

Moving toward reform? Mobility, health, and development in the context of neoliberalism

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Abstract

We explore one aspect of the relationship between migration and development: how return migrants and people who have worked or studied abroad for various lengths of time influence the health sector by bringing or sending back social remittances—ideas, practices, and know-how. Our findings are based on fieldwork in Gujarat, India. The organizations we studied and the people who work for them are embedded in both secular versus religious and highly structured versus loosely organized networks. We expected, therefore, that these returnees, and the organizations where they work, would be exposed to and appropriate different aspects of global public health. Instead, we found, that over time, their understanding of health and health care delivery became increasingly similar. Despite the different religious beliefs and philosophies of development motivating their work, how each organization understood health and how to provide it ultimately incorporated many aspects of neo-liberalism. This approach is so pervasive, and the institutions that disseminate and finance it so strong, that most providers cannot ignore it.

Keywords: international, migration, development, return, social remittances, mobility, health

1. Introduction

The world is on the move. One out of every 33 persons in the world today is a migrant (IOM 2011). There are an estimated 214 million international migrants worldwide, up from 150 million in 2000 (Terrazas 2011). According to the World Bank, in 2010, remittances sent through official channels totaled over US \$440 billion worldwide. In 2009, remittances equaled more than 10 percent of the Gross Domestic Product (GDP) in 24 countries; in nine countries they accounted for more than 20 percent of GDP.¹

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Both sending and receiving states are waking up to these dynamics and creating new ways to encourage long-term membership without residence and forms of participation that do not require full citizenship. The fact that so many people are mobile, and that state and non-state actors are taking on new functions and shedding old ones in response, means that migration is not an independent or autonomous aspect of development. Rather, development planners and policy makers need to consider migration as a central cause and consequence of development (Castles and Delgado Wise 2008, de Haas 2008, Goldring 2004, Mazzucato 2011).

But money is not the only thing circulating between sending and receiving countries. One aspect of the migration—development nexus that has not received sufficient attention is how the ideas, practices, and know-how or social remittances which migrants send back to their home countries influence development. Individual social remittances are the ideas and practices that migrants introduce to their family members, neighbors, and friends. Collective social remittances are the comparable skills and know-how individuals communicate to each other in their capacity as organizational actors (Levitt and Lamba-Nieves 2011).

We explore these questions by focusing on how social remittances influence the production and management of health. Specifically, we ask how mobility influences ideas about health and health care provision in Gujarat State, India. We focus on two mechanisms for these exchanges: the actual circulation and return of health professionals and the enduring linkages they maintain to people and institutions in the places they return from. The organizations we studied included the People's Religious Service Committee (PRSC), a religious organization which runs hospitals and clinics as part of its mission; Zenith, a private hospital chain; Health Care For All (HCFA), an organization established to strengthen public health in India; and the Rural Health Care Association (RHCA), an NGO with religious roots that provides health care in rural and tribal areas.²

These organizations and the people who work for them belong to distinct social networks. All are private, although HCFA is actively involved in training government health care workers. PRSC and RHCA are strongly connected to religious traditions, while Zenith and HCFA are secular organizations. The networks within which PRSC and HCFA operate are, by and large, informal and loosely organized. Respondents at Zenith and HCFA often belong to more formal, bounded professional and academic networks. We therefore expected that each organization would be exposed to and would appropriate different pieces of what we call global health assemblages. We found instead that over time their approaches to health and health care delivery become increasingly similar. Despite the very different religious beliefs and philosophies of development driving these organizations, their understanding of health and how to provide it is based increasingly on a neoliberal health assemblage. The assemblage is so pervasive, and the institutions that disseminate and finance it so strong, that most providers cannot escape its influence.

Before proceeding, we want to say a word about what qualifies as migration. Many of the debates about the relationship between migration and development focus on long-term migrants who have actually returned. Indeed, our original intention was to concentrate on people who lived abroad for at least three to five years and then returned to India. While many of the staff we interviewed lived overseas for much longer periods, and some left intending never to return, it soon became apparent that even short stays overseas

profoundly changed how people think about and provide health. We therefore broadened our notion of ‘length of stay’ to include short-term migrants or people who went abroad for brief but intensive experiences abroad. They too bring back many important skills and knowledge which influence the migration–development nexus.

Our findings also call into question the idea of return. While many of our respondents came back to resettle permanently in India, they still maintain strong contacts overseas. Because they are still deeply embedded in transnational social fields, and they are part of the networks that constitute them, they maintain contacts with people and ideas from abroad. One respondent, for example, continued to teach for three months each year in the USA. Others retained strong ties to their former classmates and professors through alumni networks or research collaborations. The networks they established, and the flows of new ideas and practices that circulate through them, do not stop when they return. They come back physically but, in many ways, remain intellectually and professionally abroad and are, therefore, a continuous source of ideas and practices. It is not just the actual circulation of people, therefore, that drives forward changes in the health sector but also the accompanying circulation of ideas and practices within the health care institutions and networks to which they are connected.

1.1 Literature review

When such large numbers are on the move, health and health care are increasingly globally produced. In 2009, only two months after it was first identified, the H1N1 virus infected people in all 50 US states and 70 countries around the world (CDC 2010). Nearly a year later, the World Health Organization (WHO) reported that the virus spread to more than 214 countries and overseas territories and resulted in 18,036 deaths (WHO 2010). The spread of global disease requires a global response. As Magnusson (2007: 1) writes: ‘Responding to the global burden of chronic disease requires a strategic assessment of the *global processes* that are likely to be most effective in generating commitment to policy change at country level, and in influencing industry behavior.’

Medical tourism is also on the rise. According to Harvard Business School professor Tarun Khanna: ‘We used to move the input around, and make doctors go to new locations outside their country of origin. But in many instances it might be more efficient to move the patients to where the doctors are as long as we are not compromising the health care of the patients’ (Lagace 2007). In 2005, an estimated half a million Americans traveled abroad for health care. In the following year, the global medical tourism industry grossed about \$60 billion (Herrick 2007). In India, medical tourism is especially strong. In 2004, the country hosted 1.2 million medical tourists. Of the estimated \$4.4 billion earnings projected by the industry in 2012, about half will go to India.

And while some patients travel internationally to get care, even more health care workers migrate. As of 2004, eight percent of registered nurses in the UK, four per cent of those in the USA, and 23 percent of those in New Zealand trained abroad (Aiken et al. 2004). These migrants can contribute to brain drain—the loss of important skills and know-how, especially when they have been educated and trained in sending-country institutions before moving abroad. Developed countries also export medical professionals, however. In 2007, American-trained physician assistants worked in Australia, Canada, England, the

Netherlands, and Scotland as expatriates (Hooker et al. 2007). Because US medical professionals invented the physician assistant position, these trends reflect not only how personnel but also how models of health care provision and management travel.

