about the coercive tactics of big pharma to safeguard the interests of profit, often ignoring the huge human costs. Some of these tendencies are getting played out aggressively during the current pandemic and the united resistance of the developing countries against patent protection is getting systematically stifled. Had Sengupta been amidst us, he would have definitely been one of the strongest and the most passionate global voices of resistance—he is missed immensely within the health movement.

Under the Patents (Amendment) Act of 2005, in compliance with the TRIPS regime, multi-sited clinical trials were allowed in India in 2005. This opened up newer opportunities for the domestic clinical research community and led to the blossoming of the commercial clinical research industry, which depicts the classical political economy contradictions of powers and intellectual dominance. Roger Jeffery and his colleagues, in their piece "Structure, Organization,

and Knowledge Production of Clinical Trial Industry," argue that the domestic regulators and research organisations were largely unaware of the complexities involved in regulating the global clinical trial industry. As a result, the terms of participation for the Indian research community were set by their global counterparts in accordance with the global aspirations and standards. These arrangements provided the global pharma and trial sponsors with access to heterogeneous trial subjects and financial opportunities to contract research organisations (CROs). It also exposed a population faced with multiple socioeconomic disadvantages to further experience exploitation and vulnerabilities as the regulatory safeguards were either at a nascent stage or absent.

The authors tracked the websites of around 120 CROs to investigate their role and the scale of financial operations to argue that they have very little access to the key processes of knowledge production and largely remain engaged with the execution of the predefined research. There have been instances of violation of ethical principles and the safeguards of trial participants have been compromised. The point is also elaborated in the piece, "Body as 'Resource' in Surrogacy and Bio-Medical Research," authored by Sarojini Nadimpally and Vrinda Marwah. These instances have been brought to notice by the civil society and media. Consequently, the Supreme Court has brought about reforms to strengthen the safeguards. However, Jeffery and his colleagues note that some of the compensation clauses depart significantly from the existing standards in other countries.

Innovations for Marginalisation

The advancements in science and technology have led to the emergence of newer markets and innovative forms of exploitation of women's bodies throughout the history of human civilisation, and particularly under capitalism—commercial surrogacy being the latest form. The plight of surrogate women, depicted by Sarojini and Marwah in their piece, exemplifies how the health system thrives on the vulnerabilities of the working-class women and perpetuates inequalities. The doctors and the agents exploit the information asymmetries to co-opt the surrogates to enter into contracts that largely cater to the interests of the intended parents rather than the surrogates. In a globalised economy, working-class women are increasingly being pushed into work that is largely conforming their role as caregivers and is also more home-based and informal in nature with little social security. Commercial surrogacy further impinges on the reproductive rights of women and takes away their autonomy over their body and impinges on other forms of basic freedoms. In a way, by alienating the rights of surrogates over the child, commercial surrogacy equates childbirth with other commodities and services produced under capitalism where the worker who produces the output with her labour does not retain any rights over the product.

Madhumita Biswal, in her essay "Caste, Class, and Gender on the Margins of the State: An Ethnographic Study among Community Health Workers," explores how gender, class, and caste biases are perpetuated through the delivery of the health services by the state, even though the state tries to project itself to be working on the principles of universal rationality that transcends identities. The author brings out special and scalar hierarchies nested within the system of health services by the state through an ethnographic study of the accredited social health activist and anganwadi workers. On the one hand, these women frontline health workers act as representatives of the community and, on the other, act as an agent of the state, being present at the bureaucratic margin of the state apparatus. These frontline health workers, often belonging to the upper castes or dominant communities, promote discriminatory practices while performing their duties of catering to the most marginalised communities. The author quotes Gopal Guru's seminal work on untouchability to argue that these functionaries are able to retain their sovereignty over their domestic space through the creation of a dichotomy of space between public/private and domestic/state (Guru 2009).

