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Contextualising Health Policies in Colonial and Independent India

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Abstract

Public Health Policy in India has had a strong colonial legacy which is evident in the successive health plans. Modern medicine and health care were introduced in India during the colonial period. During the colonial period hospitals and dispensaries were mostly state owned or state financed. The private sector played a minor role as far as this aspect of health care delivery was concerned. Eighteenth October 1943 marks a watershed in health policy making and health planning in India. It was a great historical moment. Ever since the Bhore committee report, the relevance of good health was considered as a major precondition of nation building and overall national development. From 1980 onwards, a deliberate attempt has been made to 'decolonize public health care system' by inducting the indigenous system of medicine and health practices under the fold of official health care policy. The National Health Policy 2017 aimed to widen the reach of each and every person in the country, promoting complete wellness and health while making all quality healthcare services accessible to all. Universal coverage of the population through some health plan is historically well entrenched today, whether this be through health insurance or state run health services.

Keywords- Colonial, Public, Health, Policy, Private, Preventive, Stakeholders, Diseases, Programme.

The first document which is said to have laid out the foundations of public health administration in India was actually commissioned by the colonial administration[1]. The successive Five Year Plans and several expert committees bear the colonial imprint. Emerged out of a long colonial subjugation like most of the post-colonial countries, India had embarked upon a comprehensive providential nature of public health policy with a country wide network of primary health centres and sub-centres. The need for a national health policy was mooted as early as 1930s by a group of modernizers in and around Congress. However, the major watershed in the field of health policy came with the Bhore Committee Report, although the country had to wait till 1983 to have a National Policy on health[2].

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Since Colonial period, practitioners who were not formally trained professionals but inheritors of a caste-based occupational system provided health care within ones homes By early 19th century hospitals for the general population were established in chief mofussil towns, besides the Presidency headquarters. Another aspect, which received early attention, at least in the cantonments, were public health measures. The continued high mortality of British soldiers despite good access to medical services led to the appointment of a Royal Commission to enquire into sanitary conditions of the army in 1859. The rural areas had to wait till the Government of India Act of 1919 whereby health was transferred to the provincial governments and the latter began to take some interest in rural health care. During the colonial period hospitals and dispensaries were mostly state owned or state financed. The private sector

played a minor role as far as this aspect of health care delivery was concerned. However, the private health sector existed in a large measure as individual practitioners. Sometimes the colonial administration had resorted to military interventions to push through its agenda of public health. The sanitation drive or the anti-plague initiatives adopted by the colonial administration with the help of the army are examples of it. Our Nationalist leaderships were also designing alternative models of healing, based on indigenous medical and healing practice[3]. One such committee under the Chairmanship of S.S.Sokhery was formed to study the state of health in India. The committee had recognized poverty as the major source of the health problem.

At the time of independence the country inherited a health system devised during the British imperial rule, essentially to provide services to defence forces and the colonial administration, including the native gentry. By and large, the health system was urban based, elite based and curative –oriented and was not geared even to providing minimum health care services to the mass of the rural people. There were four major problems associated with health status of population: overpopulation, widespread incidence of communicable diseases, malnutrition and inadequacy of health care infrastructure[4]. Commissioned by the colonial administration, to take stock of the state of health in colonial India under the Chairmanship of Sir Joseph Bhore Committee came into being on the eve of independence. It is still considered as the template of public health policy and administration in India. The committee had proposed universal providential health services for Independent India. The committee though

commissioned by the colonial administration in 1943 had very little characteristics of the colonial administration.. The Committee's recommendations for future development of the health sector were based on the following main principles namely, that no individual should fail to secure adequate medical care because of the inability to pay for it, the health programme must from the very beginning lay emphasis on preventive work with consequential development of environmental hygiene. the health services should be placed as close to the people as possible,. The Committee also stressed on the active cooperation of the people in the development of health programmes, also it said that doctor who is a the leader of the health team, should be a 'social physician' should combine remedies and preventive measures to confer maximum benefits on the community[5]. The Bhore committee laid special stress on provision for safe drinking water,

Several health schemes and health programmes were earmarked in every five year plan with their respective priorities. However there were hardly any systematic policy on health, integrating several health programmes until 1983. During 1950s and 1960s, the primary focus of Indian health sector was to contain the periodic bout of epidemics. Campaigns were launched to eradicate various diseases, like malaria, smallpox, tuberculosis, leprosy, filarial, trachoma and cholera, by UNICEF, WHO, and Rockfellar foundatiom. The health policies during the first two plans remained unchanged with a seemingly urban bias. The Third Plan had witnessed a rapid increase in the number of PHCs and the delivery of health services continued to be done by health workers .The

family planning which got a a real impetus during the Third Plan continued to enjoy the same predominance in the Fourth Plan period with huge spurt of plan allocation. The Fifth plan envisaged accessibility of health services to rural areas through Minimum Needs Program. From the Sixth Five Year Plan, the community based health system came to occupy the centre stage of health policy. An important milestone in India's health services development was reached with the signing of the Alma Ata Declaration (WHO-UNICEF-Sponsored International Conference on Primary Health Care) on 12 September 1978 at Kazakhstan, recommending "Health for All by 2000 AD', through Primary Health Care approach[6].

