PUBLIC HEALTHCARE IN INDIA: ITS EVOLUTION AND TRANSITION FROM INDEPENDENCE 1947 TO 2018

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Abstract

India with its vast population in on road to development, the growth rate of which is probably one of the fastest among developing countries. There are many factors which will take this way forward but also which can derail the process. Healthcare is one such factor. Unless this is integrated into the development process and the availability is inclusive for all, the derailing might be a reality. Research shows health can be a causative factor for the economic development especially for a country like India. It also reveals that a healthy nation is a pre requisite to a wealthy nation. If this is the case, is the country awakened to this reality. Systems are developed over time. At Independence and thereafter a number of programmes / policies on healthcare were framed with an aim of eradication of specific diseases and making healthcare available to masses. Also committees formed at various stages to go into specifics for highlighting and giving specific solutions to health related issues gave their verdict. This paper traces the journey of such committees, programmes and policies from Independence till date, analyses their performance and takes us forward to reason out the new ways and paths which will help in ensuring pragmatic positive outcome of present initiatives.

Keywords: *healthcare, health-policies, health-programmes, health-status.*

Introduction to Health and Health Care Services

The well-being and health of people is one of the most important aspects of life and society. The need and the demand for health related services have seen tremendous growth in past years. As per the WHO's constitution (amended in 1986) the principles advocated are:-

Health transcends the physical aspect and encompasses the mental and social wellbeing also. The availability of health care should not be restricted to a few but be a fundamental right and any one irrespective of one's religion, race and political affiliations, social and economic condition should be able to access it. A pre requisite to peace and security is attainment of good health. Concern exists of development of health care in various countries which if lopsided would have bad repercussions in other areas. Every child should have access to the benefits of health care and is so very important for having a harmonious environment. Health for all is attainable only if the benefits of medical and related knowledge are made available. Government commitment in terms of policies and commitment of resources is necessary for attainment of goals along with cooperation of the populace.

The principles as reflected above are so important in today's world for ensuring health for every individual living on the planet. That's not just all to what health really is, instead health is a broader concept and can also constitute other things. Health in the today's perspective clearly means to identify and seek to ensure notonly ahealthy lifestyle but also to continue and want to keep on being mentally and physically healthy.

Healthcare is not possible without the help of the stakeholders in the environment we stay in. We require a structured system of many entities towards this end. WHO's definition of the health system gives a very realistic and a holistic view and defines the purpose of such a system tobe able to firstly promote health for all. Then comes the restoration part and the maintenance of health. In this scenario the constituents of a health care system at a broader level would thus be :-

- Hospitals at various levels of various sizes to include general and specialist types. To include medical practitioners such as doctors, nurses and para medical staff.
- Manufacturers of medicines (pharmaceutical firms).
- Manufacturers of medical and diagnostic equipment.
- Medical centres providing diagnostic services.
- Support services e.g., catering, maintenance, catering for patients and outsiders.

The application and aspects of health care are different in all the countries and this basically depends upon the socio-economic and political forces of the country and the society. There are basically these broad categories of provisions: First, there are countries in which the state provides the finance, provision and administration of services but there are private interests in the form of individual practice, hospitals and other supportive services. Second, there are countries where the state is the one that provides medical care and no private hospital provides such services. Third, there are countries which completely rely on the market for the availability of services.

State of Health Care during the period from Independence (1947) - 1983

At the time of independence and till 1983 there was no formalized planning for health care. Being a state subject as per the constitution, the health care was taken care of through the five years plans. Coupled with this was setting up of various committees related to health and other specific schemes that targeted a specific disease or a medical cause. The 50's and 60's saw multiple programmes being launched to eradicate diseases present those times which were assumed to become an epidemic if not controlled. The programmes for eradication of malaria TB, small pox and cholera saw specific actions and training of manpower. During the first two five year plans no structural change in health care took place. The third five year plan launched in 1961 highlighted the serious shortcoming of infrastructure and manpower but did not give any concrete steps in overcoming these. The 4th five year plan launched in 1969 was no different than its previous version. The 5th five year plan acknowledged the shortcomings of the delivery system and the great divide between rural and urban facilities. Thus the Minimum Needs Programme for bridging the divide was launched.The 6th plan was influenced by the Alma–Ata declaration which advocated 'Health for all by 2000'. It was during this plan period that a serious thought was given to have a policy at the national level and NHP 1983 was conceptualized.