When patients and providers circulate around the world they bring disease, ideas, practices, and know-how with them. Migrants who maintain strong homeland ties and social networks, or who return after short or long stays abroad, medical practitioners or not, also carry ideas about health and health care provision. These social remittances potentially influence the health care sector and the relationship between migration, development, and health. They also circulate within the context of the increasing globalization of the health care sector. Not only are diseases, health care workers, and patients traveling, but health care governance, financing, and research falls increasingly under the purview of international organizations like the WHO or the Gates Foundation. These institutions create and spread global goals, institutional arrangements and strategies (such as the Millennium Development Goals) at the macro level while individual migrants drive these exchanges on the ground.

Our study employs a transnational optic (Khagram and Levitt 2007). We see the people and organizations we study as potentially embedded in transnational social fields constituted by cross-border, interlocking networks of individuals, institutions, and regimes of governance (Levitt and Glick Schiller 2004). We want to specify what Ong calls an ‘analytics of assemblage’ over an ‘analytics of structure’, which means focusing ‘on the emerging milieus over the stabilization of a new global order—not a fixed set of attributes with predetermined outcomes but as a logic of governing that migrates and is selectively taken up in diverse political contexts’ (Ong 2007: 3). Assemblages are ideational and material packages of people, who are often elites and/or experts, objects, technologies, laws and policies, and formal and informal institutions that circulate widely through transnational social fields (Ong and Collier 2005). Although they are dynamic, shedding and accruing elements as they travel, a certain core can be identified, which is reshaped each time new items fall off and attach again (Levitt and Merry 2009).

Broadly speaking, our field-work in India revealed three types of assemblages. The first can be described as *neoliberal*. It favors privatization or public–private partnerships as the core of health care provision and financing and employs corporate management practices that emphasize efficiency, cost-effectiveness, professionalization, medicalization, and credentials. Economic efficiency is stressed more than equity. From this perspective, overall development and the market will allow people to purchase the health care they need and can afford from well-run, cost-effective health care providers. In terms of national health care models, the US system most closely embodies this assemblage.

The second can be described as a *welfare state assemblage*. Although it shares some commonalities with the neoliberal model, such as its focus on curative rather than preventive care, it differs in support of a greater role for the state and placing more emphasis on access to affordable care and covering vulnerable populations. This model is embodied in the health system of many European countries, although there is considerable variation and, in recent years, a general trend towards outsourcing services and emphasizing efficiency.

The third assemblage is less clearly defined and includes a number of more loosely connected ideas and practices. Because it emphasizes the connection between health and

other aspects of development, we call it an *integrated health assemblage*. It favors more local, public health oriented, and preventive approaches to care that emphasize basic, low-cost, and simple solutions provided by low-level health workers in non-institutional settings. Because health is understood to be one piece of a larger development package, health care often goes hand in hand with education, job training, or income generation programs. Social justice, equity, and sustainability are stressed over short-term efficiency and cost-effectiveness. In this model, the state still plays an important role as service provider and skill builder, although often only partly through public–private or state–non-profit partnerships.

On the whole, the neoliberal and welfare state assemblages our respondents described form the building blocks of a generic medical system that is supposed to be suitable everywhere and can be held to universal standards of efficiency and productivity. Health means freeing people from disease and allowing them to live as long, independently, and actively as possible by providing preventive and curative services. People should be able to purchase the cosmetic and elective interventions they can afford. They should have access to the most modern, state-of-the-art services. Care is provided in institutionalized settings that grow increasingly sophisticated as they move from rural to urban areas. The physician is the key decision maker, although some tasks may be delegated to less-skilled practitioners. Technology is privileged over clinical skills. Institutions and their staff should be accredited according to international standards. The Patients' Bill of Rights also helps ensure that patients receive a certain standard of care. Services are managed with efficacy and efficiency according to standard protocols, although management hierarchies can be flattened to encourage innovation and creativity. Insurance schemes are the wave of the future. In general, efficiency trumps equity because, the thinking goes, as more and more people purchase care, the state will be freed up to provide for the poor and improve the quality of care because of heightened competition.

All three global health assemblages relate in complex ways to the agendas of national governments and to the health-related programs of international institutions like the United Nations, the WHO and the World Bank. Global philanthropic organizations such as the Ford, Rockefeller, Gates, and MacArthur Foundations, as well as the Canadian International Development Centre and others, have also been active in promoting certain types of global health ideas and practices that reinforce particular assemblages. This is the prevailing repertoire from which global health is produced and provided (Swidler 2009). When health professionals work and study abroad, they are exposed to aspects of these assemblages because they are widely disseminated by the programs and institutions where health workers work and train.

Among our sample of health organizations in India, we found that the neoliberal assemblage clearly predominates because it resonates so clearly with the marketization and privatization going on in the country as a whole. Whether they attended Masters in Public Health programs in the USA, Australia, or the UK or they worked in large public or private hospitals, our respondents were consistently exposed to the language of management efficiency, neoliberalism, evaluation, and privatization. As a result, despite the very different religious beliefs and philosophies of development they began with, their understanding of health and how to provide it ultimately looked remarkably similar. The kinds of services these four institutions offered, their organizational charts, and the approaches to

development that underlay their choices shared much more than they differed. Even HCFA, which started out firmly committed to the integrated health assemblage, took on aspects of the neoliberal model. While the staff members we interviewed regularly expressed reservations about its suitability to the Indian context, they could not escape adopting its basic parameters.

1.2 The Indian context

In the early 1990s, the Indian government liberalized restrictions and opened the economy to foreign investment and trade. The state also withdrew from various industries, thereby paving the way for privatization. As a result, India experienced unprecedented economic growth. According to Ahuja (2006: 3): ‘Reforms undertaken after the 1991 fiscal crisis . . . lifted India from decades of slow growth under socialist rule’. New jobs created by outsourcing, new Indian hi-tech companies, and foreign investment expanded the ranks of the middle class and fueled their consumption aspirations. Stories of ‘new Indians’ who got rich quick and enjoyed lifestyles that their ancestors never could have dreamed of (or did not necessarily aspire to) pervaded the media. But as the economy grew, widespread poverty persisted. The income gap between rich and poor endured, or even widened (Pal and Ghosh 2007).³

Privatization also transformed the health care industry, building upon trends already long under way. Until the 1990s, the state, in combination with a host of informal private providers, such as pharmacists and unregulated street vendors, provided most of the health care received by the urban poor, creating what Nishtar refers to as a ‘mixed-health systems syndrome’ (Nishtar 2010, Shah and Mohanty 2011, Kamut and Nichter 1998, Das and Das 2007). But deficiencies in ‘accessibility and availability in the public sector’ drove growth in the private sector (Mavlankar 2000: 5, cited in NRHM 2012). Also driving these changes were neoliberal reforms imposed by the World Bank and other international finance organizations that forced developing countries like India to reduce public expenditures in social sectors including health (Jha 2005).

