Development of healthcare services in India

VIKAS BAJPAI, ANOOP SARAYA

INTRODUCTION
Healthcare services in a country are influenced by its socioeconomic development as well as political trends. The colonial domination by the British was largely responsible for the modernization of healthcare services in India. This influence remained even after Independence in 1947.

Indian society is stratified into classes, castes and social groups based on ethnicity, race and gender. The aspirations of all these groups—often competing for a greater share—shape the developmental processes including healthcare institutions. Though policy-planners seek to reconcile these competing interests, the dominant sections corner the lion’s share of invariably limited resources. This is reflected in the way health resources are utilized and appropriated.

Like competing social groups at the national level, unequal power relations exist among nations resulting in unequal distribution of international resources for healthcare. This too shapes health policies, and the development of healthcare systems in both the smaller and weaker nations.

Thus, the development of healthcare services in a country needs to be understood as a process that takes shape under the influence of competing and contradictory aspirations of different sections of society and countries. We need to understand these influences to develop equitable health services in India.

PUBLIC HEALTH UNDER THE BRITISH
The Indian Medical Service of the East India Company acquired an all India character in April 1896, with the amalgamation of the Bengal Medical Service, the Madras Medical Service and the Bombay Medical Service.1 The medical services under the British served their interests, i.e. ensuring the health of their troops and that of the European settlers, rather than the health needs of the local population. However, frequent outbreaks of disease in the general population due to poor sanitary conditions left British settlements vulnerable, forcing the British administration to take steps to control the epidemics as well as other public health measures. For example, the Royal Commission of 1859 recommended the establishment of a Commission of Public Health in each presidency and pointed to the need to improve sanitation to prevent epidemics in the general population, so that the health of the British Army could be better taken care of.2 The Central Sanitary Department was formed in 1870, followed by sanitary departments in different provinces by 1879.1 The Vaccination Act (1880), the Births and Deaths Registration Act (1873) and the Epidemic Diseases Act (1897) were other such measures. In 1939, the Madras Public Health Act was passed, which was the first of its kind in India.3

The Montgomery–Chelmsford Constitutional Reforms of 1919 led to the transfer of public health, sanitation and vital statistics to the provinces under the control of an elected minister. The Government of India Act, 1935 gave further autonomy to provincial governments. All health activities were categorized in three parts: federal, federal-cum-provincial and provincial. This scheme continues till date.

With the British deciding after World War II to transfer power to the local leaders, plans were made for the development of health services in independent India. The most important development was the appointment of the Health Survey and Development Committee (popularly known as the Bhore Committee) in 1943 to survey the existing health structure in India and make recommendations for the future.3 The recommendations made by this committee are important in as much as they epitomized the hopes and aspirations of the people, and committed the government of independent India to the all round development of the health of the people.

THE BHORE COMMITTEE
The landmark recommendations made by the Bhore Committee in 1946 continue to be relevant even today. The committee said, ‘Expenditure of money and effort on improving the nation’s health is a gilt-edged investment which will yield not deferred dividends to be collected years later, but immediate and steady returns in substantially increased productive capacity. We need no further justification for attempting to evolve a comprehensive plan which must inevitably cover a very wide field and necessarily entail large expenditure, if it is to take into account all the more important factors which got the building up of a healthy, virile and dynamic people.’4

Committing the State as the chief guarantor of the health of its people, the Bhore Committee said: ‘The idea that the state should assume full responsibility for all measures, curative and preventive, which are necessary for safeguarding the health of the nation, is developing as a logical sequence. The modern trend is towards the provision of as complete a health service as possible by the state and the inclusion, within its scope, of the largest possible proportion of the community.’4

The Bhore Committee epitomized an epidemiological approach to development of health services in conformity with the principles of social justice, equitable access, community participation, integration of preventive, promotive and curative services, and primacy to the needs of the rural people. There was a short-term plan and a long-term plan for developing the health infrastructure.4 The Interim Government which was formed before Independence, accepted the recommendations of the Bhore Committee.

Meanwhile, the sub-committee on health of the National
Planning Committee of the Indian National Congress (Sokhey Committee) provided its own set of recommendations which underscored the direction given by the Bhore Committee. In addition, it stressed upon the need to integrate the indigenous systems of medicine within the mainstream to achieve self-sufficiency in healthcare.5

HEALTH SERVICES SINCE INDEPENDENCE
Post-Independence, health planning became an integral part of planning for socioeconomic development. Indian planners conceived the development of health services integrated with plans for tackling unemployment, malnutrition, social justice, housing and environmental sanitation.6 However, this seemed difficult to achieve in practice.