Some of the important legislations prior to independence which were enacted were Quarantine Act 1825, Vaccination Act 1880,Public Health Community 1864, Birth and Registration Act 1873 and Plague Commission 1886. Certain Bureaus and institutions were established for the country by the British. Some important ones were Central Malaria Bureau 1909,The Indian Research Fund association 1911, All India Institute of Hygiene and Public Health 1930 and Rural Health Training centre 1939.

Policy can be defined as a course or principle of action proposed or adopted by institutions or organizations. Before the policy National Health Policy (NHP) of 1983 policy was drafted and accepted as a document to be followed across the country a number of committees were set up during the period of independence reaching out to 1983. One of the earliest committees was the Bhore Committee set up in 1946 just prior to independence. It was also known as Health Survey and Development Committee and Sir Joseph Bhore was appointed as Chairman. The focus was on curative medicines and preventive actions. Some of the important recommendations of this committee were:-

- Integrate the services being offered for curative and preventive aspect.
- Develop Health care centres at Primary level in stages:-
  - Short Term – Measures to include setting up of Primary Health Centres(PHC) at places with population of 40,000.
  - Long Term – Measures to include setting up of 75 bed hospitals for a population of 10,000 to 20,000. Bigger hospitals at district level.
- Training in medical care to prepare physicians trained in preventive aspects

Another important committee was the Mudaliar Committee of 1962 under the chairmanship of Dr AL Mudaliar. It was called the Health Survey and Planning committee. One of the taks given to this committee was to report on the progress made after the implementation of Bhore Committee. The general finding was healthcare provided was highly unsatisfactory. It also gave certain suggestions which were:-

- To see and consolidate the progress made in healthcare system during two five years plans.
- To establish a service on lines of IAS ; to be called 'Indian Health Service'
- To consolidate the Primary Health Centres (PHC).
- Maximum population to be catered for per PHC not to exceed 40,000.
- The next level of referral after PHC to be at District level which is to have a hospital.
- Setting up of additional administrative set up between state and district level for better monitoring up of district medical machinery.
- To have a single entity to cater for all health related issues by merging medical services and health related set up.

In 1975 another Committee was set up called the Shrivastav Committee (1975). It was basically set up as 'Group on Medical Education and Support Manpower'. Mandate was to:-

- To have a relook at the medical education in keeping with the needs.
- To recommend introduction of health assistants cadre – a bridge between medical practitioners and multipurpose workers.

  The recommendations of the Shrivastava Committee were as under:-
  - Health workers to be trained as para professionals and semi professional workers.
  - Primary Health Centres to have three cadres namely Doctors, Health Assistants and Multi-Purpose Workers.
  - Development of a structured referral system.
  - Setting up of Medical and Health Education commission on lines of UGC for suggesting reforms.

The Committee recommendations were accepted which also saw Rural Health Service being launched in 1977.

National Health Policy 1983

National Health Policy 1983 was a turning point of the century in the area of healthcare as after independence this was the first instance that the healthcare was being looked in a holistic way. It was probably the Alma –Ata declaration of 1978 which focused on primary health care being the pillar towards the attainment of health for all by 2000.This paved the way to formulation of NHP 1983.The NHP 1983 was also an effort to integrate the recommendations of the earlier three committees. The policy emphasized the fact that health was an important ingredient in development of the country. It also stressed on the fact that health services needed to be taken to the grass route levels. It also lays stress on the fact that a holistic approach in terms of good nutrition, actions to prevent the adulteration of food articles, provisions of effective drugs , supply of quality drinking water , effective immunization programmes , services looking after child and maternal care, programmes run at school levels for the children, and health care services related to specific occupations were also priority matters . The policy also called for changing the orientation of present setup of health care services starting from lowest to highest.

Key Features of NHP 1983

- Ensuring creation of awareness among the population on health problems and measures to solve them.
- Using technology for making drinking water available.
- Ensuring provision of basic sanitation to populace.
- The acceptance of existence of vast differences in healthcare services at urban and rural areas and actions to bridge the same.
- Establishing an information system related to health management to help in implementation of health programmes.
- Provide support by enacting suitable legislations.
- Collective efforts at different levels to fight malnutrition.
- Research to ensure use of technologies in ensuring better delivery of health care.
- Recognize the fact that alternative medicines can also play an important part as part of health care and its integration in overall scheme.
- It recommended the different plans of various other governmental institutions for the development of human welfare be integrated.

Drawback of NHP 1983

- No mention of social justice which is a pre requisite for ensuring health for all.
- For promotion of community participation no specific measures have been highlighted.
- No mention of health budget for achieving the goals.
- Non communicable disease like heart disease, diabetes had no mention.
- With increasing health benefit to population leading to increasing numbers of elderly persons, no mention of geriatric care.