Private firms are now estimated to provide approximately 60 percent of all outpatient care in India and as much as 40 percent of inpatient care. Nearly 70 percent of all hospitals and 40 percent of hospital beds are in the private sector (PricewaterhouseCoopers 2007, cited in NRHM 2012). In rural areas, dependence on private providers is also high, estimated by the National Rural Health Mission (2012) at nearly 75 percent. These developments have created what some call ‘two Indias’. The urban health care industry, which is dominated by private providers, caters to the emerging middle class and, increasingly, to medical tourists, while the vast majority, or the urban and rural poor, still lack access to care. Only about 10 percent of the Indian population has health insurance, served by a mix of public and private schemes.⁴ In Gujarat, the government instituted its own initiatives to achieve the Millennium Development Goals, including a public–private partnership called the ‘Chiranjivi scheme’ to improve birth outcomes for families living below the poverty line in five pilot districts. It also launched a ‘save the girl child’ program to reverse the declining sex ratio.⁵

Still, in 2012, the commission charged with developing India’s five-year plans identified health care as a key strategic challenge, recognizing that India’s health is not improving as

fast as other socioeconomic indicators (Chandra 2010, Navarro & Shu 2001).⁶ Gujarat falls in the middle of Indian states in terms of per capita GDP and state expenditures on health. Life expectancy is slightly higher than the national average, at 65 for men and 65 for women (Panchal et al. 2012). Deaths from diarrheal and many traditional communicable diseases are now quite rare, but tuberculosis and malaria are still serious problems (*ibid.*). At the same time, lifestyle-related diseases are on the rise; Gujarat has the tenth highest obesity rate of 28 provinces (WGDB 2011b).

By the beginning of the 2000s, an estimated 20 million Indian-origin people lived in over 110 countries around the world (Kapur 2010). Elite migration rates are high compared to the general population. By and large, these expatriates thrived and the Indian government instituted various policies to tap into their economic and political power and to encourage their continued support. In 2004, the government created the Ministry of Overseas Indian Affairs (MOIA) to monitor and manage departure flows, protect Indians living abroad, and harness the development power of the diaspora. The government also introduced the Overseas Citizenship of India (OCI) scheme. In addition to the Non-Resident Indian (NRI), who lives abroad but still retains Indian citizenship, it created the Person of Indian Origin (PIO) category for people of Indian origin who are naturalized citizens of other countries. Both statuses grant expatriates a series of economic and educational rights, although they are still not able to vote from abroad.⁷

State governments also boarded the NRI bandwagon. This was particularly true of the government of Gujarat, which offered incentives to potential investors. ‘How can we be helpful to our native place and our State?’ asks Hasmukh Adhia, Secretary of the Non-Resident Indian Division and President of the Non-Resident Gujarati Foundation, in the Preface to the program booklet for the Global Investors’ Summit held in Amdavad in January 2009. Attendees were encouraged to contribute to various charitable programs including the Gokul Gram Yojana, an initiative to equip Gujarat’s 18,242 villages with basic amenities or a midday meal scheme for school children (‘Vibrant Gujarat’ 2009).

Thus, the institutions we investigate operate in an environment in which many view privatization and marketization as key to India’s recent economic success and to solving its future problems—a stance shared by many national actors and the international non-government organizations (INGOs) and foundations that support them. Health care providers in Gujarat increasingly support this neoliberal approach that, in turn, resonates with ideologies and practices that respondents have encountered when they work and study abroad. At the same time, India is also actively courting its diaspora. There is an openness to migrants’ enduring social and economic contributions and, in some regions, a dependence on them, which also ‘greases the wheels’ of social remittance exchanges. Taken together, these conditions encourage the circulation of ideas and practices in general, and those supporting a neoliberal agenda in particular.

1.3 Research methodology

We selected the institutions we studied to avoid focusing too strongly on national level institutions that are uncharacteristically well endowed with human and financial capital. We opted, instead, to conduct field-work in the provincial/state capitals of Gujarat and in institutions working in its smaller cities and villages. This level of analysis is

particularly helpful in understanding the relevance of health-related knowledge and practices to the challenges faced by relatively poor areas undergoing rapid social change, urbanization, and privatization. Gujarat, as mentioned above, also has a long history of emigration.

The team designed a common list of questions to guide the field-work, which was adapted in each case to the specific circumstances of each institution. These covered such topics as individual respondents' backgrounds; their decision to go abroad; how they thought about development and health before leaving; their education, work experiences and civic engagement while living overseas; and their experiences and reflections upon return. Our questions asked about the ideas and practices respondents wanted and did not want to bring back to India, and about what worked and what did not work in the Indian context. At each organization, we spoke with staff working at all levels; observed health care provision; sat in on staff lunches, meetings, and prayer sessions; attended classes; and reviewed educational and promotional materials. In addition, a research assistant conducted follow-up interviews and carried out additional participant observation. She also reviewed government documents and newspaper accounts. All told, our findings are based on 65 interviews across our four organizations. Our respondents are all middle or upper class. Twenty-four respondents were women and 41 were men.

During our first field-work trip, we narrowed down the universe of institutions upon which to focus. After visiting 15 institutions dedicated to training health care workers or providing direct care, and consulting with academics and policy makers in the field, we selected four groups that provided us with the broadest perspective on the different actors in the field: private, for-profit providers; community-based groups; public sector services; and religious institutions. Table 1 includes descriptive characteristics for each institution. At least half of the staff had to have lived, worked, or studied abroad. We also chose institutions embedded in different kinds of social and professional networks, anticipating that their different locations would expose them to different packages of imported ideas and practices. While the organizations in our study do not represent, in a strict sense, the universe of health care providers, they broadly capture the key types of providers and the different ways in which migration and mobility can shape institutional development. While working at the state level allowed us to see how local level institutions use the knowledge and skills traveling through international networks, and in some cases privileged certain 'assemblages' over others, it limited our ability to access how circulation affects policy making at the national level.

The organizations we studied are producers and consumers of the ideologies and technologies that constitute global health assemblages. In general, while all were present to varying degrees, the neoliberal health assemblage exerted the greatest influence over their operations. Zenith hospital chain and the People's Religious Service Committee (PRSC) happily embrace this model although some staff expressed reservations about its goodness of fit with India. The Health Care For All Foundation (HCFA), while created to strengthen public sector capacity (and thus sympathetic to the welfare state approach), often finds itself foregrounding the market-oriented aspects of this model. The Rural Health Care Association (RHCA), while formally an exemplar of the integrated global health approach, and despite deep reservations, is now also being pulled into its orbit.