In the two decades after 1947, health planning was done by way of schemes and programmes that were formulated as part of 5-year plans. During this time several committees were formed to evaluate the achievements and failures of these programmes.7 Some important landmarks are discussed.

VERTICAL DISEASE CONTROL PROGRAMMES
Faced with a large burden of communicable diseases, limited resources and a need for rapid progress, there was impatience among health planners. Hence, a number of short-term measures were proposed for these problems, looking the need for overall socioeconomic development of the people, as had happened in the West. This resulted in a series of techno-centric campaigns against malaria, smallpox, leprosy, filariasis, trachoma, cholera and for family planning. Large sums of money were made available for these programmes, at times at the cost of general medical services, in the hope of controlling or even eradicating these diseases.6 The limitations of such an approach were apparent rather early. Even though the National Malaria Control Programme considerably brought down the incidence and prevalence of malaria, efforts to eradicate malaria through an eradication programme were ineffective due to inefficiency of general health services to be able to maintain the gains of the control programme. As a result, outbreaks of malaria continue to occur in different parts of the country till date. The leprosy eradication programme suffered a similar fate. India launched the National Leprosy Elimination Programme in 1993 to decrease the prevalence of leprosy to the WHO defined target of <1 per 10 000 population. This target was achieved in 2005. However, India still has 64% of prevalence and 78% of new case detection worldwide.7 About 7 years after achieving the WHO target of leprosy elimination, there are reports of leprosy increasing again.8,9,10

The work done by tuberculosis workers was a notable exception to this general trend. The National Tuberculosis Control Programme (NTP) that was formulated by the National Tuberculosis Institute (NTI), Bangalore, based on some pioneering research done in India, served as a model for designing of tuberculosis programmes in many other countries. Halfdan Mahler, who later became the Director General of WHO and had worked as a researcher at NTI, said that many of the principles developed in the course of formation of the NTI directly fed into the Alma Ata declaration of 1978.11 However, these notable achievements also failed to deserve the support they needed from the government.12 In 1988, the Institute for Communications, Operations Research and Community Participation (ICORCI), which did a detailed study of the NTP provided 86 detailed recommendations to improve the functioning of NTP. It observed: ‘It has been repeatedly brought to the attention of the Expert Team that NTP has been given a low priority. This has also been confirmed by the analysis of information collected.’13 Unfortunately, not even one of the ICORCI recommendations was acted upon by the government.

PRIMARY HEALTH CENTRES
The establishment of the first primary health centre (PHC) in October 1952 as part of the Community Development Programme (CDP) to provide integrated preventive, promotive and curative services, was a landmark in the development of healthcare services in rural India. This was the first step towards implementation of the recommendations of the Bhore Committee.14

SOCIAL ORIENTATION OF MEDICAL EDUCATION
In 1952, upgraded departments of preventive and social medicine were established in medical colleges to integrate the social, cultural and economic context of community health into the medical curriculum and provide a social dimension to the practice of clinical disciplines.6

FAMILY PLANNING (WELFARE) PROGRAMME
India was the first country to start a state-sponsored family planning programme in 1951 (First Plan period). Since then, the approaches of reducing population growth have taken a variety of forms.15

THE MUDALIAR COMMITTEE (1962)
The Mudaliar Committee was set up in 1959 to review the progress made in the health sector during the first two plans and to lay down recommendations for the future. The committee noted that even though mortality due to diseases such as malaria, smallpox, cholera, etc. had shown a substantial decline, basic health services had still not reached half the population. Not only was there a tremendous shortfall in the number of PHCs but the quality of services provided in them was very poor. Though doctors had been trained using public funds, they were actually doing private practice.16 The gains of the vertical disease programmes were imperiled due to deficiencies in the network of general health services such as the PHCs, which were supposed to have consolidated and maintained these gains.17 The condition of the secondary and district hospitals was also no better, while curative services in the cities continued to grow.

The Mudaliar Committee recommended that there should be no further expansion in PHCs and efforts should be directed at consolidating them, thus bringing about a shift from ‘coverage’ to ‘quality’ of services. The overall thrust of the committee was on the techno-centric approach to healthcare, emphasizing on training more doctors, while the numbers of other medical personnel stagnated.7 The context of socioeconomic development seemed further detached from the scheme of improving the health of the people.

OTHER COMMITTEES
Several other committees were constituted from time to time to look into different aspects of healthcare services such as the problems of implementation of disease control programmes, multipurpose workers under the health and family planning programmes, health manpower planning and development, integration of health services and medical education.18

MINIMUM NEEDS PROGRAMME
The lack of a meaningful impact of development during the 1950s and 1960s on the lives of the poor in India led to the government...
developing a Minimum Needs Programme in the Fifth Five-Year Plan. This programme was carried through to the Sixth Five-Year Plan. It included elements of health, nutrition, water supply, environmental improvement, education, etc. 19

The government came up with schemes to convert ‘unipurpose’ workers engaged in single disease programmes to multipurpose workers in 197120 (and the Community Health Volunteers’ scheme in 197721) in order to improve the delivery of basic healthcare to the people. However, these changes had little overall impact.