- Society related diseases like tobacco and drug abuse also do not find a mention.
- Failure to declare health as a fundamental right.

National Health Policy 2002 (NHP 2002)

Nearly 19 years of NHP 1983 being in practice and being implemented saw very little gain in the goals and targets it had set for itself. Thus a need was felt to revise the policy keeping the realities in mind. The state of medical health of the system was not too good during the period prior to 2002. The central government share of finances was limited to just 15%. The public expenditure on health had declined from 1.3% in 1990 to 0.9% in 1999of GDP. The main focus of the new policy was thus to ensure achievement of acceptable levels of health to all the populace of the country and increasing the infrastructure where ever the deficiency existed and increasing access of everyone to the revamped decentralized system.

Key Features of NHP 2002

- Specific goals to be set for achievement in eradication of diseases and establishment of infrastructure in keeping with prevailing circumstances.
- The dawning of the realization for enhancing the funding and revamping of the organizational setup for ensuring equitable access for everyone to the facilities.
- The focal point for everyone's access to be the Primary Health Centre.
- To decentralize the existing health system to ensure better availability.
- All current healthprogrammes to be brought under single umbrella.
- More involvement of private players and the NGO's and their contribution in delivery mechanism.
- Substantial increasing the public expenditure in health care.
- Special focus on diseases like TB, blindness and malaria which are responsible for increasing disease burden.
- Specific tailor made schemes to be initiated in areas of women health care, child care, geriatric care and under privileged sections of the society.
- Ensuring availability of essential drugs at the level of PHC's. This would be in consistent with equitable access for everyone.
- Policy also aims at ensuring under writing of all health related resources for meeting acceptable health levels.
- The approach would aim at rationalizing the allocation of finances and available resources.
- The policy also brings out the role of other governmental departments both at Central and State levels and other institutions in implementation.
- The policy also realizes the fact that efforts from other social areas like improvement in availability of drinking water, ensuring minimum nutrition for everyone special the children, provision of basic threshold sanitation measures etc., would go a long way in ensuring better implementation.
- The concluding remark as part of key features can be said to be a positive attitude of all stakeholders and improved governance would be the key to success in delivery.

Goals of NHP 2002

S. No.	Goals	To be Eradicated / Achieved by
1	Polio and Yaws	2005
2	Leprosy	2005
3	Kala Azar	2010
4	L Filariasis	2015
5	Zero level growth in AIDS	2007
6	To reduce mortality rate due to vector and water borne disease by 50 %	2010
7	Reduction in blindness by .5%	2010
8	Reduction in Infant Mortality Rate to 30 per 1000	2010
9	Reduction of Maternal Mortality rate to 100 per lakh	2010
10	Establishment of one system for health related surveillance, accounts and statistics	2007
11	Increase in public spending from current .9% of GDP to 2.5% of GDP	2010
12	Central Government share to increase to 25% of total health related spending	2010

Drawbacks in NHP 2002

- It failed to achieve one system for health related surveillance , accounts and statistics.
- It failed to increase the state percentage expenditure from 5.5% to 7%.
- Decentralization in delivery could not be achieved to the extent envisaged.
- Envisaged benefits in women's health care, child health care, old age care could not be realized on ground.
- Role defined for local self-government institutions in implementation was far from satisfactory.
- The school health care programmes to ensure focus on health at an early age was not successful in most of the states.

National Health Policy 2017 (NHP 2017)

The need to have a new policy was felt as over 15 years has passed since the last policy came up in the year 2002. Many reasons like India carrying 20% of disease burden of the world (India ranking 143/ 188 on Global Burden of Disease Index 2016), increase in non-communicable diseases, growing incidences of catastrophic expenditure of health costs and as high as 86 % of rural and 82% of urban population not being covered under any kind of expenditure support for health realized the need for a new policy. Also the current pathetic state of all government hospitals needed a paradigm shift in the way we look at delivery of health care to citizens. The three pillars on which the policy is formulated is Preventive and Promotive health care, access for everyone for quality services and the availability to be at a cost affordable by all.

Key Features of NHP 2017

- The public expenditure to be raised to 2.5% of GDP from a current 1.4%. Majority of expenditure to be utilized for primary health care.