Under the National Health Policy 1983 initiatives undertaken mainly were-i) A phased, time-bound programme for setting up a well-dispersed network of comprehensive primary health care services, ii) intermediation through 'health volunteers' having appropriate knowledge and simple skills, iii) establishment of a well –worked out

referral system, iv) an integrated network of evenly spread specialty and super-specialty services[7]. Despite the impressive public health gains, still the morbidity and mortality levels in the country were still unacceptability high. With regard to the private health sector the NHP clearly favours privatization of curative care. The 7th Five Year Plan accepted the NHP advice. It recommended that "development of specialties and super-specialties need to be pursued with proper attention to regional distribution". During the Eighth Plan, resources were provided to set up the Education Commission for Health Sciences, and a few states

had even set up the University for Health Sciences as per the recommendations of the Bajaj committee report of 1987. This initiative was to bring all health sciences together, provide for continuing medical education and improve medical and health education through such an integration. The 9th Five Year Plan by contrast provides a good review of all programs and has made an effort to strategise on achievements hitherto and learn from them in order to move forward.

The main objective of the NHP 2002 was 'to achieve an acceptable standard of good health amongst the general population of the country'[8]. The 2002 policy was to focus on the need for enhanced funding and an organisational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities. Also the policy has identified those diseases which are principally contributing to the disease burden like TB, Malaria, Blindness, and 'newly emerging diseases' like HIV/AIDS. The National Rural Health Mission 2005 brought a total shift in health sector by adopting a holistic approach to health by integrating virtually all the stakeholders(namely state government, panchayats, non-governmental organizations) within its fold with the main objective being well-being of the rural people. The National Health Policy 2017 focuses on Preventive and Promotive Health Care and Universal access to good quality health care services. In order to provide access and financial protection at secondary and tertiary care levels, the policy proposes free drugs, free diagnostics and free emergency care services in all public hospitals, the NHP recommends prioritising the role of government in shaping health systems in all its dimensions[9] Apart from the public sector involvement in the provision of health care services, the NHP 2017 advocates a positive and proactive

engagement with the private sector for critical gap filling towards achieving national goals. The policy looks at problems and solutions holistically with private sector as strategic partners. The policy advocates extensive deployment of digital tools for improving the efficiency and outcome of the healthcare system and proposes establishment of National Digital Health Authority (NDHA) to regulate, develop and deploy digital health across the continuum of care. Priority areas for improvement of environment for health, namely, Swachh Bharat Abhiyan, Balanced health diets and regular exercises, addressing tobacco, alcohol and substance abuse, Yatri surakskha, Nirbhaya Nari, Reduced stress and improved safety in the work place, reducing indoor and outdoor air pollution. Ten key principles of the policy are Professionalism, Integrity and Ethics, Equity, Affordability, Universality, Patient Centred &Quality of Care, Accountability, Inclusive Partnerships, Pluralism, Decentralisation, Dynamism and Adaptism[10] Still the lacunae in the policy is the lack of public funding for health. Contracting of health services from the private sector may be inevitable given that 70% of all outpatients treatments are provided by it. It raises the question of accountability both on the quality and cost of care provided by the private sector. The need of the hour is to make health a justiciable right in the way the Right to Education 2005 did for school education[11].

Structured health policy making and health planning in India is not a post-independence phenomena. In fact, the most comprehensive health policy and plan document ever prepared in India was on the eve of Independence in 1946. However, the issue of common good, which was

supposed to be embedded in public health, was absent in colonial health intervention. Ever since the Bhore Committee report, the relevance of good health was considered as a major pre-condition of nation-building and overall national development. Subsequent governmental policies on health care took Bhore Committee Report as an important benchmark. From 1980s onward a deliberate attempt has been made to 'de-colonize public health care system' by inducting the indigenous system of medicine and health practices under the fold of official heath care policy. In current phase of globalisation, competition can improve quality and bring down costs. In this phase the development of health care services will transit from government-investment to multichannel investment by public, private and cooperative sectors[12]. Financial subsidies to health care subsidies should be borne by these three

constituents. COVID-19 had exposed the fault lines of India's public health system. The pandemic is now useful window of opportunity to undertake public healthcare reforms that are long due. Such reforms are, however, constrained by the path-dependent characteristics of private healthcare in India. In this background, India needs to expand the public healthcare system and enhance the expenditure as per the set goals in NHP-17 and WHO standards[13]. Therefore, the public health policy is needed to revisit to make it truly public in nature by enhancing the healthcare budget; improving patients' ratio: doctors, hospitals, beds, ICUs, ventilators, etc.

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