Table 1. Organizational characteristics

Organization	Zenith	Health Care for All Foundation (HCFA)	Rural Health Care Association (RHCA)	People's Religious Service Committee (PRSC)
Type	private for-profit hospital chain	autonomously governed public-private partnership	private voluntary development/health care NGO	private religiously-affiliated charitable NGO
Headquarters	Chennai, Tamil Nadu	New Delhi, Delhi	Jhagadia, Gujarat	Amdavad, Gujarat
Location studied	Amdavad, Gujarat	Gandhinagar, Gujarat	Jhagadia, Gujarat	Amdavad, Gujarat
Founded	1983; Ahmedabad: 2003	2006; Gandhinagar: 2008	1980	1907; Amdavad hospital: 2001
Geographical scope	India-wide; Amdavad: Gujarat	India-wide; Gandhinagar: Gujarat	1,500 villages in southern Gujarat	worldwide; Amdavad: Gujarat
Selected health-related services	400-bed hospital; multiple medical specialties; walk-in clinic; value-added services	postgraduate education in public health (incl. distance-learning); short-term programs and workshops; public health research fellowships	100-bed hospital; eye care (incl. surgery); post-natal care and services; primary health care training	hospital; free diagnostic/ vaccination camps; anti-addiction drives/camps; medico-spiritual conferences
Staff	70 consulting doctors	13 full-time faculty; many part and full-time researchers	15 hospital doctors; 185 other full-time staff; many more village-level volunteers	25 consulting doctors
Annual clients	10,000 patients	not available	78,000 hospital patients; 16,000+ other patients and clients	36,500 patients
Clients' demographics	~10% nonpaying poor locals ~90% paying locals and NRI visitors	not available	~100% non-/part-paying poor locals from rural, tribal villages	~33% nonpaying poor locals ~33% paying locals (often of faith)
Funding	service provision revenues, investors, investment income	service provision revenues, national government, international and Indian philanthropy	28% Gujarat state government 22% international agencies 20% Indian philanthropy 30% service provision revenues	~33% paying NRI visitors service provision revenues, international and Indian philanthropy mainly from the faithful

2. Gujarati health care organizations studied

2.1 The Health Care For All Foundation (HCFA)

HCFA was founded in 2006 to promote many of the ideas underlying integrated and welfare state approaches to health care. It aims to integrate a public health perspective into medical care in India. Its founders wanted to shift the distribution of financial and human resources away from curative care toward preventive care, health education, epidemiology, and research to address inequalities in access to care. They also sought to strengthen the capacity and managerial skills of primary and secondary health care providers, reorienting them away from tertiary care.

HCFA hopes to accomplish this through a multi-sectoral initiative. Just as India created the Indian Institute of Technology (IIT) and the Indian Institute of Management (IIM) with branches around the country, institutes which are widely respected across the globe, so HCFA plans to create public health universities.⁸ Students, who now work for the state medical system but who will eventually include those working for all kinds of providers, take courses in management, public health perspectives, biostatistics and data management, health economics, health care financing, and health policy. The Foundation also offers short-term courses and workshops on these topics. In all of these venues, however, the curriculum has come to include many of the basic tools of the neoliberal health assemblage—design, administration, and evaluation with an eye toward maximizing efficiency and effectiveness.

HCFA's Board of Directors includes prestigious international and national actors who are key players in the elite global health networks around the world. They are on the staff of or do consulting for organizations like the WHO and UNICEF, they head some of the most successful technology or banking firms in the USA and in India, they work at elite universities such as Harvard or Cambridge, and they work for or are on the boards of several well-known global foundations. The professionals who run HCFA's day-to-day operations have also studied and worked abroad and continue to be part of prestigious global and academic networks. The President is an eminent cardiologist, trained in India, Canada and the Netherlands, who holds a research appointment at the Harvard Medical School. The Director of the Gandhinagar Institute studied in the USA and lived and worked in Malaysia and Singapore for many years. The Director of Research studied and worked in the USA and in Australia. The social remittances these individuals send back travel through tightly bounded, strong networks that accommodate them easily because they are part and parcel of the system that creates them. While some staff expressed concerns about the effects of the neoliberal model in India, HCFA is too centrally implicated in its production and dissemination to significantly change its programs.

Many of the young faculty who teach these courses are sent abroad to earn Masters and PhD degrees.⁹ Their studies are supported by foundations in Australia and the UK, and by the US Agency for International Development. These programs generally last between one and three years. Students come from around the world to attend them and faculty members often have experience working and teaching abroad. The fairly consistent set of courses respondents attended and the research and evaluation techniques they were exposed to mirror the curriculum and content of the courses they teach when they return to India.

Many said they kept in touch with their fellow students or continued to collaborate on research with their former professors. HCFA's current research portfolio includes work on transparency and accountability, maternal and child health, communicable diseases, the social determinants of health, health promotion, public health and law, and health care financing.

Most faculty members savored the opportunity to study abroad and were overwhelmingly positive about their experiences. They spoke about the different teaching styles they were exposed to, including case methods, simulation exercises, and group work. They felt positively about being encouraged to write clearly and master the scientific literature. Rather than sitting in classrooms and absorbing information by rote, they were actively encouraged to challenge their professors. Said one returnee: 'I was given a free hand to think and listen and to do what I wanted to do'.

At the same time, the substantive content of the curriculum was not always India-appropriate. In other words, the language and practice of neoliberal-oriented health care did not fit with the realities on the ground. Few students had the opportunity to do practicums. They learned little about rural health care. Their courses focused more on obesity, addiction, and heart disease than on the communicable diseases and the sanitation, and maternal and child health issues that India faces. One faculty member recalled reading a study about immunizing children in Denmark. She recalled,

They only have something like a million children and they could tell a really convincing story because their data is so good... We have adopted, even, say, our medical education, we have sort of copied it, patterned it after the way it was in the West; the West has changed, and we are still being where we were... so when I came back I thought it was really important to make students understand that in every place it is localized, you know, there are so many things which are localized.

Why not, asked several respondents, send people to study in countries that are more like India? If you want to push this approach to health, at least do it in a way that is more sensitive to the Indian context.

In fact, one of the striking things about the classes we observed at HCFA was how much they resembled the halls of US universities. The HCFA campus in Gandhinagar is a cool, green, tree-lined oasis compared to the hot, dusty streets that surround it. The new building has a library, computer rooms, and multiple types of classrooms including several arranged in the 'case-study' style. In one class, a management professor presented a lesson on social capital citing only research done in the USA. Words like 'efficiency', 'transparency', 'motivation', and 'advocacy' peppered his PowerPoint presentation, which he delivered in Hindi. When we visited a former student, who is now back at work at a local health clinic, his answers in Gujarati included many of these same English buzzwords.

