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What the Debates About Founding AIIMS Tell Us About Healthcare Priorities

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The establishment of AIIMS in Delhi sparked debates over whether Indians preferred 'Western' or 'indigenous' forms of medicine. These debates masked the elite ignorance and elite self-interest that continue to shape healthcare policy.

On 18 February 1956, Health Minister Amrit Kaur rose in the Lok Sabha to [move that](#) the All-India Institute of Medical Sciences (AIIMS) bill be taken into consideration. "It has been one of my cherished dreams," she said, "that for post-graduate study and for the maintenance of high standards of medical education in our country, we should have an institute of this nature in India which would enable our young men and women to have their post-graduate education in their own country." In Kaur's vision, the primary focus of AIIMS would be post-graduate training, and "through the influence it [AIIMS] exerts, the standards of different forms of professional training in health throughout the country will be raised."

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Perhaps surprisingly for Kaur, the response of the house was a mixed bag. It began with some cautious welcoming of the bill by some members and then proceeded to strong opposition by some others. The Congress MP Mohanlal Saksena's objection would set the tone for the rest of the proceedings. Saksena argued that even though the proposed institution was named the "All-India Institute of Medical Sciences", it was side-stepping ayurveda, homeopathy, "and other indigenous systems of medicine" and privileging "only what has been dubbed and designated as modern systems of medicine that is allopathy." Such a policy, which failed to recognise indigenous medicine, was "anti-national and should be thrown out by the Lok Sabha."

Despite Kaur's repeated assurances that the ministry meant no disrespect to ayurveda and other forms of indigenous medicine, the general tone of the discussions was heated and followed the critique inaugurated by Saksena. This pattern was repeated in the Rajya Sabha a few weeks later, where the discussions were dominated by the same talking points and fierce arguments as in the Lok Sabha. We can glean some sense of the ferocity of these debates from the fact that they lasted a full four days, and in the printed record of proceedings, they take up just under 300 pages (the Lok Sabha discussions are 73 pages long). Even on the final day of the discussions, just an hour or so before the bill was eventually passed, H.P. Saksena (also a Congress member) made these strong assertions: "I am wedded to the indigenous systems of medicine. I look upon Ayurveda and Unani as the proud heritage of our country, but what I have been seeing during the last four days is the cruel banishment of these systems of medicine from our land."

The loud opposition from a few MPs notwithstanding, the Congress's majority in Parliament ensured that the bill was passed with no major changes to the institute's name or to its mandate of teaching only modern biomedicine. AIIMS officially opened for classes later that year, and the passionate debates that it had catalysed in the Parliament quickly receded to the background. With significant support from the union government and enthusiasm from modernising elites, the institution began accumulating high praise as an excellent education centre in biomedicine and as a well-equipped hospital for the public. Kaur became its first president (her last month as health minister was April 1957) and was the public face of AIIMS in its early formative years.

Indigenous Mythmaking

Kaur frequently said that she wanted the "benefits of modern medicine" to reach every person in India. AIIMS was regarded as a powerful symbol of that ambition and commitment of the postcolonial state. Yet, as the debates over the AIIMS bill make it obvious, one of the major preoccupations of policymaking elites then was a cognitive framework that put biomedicine, or so-called 'allopathy', in diametric opposition to indigenous or Indian systems of medicine. Traditionalist elites like the two Saksenas claimed that rural and subaltern Indians preferred indigenous systems of medicine, and modernist elites like Kaur believed that the Indian public needed biomedicine and modern public health. As it turns out, both stances were only partly reflective of the situation on the ground.

For traditionalists like H.C. Dasappa, allopathy took "the Western system as its model" while indigenous medicine was "our own inheritance for centuries past." Biswanath Das wondered how long he was to see his money "being spent in developing a culture which is foreign to my culture." As we can see from these comments in Parliament during the debate over the bill, there was an

understanding that 'allopathy' was foreign and that India's leaders owed a moral responsibility to encourage the country's 'own' indigenous medical systems, which were better suited for the large majority of the country living in rural India (and for subaltern Indians in general).

The primary reason given for this suitability was its presumed affordability. H.P. Saksena, for example, [believed](#) that the "encouragement of Indian systems of medicine [would] provide for the large population of the country that type of medical treatment that suits them, to which they are used, which is germane to their nature, and which is cheap and within their scanty means." Presumed affordability and suitability (vaguely defined) carried more weight in MPs' minds than clinical efficacy, which they seemed to implicitly acknowledge was equal or better in biomedical practice. To [quote](#) Thakur Das Bhargava: "It might be that the expensive allopathic system is helping officers, ministers, and members of Parliament like us in Delhi. But it is incorrect to claim that it helps rural Indians [since it is beyond their 'scanty means']."

The immediate beneficiaries of the establishment of AIIMS were not the ordinary people of India, but the country's chiefly urban-based elite groups which received the gift of a publicly funded biomedical training institution.