- Setting up of Health and Wellness Centres which would contribute to overall improvement in health.
- Emphasis also given to non-communicable diseases like BP, Obesity, diabetes etc.
- A policy shift in which the patient does not have to pay for drugs, emergency services and other related services thus providing financial protection to citizens.
- Tracking of Disability Adjusted Life Index which is an indicator of burden of disease and suitable steps.
- Setting up of a strong regulatory system to ensure good delivery.
- Initiation of reforms for manufacturing in medical and drugs in keeping with 'Make in India' initiatives.
- Introduction of new cadres (mid level) in field of service providers, nursing personnel for effective implementation.
- Increasing the role of private sector.
- Important Targets
  - Availability of 2 beds per 1000 population
  - Increase life expectancy to 70 from a current level of 67.5 by the year 2025.
  - Reduce fertility rate to 2.1 by 2025.
  - Reduce infant mortality rate to 28 (2019), mortality rate of children who are below 5 years of age to 23 per 1000 (2025) and maternal mortality rate to 100 (2020).

Health Related Programmes / Schemes in India

A number of health related programmes have been initiated since independence which was the trend that time to target a particular disease for control /eradication. A few important of these are:-

National TB Control Programme

This scheme was launched in 1962 with an aim to provide prevention of disease by way of vaccination. Also if early cases were detected the control was much more effective. The Revised National TB Control Programme was launched in 1993. By 2015 this programme had treated about 14.2 million patients.

National Diarrheal Disease Control Programme

The statistics of a large number of infants and children falling prey to diarrhea below 5 years made the Government launch this programme in 1978. The focus of this programme was making available salts for oral rehydration and education of the mothers.

Universal Immunization Programme

The expanded programme was started in 1978 for immunization for improving the child mortality rate. The immunization covered six diseases – Dipheria, Tetanus, Pertusis, TB, Measles and Polio.

National Family Welfare Programme

This programme was launched in the year 1952 for control of population. The start was rather slow because of inhibitions, traditions and reluctance of the populace to adopt the measures. It got an impetus in third year plan when the approach shifted from clinical to educating the masses. In the sixties this programme another boost when IUD was introduced.

National Leprosy Eradication Programme

The leprosy control programme was launched in the year 1955 for control of this dreaded disease. This was redesigned with an aim of eradication of the disease in year in the year 1983. The implementation was through control units and centres , temporary hospitalization wards , units for reconstructive surgery etc.

Sexually transmitted Control (STD) Programme

STD spreads person to person by venereal diseases. The programme was launched in year 1955. The focus of the programme was research in various aspects of the disease and training at all levels. As part of these regional centres were to be established for training and testing laboratories for testing purpose. However the achievement of the programme has not been very satisfactory.

National Rural Health Mission (NRHM)

Launched in 2005 -2012 in 18 states with an aim for improving health care indicators, ensure universal access to public health services like safe drinking water ,nutrition ,sanitation and hygiene; prevention and control of communicable and non-communicable diseases, revitalizing health traditions, giving impetus to AYUSH and promotion of healthy life style.

National Health Mission

was launched in 2013, subsuming the NRHM and National Urban Health Mission; initially planned to end by 2018 and now extended till 2020. ASHA (Accredited Social Health Activists) are the first point of contact with the under privileged section of society. The ASHA programme has been successful in bringing people back to public health care. National Mobile Medical Units are covering unassessed areas. National Ambulance Service provides free ambulance service. Janani Shishu Suraksha Karyakram (JSSK) a complimentary programme provides free services to pregnant women. RashtriyaBalSwasthyaKaryakram (RBSK) gives services to specific diseases related to child hood development an, birth defect and disabilities.

Support Policies related to Health

A number of other policies have been promulgated which are specific to a certain aspect. These include the National Population Policy 2000 which lays down the framework for meeting the reproductive and child care needs of the following decade. The National AIDS prevention and Control Policy, 2002, lays stress on measures to be taken for control of AIDS which had threatened to take the shape of a epidemic. The National Blood Policy, 2007 aims to ensure the easy availability of good quality blood from voluntary donors which are free from any type of infections. The National Policy for Women empowerment 2001 dwelled on effective measure to be taken to raise the stature of women at home and workplace and setting up of institutions and mechanism for prevention of violence and harassment. It also contains measure to stop trafficking of girls and women.