Most of the students who attend HCFA's courses are government workers who are required to attend. They have been out of the classroom for many years and are not accustomed to sophisticated technology. The language of instruction is English although several professors said they often had to switch to Hindi or the local language to get their points across. Successfully completing the course does not guarantee a raise or promotion. So, in the language of neoliberalism, there are few incentives for students to actually change what they do once they return to their positions in the field. Several professors

acknowledged that they did not know how much students can or will apply what they take away from the classrooms. Some alumnae complain that their training is too technical or theoretical, saying ‘Oh, this is very good but this is not how government works’. According to one health economics professor: ‘I cannot vouch that after they go back to their village, they are going to do these things better. Because, for example, the government doesn’t — is not always looking for change.’ It is also creating what one professor called a two-tiered system:

When I teach human resources management, 85 to 90 percent of the doctors don’t want to go back to rural areas. They want to serve in urban areas, because of the money and better policies there and because there will be better schools for their children. If we teach them skills but they don’t want to go back and use them in the places where they are most needed, this is a problem we have to deal with.

A number of respondents worried about the disjuncture between what is being taught and what skills health care workers actually need on the ground. Their fears reflect the tensions inherent in vernacularizing global health for India.¹⁰ According to the Director of Research, whose comments reveal the difficulties inherent in adopting neoliberal models without integrating local knowledge and approaches,

We are creating a global public health that is a mishmash of perspectives gleaned from around the world but that is definitely generated in Western powerful institutions. Most of us are part of very elaborate networks, globally, and that influences the world that we live in . . . This institution aims to be very progressive, not to be bound by historical baggage, and to be very India-centric. That’s what we keep on trying to do in our daily work, we always say this has to be important to the priorities of India . . . We don’t want to be disconnected from the rest of the world because a lot of good things are happening, we’ve learned a lot from ideas and developments in public health, in team research and training elsewhere in the world. And certainly we want to welcome that; we want to be constantly exposed to that. We also believe that this should not bias us toward what is important for India, India’s public health.

What is also clear is that India has a lot to contribute and teach and that effective health care models would need to take that into account. The Director of Research continued:

One of the problems with accepting money from foreign people is that you get driven by their motives and things like that . . . I’m very sensitive, being an Indian, and I don’t like anyone ever suggesting that, you know, we are giving you this money and so you do as we say. I take that not well at all. In working with people globally there were many mature people who have always realized that it’s a mutual gain, and so that works very well with me.

In general, however, the faculty, staff, and directors of HCFA are firmly entrenched in the universities, foundations, and international organizations that create the neoliberal global health assemblage. They produce the ideas, organizations, and technologies that constitute it and change and adapt in response to its circulation. While HCFA is committed to enhancing the capacity of public sector providers, it does so by teaching them this neoliberal tool kit. Students learn more that is applicable to professionalized, institutionalized, urban-based settings and less about community-based approaches. There is much more talk about efficiency and accountability than about equity and access. And while a number

of HCFA staff questioned aspects of this model, or tried to modify it by adding Indian approaches into the mix, they generally supported its overarching assumptions, leaving the economic and political structures that undergird them unchallenged.

2.2 The Rural Health Care Association (RHCA)

‘The poor, the illiterate, the ignorant, the afflicted—let these be your God.’ This quote, from Swami Vivekananda, features prominently on the cover of RHCA’s 2009 Annual Report. Its founders are followers of this important leader who became famous for ‘introducing’ Hindu philosophy to the West at the Chicago Conference of World Religions in 1893 and for his role in shaping the intellectual debates and leadership development that made ‘modern India possible’.

RHCA staff members are also exposed to global health assemblages. And like the HCFA, RHCA’s directors and staff are embedded in far-reaching international social networks. Until recently, however, these operated largely in isolation from the elite global networks that drive HCFA. Instead, information, resources, and know-how circulated through social relations between other Swami Vivekananda followers and supporters who shared a similar worldview and commitment to holistic, grassroots development. The ideas and practices that traveled through these networks resonated primarily with the integrated health assemblage.

RHCA was founded over 30 years ago by two middle-class physician couples who traveled abroad to be able to come back to India with the money and skills they needed to serve the rural poor. The RHCA’s mission is to reach the poorest of the poor through health and development programs based on community needs and available manpower. According to its annual report: ‘In all the activities, an attempt is made to incorporate as well as balance the three basic principles: Social Service, Scientific Approach, and Spiritual Outlook.’ Today, RHCA’s projects include a 100-bed hospital which provides subsidized care to 1,500 tribal and rural villages, a community health project to decrease infant and maternal mortality among a catchment area of over 170,000 people, a comprehensive eye program serving approximately two million, a vocational training program for rural youth, an income generation project for women, and a training center which serves about 1,000 government and NGO trainees from India and abroad each year. In 2008, RHCA received 28 percent of its funding from Gujarat State, 22 percent from international funding agencies, 20 percent from Indian philanthropic organizations and individual donors, and 30 percent from revenues generated by service provision. Over the years, it has grown from an organization of 15 to 200 full-time staff and a host of village-level health volunteers. Its Board of Directors includes only individuals based in India who are currently working for or who have been strong supporters of the organization. While about half of the senior staff have worked or studied abroad, most of the employees actually providing health care have not traveled outside of India.

The staff and volunteers who work at RHCA live in a self-contained, insular community. Many workers live in rooms and apartments on the hospital campus. They eat most of their meals together. They work seven days a week. While not all are followers of Swami Vivekananda, a religious commitment and shared moral vision shape much of RHCA’s activities. Their work reflects many Gandhian principles including self-sufficiency,

simplicity, and minimizing the social distance between the server and the served. They also trust in God's plan. For example, when they were building their new training center and were short on funds, 'Time and again, we have experienced that any time we are in crisis, God's hands come up and lift us up', the Director said. He asserted, however, that RHCA is an independent organization. While many staff members embrace these values, it is not a requirement for getting a job; RHCA is not a Ramakrishna Mission. Voluntary daily prayer sessions are held in an interfaith space decorated with symbols from all world religions.

Many of RHCA's supporters, though, who embrace its religious and social justice philosophy, contribute financially or donate their time and skills during visits to India. They make up a thick, broad, informal network through which, until recently, a select group of ideas, practices, and resources traveled that resonated with an integrated health approach. Sometimes, the Director said, this happened by word of mouth:

There are people whom we don't know directly but who are friends of friends, and they also want to help us out. One big example, I recall, was the vocational training center. We had that center for about 20 years and the buildings needed a lot of maintenance. We didn't know where the funds would come from. One of our doctor friends in the US from Cincinnati, he is one of our close friends. He brought this matter to another Indian friend over there with whom we had not had any contact. He got impressed and offered almost two hundred thousand US dollars for the total renovation . . . When he came and visited, he realized this was not enough and he funded the rest of the project.

Therefore, while RHCA operated in the same political and social environment as HCFA, it could remain faithful to an integrated approach to health that stressed social justice, income generation, and education, in combination with medical and public services, and circumvent pressures to adopt neoliberal models.