How correct were these claims about subaltern Indians and their preference for their 'own' indigenous medical systems over 'foreign' biomedicine? Across India during this time, there existed what scholars call medical pluralism: people trusted and utilised a whole spectrum of different healthcare options and medical treatments. This pluralism was more diverse than the limited pluralism that MPs were projecting in the Parliament. For the MPs (and other elites in general), indigenous medical systems comprised ayurveda first and foremost, then unani, and sometimes homoeopathy. (A few did not even mention unani as indigenous, even as the 19th-century German-imported homoeopathy was indigenous in their reckoning.) On the contrary, the broader Indian public carried out a much more inclusive and expansive practice of medical pluralism. People [went to](#) unani hakims and ayurvedic vaidyas, to neighbourhood Dalit midwives and bonesetters, to religious places like dargahs and mandirs, to street dentists and blood-letters, and also, of course, to formal biomedical doctors and to 'informal' healers who prescribed biomedical injections and drugs (generally labelled as 'quacks' in the elite discourse).

The MPs also missed a critical aspect of healthcare choices: for most people, the 'system' of medicine was not at all the primary criterion. Saksena might have been "wedded" to indigenous systems, but there is little evidence of subaltern people being ideologically committed to a patriotic or cultural duty toward specific systems of medicine. Instead, what we know from extensive anthropological and sociological research during that time and later is that if people were committed to anything at all, it was to the likelihood or "[expectancy of cure](#)". In other words (and unsurprisingly): when ill, people were primarily interested in feeling and getting better. If one were to impose a dichotomy on public attitudes, it would not be that of indigenous medicine vs allopathy, but of effective treatment vs ineffective treatment.

People's perceptions of medical efficacy were also in constant flux and subject to change on the basis of new information and new experiences. Scholars in the 1950s and 1960s [observed](#) that rural and subaltern Indians were becoming increasingly familiar with biomedical drugs and procedures. Indeed, their attitudes towards biomedicine were often positive, even as they continued to simultaneously utilise older and traditional knowledge systems and practices. A striking manifestation of this subaltern comfort with biomedicine was that a large number of local, community-based practitioners—often termed "indigenous practitioners" by scholars and policymakers—utilised biomedical symbols (like the thermometer), concepts, drugs, and injections in their thriving practices. The India-born and Johns Hopkins-based global health expert Carl Taylor in 1976 [summarised](#) the observations of his years-long research projects across India thus: "when we use the term 'indigenous practitioner', we are really talking about indigenous practitioners of medicine, and not [necessarily] practitioners of indigenous medicine."

In other words, even as the MPs opposing the AIIMS bill were assuming cultural and moral authority on indigenous medicine and alleging that Health Minister Kaur was ignorant of the ground realities in India, they were themselves highly disconnected from people's beliefs and attitudes.

Biomedical Paternalism

Like her opponents, Kaur was also confidently claiming moral authority, and making claims about knowing what it is that the country needed and that the people wanted. For her, the insistence of some MPs to look at indigenous medicine and allopathy in a binary framing was a [distraction](#): "One Member said that it [biomedicine] was too modern, it was too western. I do not understand what western and modern mean - for surely in the world in which we live we must take everything that is good from every part of the

world." When modernist elites like her said that the people of India, particularly rural India, needed or deserved biomedicine, what they had in mind was the setting up of hospitals and health centres, and the stationing of full-fledged biomedical doctors, in villages and towns. In this regard, the modernists, unlike the traditionalist elites, acknowledged their own use of biomedicine and proposed that the general public should be able to access it.

However commendable this stance was, it was also paternalistic. While subaltern Indians were increasingly utilising biomedicine in its different forms, they were still not comfortable with hospital-based care or with seeing elite biomedical doctors. People from subaltern backgrounds frequently experienced paternalism at the very least, and often disrespectful behaviour, including even abuse, from doctors and other hospital staff. Most subaltern Indians saw doctors—who were generally from dominant caste backgrounds—less as friendly healers and more as [elite sahabs](#). Experiences in hospitals amplified this social gulf. As a 1956 [article](#) argued: in government hospitals "hundreds are humiliated every day because thousands go for treatment where facilities are not enough for five hundred."

The ignorance of India's elites about the realities of the people and communities they make policies for was in stark display in the 1956 AIIMS bill debates.

Among the research studies that highlighted these realities well was a 1969-70 study by [Djurfeldt and Lindberg](#) who worked in a village in southern India. The perceptions and experiences of the people from that village are summarised in this telling quotation in that study: "If I go to the [biomedicine] clinic, I have to spend half a day for the treatment. I have to stand in a queue [...] But [the local practitioner] will come to my house. I can freely talk to him. His medicines are not any more costly [...] When I go to the clinic I am not informed about the disease and its treatment. But I can talk about that freely with the local [practitioner]."

This and other studies show that in most cases when in need of medical attention, people chose to first take advice from a local or community-based practitioner, and not a clinic- or hospital-based doctor. Such local "indigenous practitioners", as Carl Taylor—the health expert quoted earlier—called them, did not necessarily practise only indigenous systems of medicine, but combined them with biomedicine, and liberally prescribed biomedical drugs and injections.