Infirmities of UHC Discourse

Srinath Reddy and Manu Mathur, in their essay "Universal Health Coverage: How Viable?" bring out the various notions of UHC and clarify that health assurance and UHC should not be equated with publicly subsidised health insurance programmes that are currently in practice in India. They emphasise that a path to UHC in India has to be one with the central focus on a well-functioning health system with emphasis on SDH. This can be achieved with increased public investment in publicly oriented services, greater emphasis on primary care, and with a continuum of care established with the tertiary care services through a single-payer system to provide comprehensive healthcare. The authors have predicted that such reforms are likely to be resisted by those forces who stand to gain from a profit-driven system, including those within the public sector and private healthcare and insurance industry. They emphasise that through steady investments and systematic strengthening of the public system with increased capacity and quality, better governance, and greater accountability, it would be necessary to rebuild peoples' faith in the public system. According to the authors, UHC is a political battle that cannot be fought only through technical designing, and rather has to be fought on the principles of social solidarity and health justice.

Sunil Nandraj and Devaki Nambiar, in their piece "Kerala's Early Experience: Moving towards Universal Health Coverage," have examined the progress of UHC in Kerala, a state with levels of development similar to many high-income countries, to propose certain important pathways towards achieving UHC. They make a strong case for viable public sector-driven model with a greater focus on population-based strategies of prevention, early detection, and promotion as well as provision of quality care for acute diseases. This could provide an alternative to highly privatised and tertiary healthcare and reduce reliance on financial protection-based schemes. Ravi Duggal, in his essay "A Financing

Strategy for Universal Access to Health Care: Maharashtra Model," argues for a combination of increased public investment and an expansion of collective financing mechanisms like social insurance as a path to universalise healthcare access where public and private resources should be used to organise care around public values rather than the motivations of profit.

Kajal Bharadwaj, Veena Johari, and Vivek Divan, in their essay "The Right to Health: A Winding Road to Actualization," analyse the role of laws, policies, and litigations related to health, with a focus on the role of the Supreme Court in holding the state accountable for the provision of care and regulation of healthcare markets. They point out the compromising role of state, which arbitrates between public interest and private profit and continuously brings out policies in favour of the market and those who violate health rights; examples of HIV programme or free medicines programme in Tamil Nadu or Rajasthan demonstrate that despite repeated attempts to weaken the public sector, it can provide high-quality care. They argue that progressive realisation of the right to health requires a central role for the public sector, which needs to be strengthened and made accountable to people through popular struggles and movements.

This edited volume provides a comprehensive and multifaceted understanding of the structural causes of health inequalities, with fascinating insights, rich analysis, and diverse perspectives. Every public health scholar, every citizen passionate about bringing about progressive change in the Indian health system, and every well-intentioned policymaker should read this book. The fault lines of the Indian health system, its elitist biases, the insensitivities of the state apparatus towards the overwhelming majority of working people, its complete surrender to the interests of profit, and its deafening silence against irrationalities and exploitation of market that we have observed during the pandemic have already been highlighted in the book, even though it was written much before. The book is immensely relevant today—much more than ever before; it provides insights to avert such human calamities in the future.

The arguments presented in the volume could have been complemented with empirical analysis of the nature, trends, and patterns of inequities in India. The book could also have benefited if the editors had systematically presented the multiple forms of market failures that private, for-profit healthcare organisations bring into the system. Some of these structural deficiencies of the market are theoretically and practically impossible to counter unless a robust publicly oriented and publicly provided alternative healthcare delivery system is built on the principles of rights and democratisation. However, the political economy perspective brought about in this noteworthy volume clearly points out that such a progressive alternative system can only be realised through political struggles and a shift of balance of power in favour of the working class.

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REFERENCES

Doyal, L and I Pennel (1979): *Political Economy of Health*, London, UK: Pluto Press.

Engels, F (2009): *The Condition of the Working Class in England*, Oxford, UK: Oxford University Press.

Guru, Gopal (2009): "Archaeology of Untouchability," *Economic & Political Weekly*, Vol 44, No 37, pp 49–56.

Harvey, M (2021): "The Political Economy of Health: Revisiting Its Marxian Origins to Address 21st-Century Health Inequalities," *American Journal of Public Health,* February, Vol 111, No 2, pp 293–300.

Krieger, N (2001): "Theories of Social Epidemiology in the 21st Century: An Eco-social Perspective," *International Journal of Epidemiology*, Vol 30, pp 668–77.

Prasad, Purendra and Amar Jesani (2019): *Equity and Access: Health Care Studies in India*, India: Oxford University Press.