This began to change as RHCA became more widely recognized nationally and internationally and more and more outsiders came to work with the organization. Several years ago, a member of the directorial team received a Hubert Humphrey Fellowship to study at Emory University in the USA; he maintains strong connections to many of his former classmates and professors who are now strong supporters of the organization. He came back, he said, committed to doing a better job at documentation, evaluation, and communication. He wanted to try things like telemedicine and different pharmaceutical management systems that he observed. He also became a convert to the wonders of computing. These shifts and new social contacts were the first steps toward making RHCA more vulnerable to and, ultimately, more integrated into the neoliberal orbit.

The Director's trip abroad also made him realize that RHCA had a lot to teach the rest of the world and that the rest of the world was interested. They began disseminating information about their experiences more widely. In 2007, the organization received a prestigious award from a prominent Western foundation for its innovative programming. These developments drew RHCA further into the elite global public health networks. As the organization attracts more funding and embarks on more international collaborations, it is becoming more dependent on outside monies and more exposed to and beholden to aspects of the neoliberal model. It has had to adopt new ways and foci of work to fit with

funders' and collaborators' priorities. While some staff support these developments,¹¹ they are also aware of its costs. 'This is a big debate among us', a senior staffer said. 'We need to keep our windows open but not to the extent that we get blown out, so that's our motto. We need to have checks and balances.'

In short, RHCA is entering a new era in which, in response to its desire to expand its resource base and disseminate its approach more widely, it is adopting aspects of the neoliberal model. To accomplish its goals, get credit for its innovations, and reach larger numbers, RHCA must partner with neoliberalism's proponents which necessarily moves it away from its community-based, holistic roots. According to one staff member:

We might lose our guards, our values. Now you are famous, you are great, that is the most difficult phase . . . our challenge is to make sure that our mission and principles do not get diluted at all. We have not forgotten them for the last 30 years but if we get distracted now we are in big trouble . . . Health is a tool for development but not an end in itself.

'I think that health should be viewed as a process, which helps other areas to contribute to integrated development', one of the Directors concluded. Yet, to stay loyal to that integrated approach, RHCA must collaborate with and accept support from partners that push it in the other direction.

2.3 The Zenith hospital chain

'At Zenith, you are not just a patient, you are our guest', reads the website of this 8,500-bed private hospital chain with 54 hospitals across India, one in Mauritius, and 'global health partners' in many countries where people of Indian origin live overseas. The corporation's success, the website goes on to say, derives from their unique combination of exceptional clinical care, state-of-the-art technology, and 'centuries-old traditions of Eastern care and warmth'. Over 19 million patients in 55 countries are now part of Zenith's 'extended family'.

Zenith opened its first hospital in Chennai in 1983. The Amdavad facility we studied opened in 2003. Its specialties include heart, orthopedics, spine, cancer, gastroenterology, nephrology and urology, and critical care. Cosmetic surgery, infertility treatment, stem cell transplants and bone replacement surgeries are available. Zenith also offers 'value-added' services including telemedicine, portable online health records, and phone hotlines for physical and mental health concerns. In short, Zenith provides the most advanced care by highly-trained staff in a state-of-the art facility. Its brand is meant to inspire confidence among patients around the world.

Zenith actively recruits clinicians who have lived and worked overseas because many Indians believe, said an ear, nose, and throat specialist, 'that people trained overseas are necessarily better'. Many patients also come from overseas, including but not limited to NRIs and large numbers from Africa. The primary language of care is English. Our respondents estimated that anywhere between 10 to 30 percent of Zenith's clients have insurance. The rest pay out-of-pocket (they can even pay online) although Zenith is also required by the government to provide free care to approximately 10 percent of its patients.

Those requiring a hospital stay can choose between three levels of services. As the cost structure varies across sites, hospitals within the chain compete with each other for patients.

The Amdavad site has 400 beds and serves approximately 10,000 patients per year. It boasts the only 1.5 tesla MRI scanner in the city and is only the second hospital in the chain to regularly perform stem cell and bone marrow transplants. It is also the only hospital in Amdavad with a radiation oncology unit, set up by a US-based cancer center that rents space from the hospital. If a patient is diagnosed with cancer, they are often admitted to Zenith. It is, according to the website, ‘on par with any western center’. In other words, Zenith represents the *pièce de résistance* of the neoliberal model. In fact, its catchment area is the paying population from around the world, not the poor or working classes of India.

Returning physicians choose from among an array of salary schemes including a fixed salary or a fee-for-service arrangement whereby they earn more by working more but pay the hospital for the administrative support they receive. Creativity and innovation are encouraged. For example, one kidney specialist came back and established a group practice, like the one he belonged to in the USA. Zenith takes care of medical records, billing, and secretarial tasks. He pays the physicians in his group and buys the special equipment he needs. Zenith gains because he brings in so many patients. ‘I used to do two operations per month’, he said, ‘and now I do two hundred per month. That is only possible with the help of a team. The more the merrier.’

Not everything doctors learned abroad, most respondents felt, is good or good for India. They believe that Western physicians depend too much on technology and their clinical skills get rusty. ‘They won’t diagnose without a CT scan or an X-ray’, a urologist said. Insurance companies browbeat doctors into prescribing certain kinds of procedures or medicines. In India, the doctor is expected to be available at all times while, in the USA, he or she is only available when on call. It takes too long to get appointments and when you do, the doctor rushes the patient along because he is worried about his productivity. Some respondents were also surprised by how much their patients challenged them, arriving well prepared with research about diagnoses and pharmaceuticals they collected on the Internet.

At the same time, most interviewees felt that Western-style medicine comes with many benefits. Doctors are held accountable to a certain standard of care. They get productivity targets and they are evaluated on how well they meet them. Said one kidney specialist, ‘Before it was like the doctors were answerable to no one. It’s not like that anymore.’ Also, since insurance providers are now a prominent part of the scene, doctors have to work more efficiently and effectively. ‘They direct how we should bill, what we should do, what procedures to use.’ Since many Zenith patients do not have insurance, they want to be discharged as quickly as possible—another incentive for doctors to cut costs.

Zenith put in place many important systems, some introduced by people returning from abroad. There are pre-surgery protocols so patients no longer bring their cell phones into the operating room. There are consent forms, a patient ID system, and mock emergency drills. There is a grievance committee to which providers and patients can appeal. New staff members are trained using these checklists. Because Zenith competes globally, it has to meet international standards of care. It recently received accreditation from the National Accreditation Board of Hospitals in India. It is now seeking accreditation from the Joint Commission International (JCI) in the USA, which establishes international standards.

The internationally recognized Patient Bill of Rights is displayed prominently throughout the hospital.

Zenith is both a producer and consumer of the neoliberal health assemblage. Its physicians trained at many of the hospitals they now want to emulate. They continue to interact with a self-contained network of like-minded providers of similar standing. Their contacts and professional networks do not expose them to alternative models of care based on different socioeconomic assumptions, nor are they looking for different ways to do things. Most respondents believed that patients who can pay should have access to the highest quality, technologically advanced care. Basic protocols, safety procedures, and rules for provider–client interactions can be standardized worldwide. As newly emerging economies grow, so will the number of people who can afford these services. While international patients and upper middle class Indians benefit today, eventually these advances will transform the public sector by freeing up more resources to improve it. Privatization, according to one oncologist, ‘does not serve the poor but at least it gives better options to those who can afford it. It’s good in a way that a certain standard of care is now expected. These heightened standards and rising expectations on the part of patients will eventually trickle down.’