In other words, even though many subaltern people across India were active users of biomedicine—something which Kaur rightly insisted in Parliament—this was seldom obtained from formally trained doctors and government-provided centres, and more commonly from community practitioners and other local sources. Neither doctors nor hospitals and clinics were the preferred mode of healthcare delivery for a majority of the subaltern public, who often only utilised these after they had exhausted other options. Despite this ground reality, MPs and other policymakers in the 1950s privileged hospital-centred medicine to the detriment of local, community-based, and home-based ways of providing medical care, and favoured university-trained doctors at the expense of other skilled and semi-skilled practitioners.

Elite Dominance and Subaltern Erasure

The ignorance of India's elites about the realities of the people and communities they make policies for was in stark display in the 1956 AIIMS bill debates. Whether speaking in favour of or in opposition to the idea of AIIMS, many of the major arguments that the modernist as well as the traditionalist elite MPs made had little basis in the attitudes and lived experiences of the majority of the Indian people. While this article mainly looks at MPs, other research like that by [Debabar Banerji](#) in 1970 shows that the elite ignorance argument can be safely extended to what Satish Deshpande [describes](#) as pan-India elite groups of "the professional-managerial class, intellectuals and top bureaucrats [...] whose native habitat was the de-territorialised space called New Delhi."

Coupled with ignorance was elite self-interest. As it turned out, the most important and immediate beneficiaries of AIIMS were not the ordinary people of India, but the country's chiefly urban-based elite groups, who received the gift of a publicly funded biomedical training institution. Among other things, AIIMS was quickly used by some as a ticket to return to India from abroad to become pioneer teachers and researchers (at least in the early years of AIIMS), and later by many as a passport to leave India and settle abroad.

The fact that AIIMS would primarily benefit urban elite groups is evident from a close, critical reading of Amrit Kaur's defence of the institution in the Parliament, though in all probability she did not imagine the institution to be elitist. Read today, her reasoning behind describing AIIMS as a centre geared towards rural India comes across as somewhat convoluted, and oriented more towards doctors and medical students rather than the general public: "[Our educational institutions](#) have up till now been always located in the cities. This [AIIMS] is also going to be located in Delhi, you may say a city, but we are going to have village hospitals attached where our students will be able to go and work. They will not only get part of their education there but will be given wide chances for research

in the villages."

Health policymaking has always faced challenging questions of resource allotment, but answers to such challenges have invariably privileged elite perspectives rather than comprehensive grassroots evidence and 'wide public participation'.

Notwithstanding the critique of AIIMS's elitist orientation, was its establishment a positive development in terms of public health, as Kaur have hoped for? Ironically, the institution has performed spectacularly well with respect to the goal of specialist education that Kaur laid out-so well that, as Anna Ruddock [has shown](#), AIIMS ended up "killing" the general practitioner. However, India (especially the Delhi region) in the 1950s was arguably not suffering from any serious scarcity of biomedical training centres and tertiary care hospitals, more so when compared with other healthcare needs. To quote Banerji's 1970s [analysis](#) again, while the state soon after independence "established a very large number of medical colleges with sophisticated teaching hospitals in urban areas, [including] an even more sophisticated All-India Institute of Medical Sciences in New Delhi [...] it took them over seven years even to start opening primary health centres" for rural India.

It is a testament to the role of power and privilege in India that elite fiction receives disproportionately more importance in policymaking than subaltern reality. If the general public in India, including in the Delhi region, had any say in policy decisions, they would most likely not have supported the allocation of precious and limited post-colonial resources to a grand medical college and training centre (whether of biomedicine or of indigenous systems of medicine) where their children had a near-zero chance of getting admitted, and where, as patients, they were sure to face immense power asymmetries and possible disrespect and humiliation. Instead of the meaningless behemoth of AIIMS (from their perspective), they would most certainly have spent public resources on local and community-based healthcare infrastructure, or schools, or perhaps even basic sanitary facilities and stable access to food and water.

Clearly, elite self-interest and elite ignorance played a significant, arguably decisive, role in the policy deliberations that led to the establishment of AIIMS. Unfortunately, this was not a one-off incident. It would become a regularly recurring phenomenon in Indian health policymaking to see major decisions based less on ground realities or collectively expressed needs and demands of the public, and more on elite individuals' (groundless) assumptions regarding what the public wanted or needed. The most notorious example of this was the enthusiastic embrace of coercive population control policies by elite groups across the board in the 1960s and 1970s, despite strong disinterest and opposition from subaltern communities.

Health policymaking has always faced challenging questions of resource allotment, but answers to such challenges have invariably privileged elite perspectives rather than comprehensive grassroots evidence and "wide public participation" (as Sunil Amrith put it in a [seminal article](#) on health policy history). The latter will make for more meaningful policy and better public welfare than answers based on the ideas and assumptions of elite individuals and organisations that are vastly disconnected, even today, from the lives of the very people for whom they ostensibly make decisions.

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