Alternate System of Medicines

Since ancient times India has enjoyed the benefit of traditional medicines practiced by saints and gurus. To ensure the optimal utilization of these systems, Ministry of AYUSH was established in the year 2014. AYUSH standing for Ayurveda, Yoga, Unani, Siddhi and Homeopathy. Earlier this ministry was called the Department of AYUSH and prior to that it was established as the Department of Indian system – Medicine and Homeopathy in the year 1995. Ayurveda has its roots in Vedic times. It looks at any disease in a holistic manner taking physical, physical and social aspect into consideration. At present India has 46 colleges and 19 institutions giving specialized treatment in Ayurveda. Yoga has been practiced in India from time memorials. The saints have kept this practice alive passing from generations to generations. It focuses on various physical postures, and controlling the mind. The result is giving a boost to the body resistance thus giving immense physical and mental benefits which is supported by scientific evidence. A number of training centres exist giving basic and specialized training in YOGA. 21 June is now celebrated as the International Yoga Day.

Unani system which originated in Greece came to India via the Arabs. The basis of this system is every human being has a different temperament and treated accordingly. There are 263 hospitals and 40 colleges in India supporting this system. Siddha system with roots in southern India has a strong resemblance to Ayurveda system. The strength of the system lies in treating skin problems and those connected with liver and intestinal tract.

Homeopathy which follows the principle of likes get cured by likes has a huge following in India with nearly 10 % of population depending on this.

SOWA-Rigpa, the Tibetan traditional system is also popular in northern states.

Naturopathy is a system where healthy living is practiced and use of drugs is avoided.

Present state of Affairs

The NHP 2017 is a very pragmatic policy having being framed after due deliberations by the government on reasons why the two earlier policies failed to deliver, understanding the ground realities, realizing the importance of the fact that private players will play a very important part in the overall scheme and the alternate system of medicines will synergize the effectiveness of the delivery system. The current demographic and economic indicators are as:-

Demographic Indicators

S. No.	Parameter	Value
1	Population Census 2011(Final)	1,210,854,977
2	Annual Exponential Growth Rate(%) 2001-2011	1.63
3	Female Literacy Rate, Census 2011	64.6
4	Sex Ratio(Females per 1000 males) 2011	943
5	Sex Ratio(0-6 years) 2011	918
6	C.B.R. (Crude Birth Rate) 2016	20.4
7	C.D.R. (Crude Death Rate) 2016	6.4
8	Natural Increase (CBR-CDR) 2016	14.0
9	"NNMR (Neo-natal Mortality Rate) 2016"	24
10	I.M.R. (Infant Mortality Rate) 2016	34
11	Under 5 Mortality Rate 2016	39
12	Maternal Mortality Ratio (MMR) 2014-16	130

(**Source:** https://nrhm-mis.nic.in/SitePages/HMIS-PeriodicReport.aspx (Ministry of Health and Family Welfare)

Economic Indicators

S. No.	Indicator	Value
1	GDP	$2.454 trillion (nominal; 2017)
2	Per Capita	$1,850 (nominal est.; 2017)
3	Health Expenditure	$ 133 billion (2016)
4	Health Expenditure as % of GDP	3.19 % (total), 1.15 % (public)
5	Per Capita expenditure on health	$ 63

The above statistics reveal a marked improvement in the demographic and economic indicators in comparison to that of 1947. However the state needs to be further improved to provide a meaningful and effective health care system for the masses of the country.

Conclusion

As accepted worldwide and what WHO preambles states that health is a fundamental right of every person in the world , various policies which have been promulgated promised to take health care to every house hold of the citizen of the country. But both the NHP 1983 and NHP 2002 even failed to give the status of 'Right' to health. Whatever the goals of these policies, they failed to deliver what they had intended to. Whether it was poor planning or short - sightedness of the planners or the lack of will to deliver, the fact remains India stands at a threshold which needs to be guided in the right direction. Inadequate infrastructure , dismal contribution of the government in public spending towards healthcare , lack of good governance in this field and lack of ways and means to eradicate the diseases excepting a very few have contributed to present state of affairs. Over 55% of the household reject the public health care. The three main causes for this is poor quality of care, large distances to reach these public facilities and long waiting times. Thus the inability of government to provide healthcare for masses that are left with no choice has driven people to private hospitals. The biggest draw back here is the exorbitant costs. The recent scheme of medical insurance Ayushman Bharat which has the private players a part of it, is also not successful because of low reimbursements. However the danger also exists of this private model going the US corporatization of private health care. The practitioners who operate independently, small clinics and hospitals that also are an important part of the system are likely to be decimated. To avoid this catastrophe, the large hospitals chains need to be discouraged and at the same time smaller clinics can be encouraged with incentives. Collaboration between large hospitals and the smaller versions need to be encouraged. Single payer system for reimbursement is one solution for avoiding complications. Thus it is time to act for ensuring the benefit of healthcare for everyone.

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