2.4 The People’s Religious Service Committee (PRSC)

The People’s Religious Service Committee (PRSC) describes itself as ‘an international Hindu socio-spiritual organization’ that is based in Gujarat. From its headquarters in Amdavad, its leaders provide spiritual guidance, education, and social services to followers and non-followers in India and around the world. In fact, wherever there is a large NRI population of Gujarati origin, be it in the Far East, Africa, the UK, or the USA, there are likely to be PRSC temples. Each local temple, in Australia or Arizona, forms part of a regional network, which belongs to a national network, which reports back to PRSC leaders in Amdavad. Each temple is organized in a similar fashion, run according to the same rules, and directed by the same leadership group in Gujarat. As a result, the PRSC oversees a strong, far-reaching, hierarchical global network of like-minded followers who embrace and spread their Guruji’s teachings throughout the world (Levitt 2007).

The PRSC not only provides for its followers’ religious and spiritual needs, it also serves the country’s poor. It runs 10 schools, including one in the UK, 14 hostels, and provides scholarships to students. It operates 14 charitable clinics and health centers (six are in the USA) and regularly organizes blood donation drives in North America and India. During times of natural disasters, in India or elsewhere, the PRSC figures prominently in relief efforts. In some cases, its impetus is to serve members. An NRI from London, for example, started a school in Gujarat so that children raised abroad could be educated according to traditional Indian values (local children can attend too). In other cases, the PRSC cures and educates not only because that is its moral responsibility but also because it enhances the organization’s public image and helps attract new followers. Since the PRSC is a wealthy organization, a strong dose of market logic goes hand in hand with its messages about justice and helping the poor.

While most of the low-income clients at PRSC facilities just want free care, many paying clients are devotees or are sympathetic to the PRSC's teachings. Critics, however, see the PRSC as too closely aligned with the government and as driving the same conservative neo-Hindu platform as the Bharatiya Janata Party (BJP) that is in power in Gujarat.

Many PRSC followers have lived abroad or have family members who work and study overseas. Whether they are migrants, students, or simply visitors, they can go to a PRSC *mandir* (temple) and feel comfortable and welcome because how each temple is organized and what people do there is always the same. The same rules and behavioral expectations apply (i.e. no addictions, no stealing, no illicit sex, a pure vegetarian diet, moral purity, and serving the poor). Followers meet regularly for communal prayers, study sessions, youth activities, and holiday and family celebrations. The temple community becomes like a substitute extended family, especially among people raising children far away from India. While devotees live and work among the native-born, their social lives take place almost entirely among fellow believers, which limits what they get exposed to in the places where they settle and how they change in response (Levitt 2007). When ideas and practices travel back to India, they circulate through tight, protected pathways that block things that contradict PRSC teachings.

While the PRSC staff members we interviewed maintained professional overseas ties, they were most often with other members of the organization. They tended not to participate in international research collaborations or host researchers who want field experience in India. Nor did they set out to attract foreign patients, although people did come from outside India to get care. They wanted to provide state-of-the-art care at their hospitals and clinics because it will enhance their status in India and among their followers around the world. They adopt the neoliberal assemblage because it furthers their religious mission—it enhances the carrot with which they attract potential converts.

Dr Patel, for example, runs a walk-in clinic at the PRSC headquarters in downtown Amdavad. He lived and worked in the USA for about 10 years but returned to India about 20 years ago. His client base falls into three roughly equal categories: nonpaying residents of Amdavad, paying residents who are often PRSC satsangees (followers or members of the organization), and NRIs. This last group comes because it is cheaper and easier to get care in India when they visit their families. They learn the importance of preventive health in the USA (healthy diet, exercise), he said, but they take care of their curative care needs back home.

Dr Patel claimed that he can put in a pacemaker or do elective cosmetic surgery much faster and less expensively in India than in the USA. He sees no problem with serving a wide range of paying clients whose fees then offset the cost of care for patients who cannot afford to pay.

Dr Patel's hospital, and others in the PRSC network, look a lot like Zenith. They care for urban residents who can afford it and provide some free care on the side. According to one PRSC hospital's website, its goal is to provide 'state of the art treatment to all, irrespective of caste, creed or religion at affordable cost' and 'to become the world's best tertiary care provider'. The hospital is a 'temple of health' as per international norms. It offers many of the same sub-specialties offered by Zenith including telemedicine where patients from across the seas and in rural areas of Gujarat can call to ask for 'advice and assistance

from experts around the world'. Neoliberal approaches to health are the best way to serve the rich and poor and to spread the Guruji's teachings.

3. Conclusion

Despite decades of scholarship, the jury is still out on the relationship between migration and development (Newland 2010, de Haas 2008, Upadhy and Rutten 2012, Levitt and Lamba-Nieves 2011). We entered these debates by looking at how mobility contributes to the construction and dissemination of global health. Our research revealed the importance of looking not only at how migrants contribute to development but also at the impact of people who live and study abroad for shorter periods. It also drove home that even when people physically return, they continue to belong to networks and professional associations that continuously expose them to aspects of global health assemblages. Understanding better the relationship between migration and development means recognizing that migration often occurs within the context of transnational social fields. Mere embeddedness, not actual movement, is the prerequisite for coming into contact with the values, norms, and technologies that circulate within them.

While aspects of all three global health assemblages we identified affected the four organizations we studied, the neoliberal assemblage was, by far, the most influential. Though the ideas and technologies contained within it traveled through different professional and social networks and were vernacularized in different religious and ideological settings, the end 'health product' and how it gets delivered looked remarkably similar on the ground. We expected that differences in secular versus religious channels and in formal, structured networks versus informal ones would result in greater variation in how the pieces of this assemblage actually get vernacularized and used. Instead, its overwhelming power and presence pressures even groups like the RHCA, with its long-standing commitment to the rural poor, to adapt at least some of its trappings. Despite reservations expressed by staff at all four organizations in our study, the ethos of the market and management trumps community-based, simple, non-institutionally-based efforts.

Changes in India reflect broader changes in health care provision worldwide. Most respondents left a country on its way to becoming 'the new India', with its expanding middle class, high growth, and increasing openness to private sector initiatives and market-driven solutions (Radhakrishnan 2011). The corporatization and 'managementization' of the health care system is one aspect of broader national trends. The buzz around public-private partnerships also pervades the education, housing, and social service sectors. As of February 2012, thousands of public-private partnership projects have been approved across the country—most focus on transportation and electricity, but others will create new convention centers, golf courses, and amusement parks (PPP in India 2012). When our respondents went to study and work in the halls of elite universities and hospitals worldwide, they heard and brought back similar messages and models that reinforced those already widely available on the ground.

It is not that health care for all is the wrong goal but that there have to be multiple ways to achieve it. There also has to be a serious discussion about whom the market provides for and whom it overlooks, and under what conditions developments benefiting people who can pay

actually trickle down to those who cannot. What we found instead was a turn away from localized basic services provided by low-skilled workers toward centralized, highly technical, institutionally-based care. We found a focus on services for the urban middle class and a shift away from services in rural areas. We found providers and educators trained in public health models that are appropriate for the West but not necessarily for India. An uncritical view of development as ‘more, modern, and managed’ drives these activities.

‘India doesn’t need migrants to bring back technical skills, what someone who has worked for MacKenzie for many years can contribute’, said an Indian-based consultant we interviewed when preparing for our study. ‘It needs people who can help to fight corruption, to make the system more honest so it works better.’ One overseas Board Member of HCFA, who is critical of their programs, told us:

There are something like 300 new medical schools in India. Many are private/non-profit but they are really for profit and they end up training doctors who will ultimately work in other countries. The Manipal University Trust in Mangalore specializes in training physicians who are the children of immigrants living abroad. They go back to India for training because it’s cheaper and they can’t get into school elsewhere. They don’t stay to work in India but go elsewhere. There are different dormitories for NRI kids than for Indian kids. Does that sound like the right use of resources?

Privatization, he feels, is inevitable but it has to be controlled and regulated by a government that can keep up with these changes. If the government can’t provide health on its own, it needs to regulate and steward the work of others.¹²

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To protect the privacy of the respondents and organizations in our study, all names have been changed and we use pseudonyms throughout. We thank each organization and the many staff members we spoke with for their time and insights. The findings described here form part of a larger study on the impact of return migration on health in India and China. We thank our colleagues Jennifer Holdaway (SSRC) and Fang Jing (Kunming Medical University) for their contributions.

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Conflict of interest statement. None declared.

Notes

1. <<http://www.migrationinformation.org/datahub/remittances.cfm>> accessed 15 October 2012.

2. To protect the anonymity of the staff members and organizations we studied, we use pseudonyms or only identify our respondents by referring to their organizational roles.
3. Large-scale migration from India began in the 1990s. For a general overview see Kapur (2010).
4. The NHRM (2012) states that 'only 10 per cent of Indians have some form of health insurance, mostly inadequate'. PricewaterhouseCoopers (2007: 7) puts this estimate at 11 per cent.
5. India's public health system is particularly weak. According to DasGupta (2005) public health was much stronger in India prior to Independence. After 1948, and the emergence of antibiotics, a focus on clinical medicine sidelined public health efforts. The country's sole public health school, located in Calcutta, opened in 1932 (although there were departments of preventive and social medicine within medical colleges). Recently, power has been shifting from technical managers to elected officials who rotate in and out of their positions and lack the technical expertise to make critical decisions. Lower-level workers shape policies but then lack the power to implement them.
6. The pressing health problems in 21st century India involve both the infectious diseases that have claimed vast numbers of human lives for millennia and non-communicable diseases, including so-called 'lifestyle diseases' or 'diseases of affluence' linked to increasing socioeconomic development. Tuberculosis, malaria, other insect-borne diseases, and water-borne diseases like cholera, eradicated in the Global North, persist in various pockets around India. Diarrheal diseases, respiratory infections, tuberculosis and malaria still cause about one quarter of all deaths in the country (WGDB 2011a: 6). Non-communicable diseases including cardiovascular disease, cancer, and diabetes account for nearly half of all deaths (WGDB 2011b: 9). The Planning Commission's Working Group on Health notes with concern that 'more than 20% of the population has at least one chronic disease and more than 10% have more than one', and that such afflictions are especially prevalent among younger and poorer Indians. The Group attributes these troubling trends to increasing standards of living, noting: 'whereas socioeconomic development tends to be associated with healthy behaviors, rapidly improving socioeconomic status in India is associated with a reduction of physical activity and increased rates of obesity and diabetes. The emerging pattern in India is therefore characterized by an initial uptake of harmful health behaviors in the early phase of socioeconomic development' (WGDB, 2011b: 9). Such behaviors include smoking, reduced physical activity, drinking, and consuming unhealthy diets, all classic risk factors for lifestyle diseases.
7. In addition, the state created a series of institutions to involve the diaspora in Indian development including the Overseas Indian Facilitation Centre (OIFC), a non-profit group that works with the Confederation of Indian Industry (CII) to encourage investment and business development; the India Development Foundation of Overseas Indians (IDF), also a non-profit organization, which facilitates philanthropic investments; and the Global Indian Network of Knowledge (Global-INK), an electronic platform that facilitates knowledge transfers to enable India to benefit from the skills and know-how of people living overseas. The first Pravasi Bharatiya Divas (PBD), or Day of Non-Resident Indians, took place in 2003. The government's latest initiative to foster diasporic links is to create a PIO/NRI University in Bangalore for children with

- Indian ancestry (Vezzoli and Lacroix 2008). An estimated 100,000 ‘returnees’ including Indian-Americans and Non-Resident Indians will return to India between 2009 and 2014. When Prime Minister Manmohan Singh visited the USA in November 2009, he personally extended an invitation to all Indian origin people to come home (Timmons 2009).
8. As of this writing, the institutes had not yet been granted university status by the government, and thus graduates only receive certificates.
 9. The respondents we spoke to attended Harvard, Johns Hopkins, Emory, the University of North Carolina, Yale, National Institutes of Health, and a consortium of 14 universities in the UK that is headed by the London School of Tropical Hygiene.
 10. The places where the ideas migrants bring or send back come into contact with existing ideas and practices are sites of encounter where some kind of adaptation takes place. Vernacularization and translation are two different processes (Levitt and Merry 2009). Translators communicate to be understood while vernacularizers communicate in ways that make things understandable and usable. Vernacularization on the ground is a process of creating meaning by connecting, in various ways, the discourse of the global with local ideologies, within the context of a particular organizational style and ethos. Instead of simply introducing ideas about global health and health care, vernacularizers redefine and adapt them so they are accessible and functional.
 11. One senior staff member, for example, said: ‘The increase in public–private partnerships is a good thing. People are accusing the government of absconding its responsibilities but [after] sixty years the government is not able to deliver . . . If poor patients finally get access to services, what’s so wrong with that?’
 12. This paper forms part of a larger study about the impact of migration on health care and health education in India and China conducted in collaboration with Jennifer Holdaway (SSRC) Fang Jing (Kunming Medical University). We thank them for their major contribution to this effort. The MacArthur Foundation generously funded our research. To protect the anonymity of the staff members and organizations we studied, we use pseudonyms or only identify our respondents based on their organizational roles.

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