PRIMARY HEALTHCARE
India committed itself to the WHO goal of ‘Health for all by 2000 AD’ in 197722 and was a signatory to the resolution on provision of ‘Comprehensive Primary Health Care (PHC)’ as a strategy to reach the goal of ‘Health for All’ at the WHO conference in Alma Ata in 1978.23 However, these commitments have not translated to visible action and improvement in the health scenario.

ERADICATION OF SMALLPOX
The eradication of smallpox comes through as a major achievement. The last case of smallpox occurred in India in May 1975 and WHO declared India a smallpox-free country in 1977.

NATIONAL HEALTH POLICY (NHP) 1983
It was not until 1983 that the need for a health policy was recognized by our health planners. The NHP 1983 was a feeble attempt in the middle of the Sixth Plan period to synthesize recommendations of three important earlier committees—the Bhore Committee of 1946, the Mudaliar Committee and the Srivastava Committee.24 In the backdrop of ‘Health for All by 2000 AD’ and the Alma Ata declaration on primary healthcare, the NHP 1983 recommended ‘universal, comprehensive primary healthcare services which are relevant to the actual needs and priorities of the community at a cost which people can afford’.25 However, the policy failed to declare healthcare as a fundamental right of the people.

FIVE-YEAR PLANS
With respect to health, the 5-year plans have been high on rhetoric but have not been able to deliver on the ground. The die was cast from the First Plan when only 5.9% of the total plan outlay was committed to health as against a minimum of 15% recommended by the Bhore Committee. For the Second and Third Five-year Plans the outlay for health was 5% and 4.25%, respectively.26

After a series of lacklustre plans, the Sixth Plan stated that ‘there is a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and superspecialization and highly trained doctors which is availed of mostly by the well-to-do classes. It is also realized that it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services’.27 This plan was influenced by the Alma Ata declaration of Health for All by 2000 AD and the ICSRR–ICMR report of 1980.28 As a corrective measure the plan strategized provision of health services to the rural areas on a priority basis, training of a large cadre of first-level health workers selected from the community and emphasized that horizontal and vertical linkages had to be established among all inter-related programmes, such as water supply, environmental sanitation, hygiene, nutrition, education, family planning and maternal and child health (MCH)29–30—an integrated approach at developing the health system and not just the health services system.

However, not only were no concrete plans drawn to implement the strategy of the Sixth Plan, but by the time of the Seventh Plan (1985–90) there was a discernible change in the tone, which set the stage for implementation of what is commonly referred to as ‘Health Sector Reforms’ (HSR). The Seventh Plan stated that ‘our emphasis must be on greater efficiency, reduction of cost and improvement of quality. This calls for absorption of new technology, greater attention to economies of scale and greater competition’ and ‘development of specialized care and training in superspecialties would be encouraged in the public and the private sectors’.29

Beginning with a major economic crisis at the start of the Eighth Plan (1992–97), there has been a free fall through the Ninth (1997–02), Tenth (2002–07) and Eleventh Plan (2007–12) periods, in terms of what had been set out by Bhore Committee. ‘Health for All’ got changed to ‘Health for the Underprivileged’ in the Eighth Plan.30 Subsequently, the structural adjustment policies (SAP) and HSR were key elements as part of the philosophy of globalization, privatization and marketization of the health sector.

While the expenditure on communicable diseases decreased substantially from 28.4% of the layout for health in the Second Plan to 4.2% in the Eighth Plan, in the same period the expenditure on family planning increased from 1.3% to 26% of the layout for health (Table I).31 This was possibly a policy shift dictated by and reflecting the concern of international agencies and the western world on population growth in developing countries.32,33 However, socioeconomic development is a necessary condition for population stabilization, as has happened in developed countries. The achievements of our population policy are a testament to this omission. Meanwhile, communicable diseases continue to claim many lives every year.

STRUCTURAL ADJUSTMENT PROGRAMME AND HEALTH SECTOR REFORMS
In the 1990s, we saw the implementation of what has been called the ‘new economic policies’ and ‘structural adjustment’ policies. Before being implemented in Asia, similar policies had been implemented in Latin America and Africa. These were a set of uniform strategies prescribed to countries by international funding agencies irrespective of the country’s context and needs.32 The SAP led to the introduction of HSR in India. The main aspects of the International Monetary Fund–World Bank inspired reforms were: cuts in health sector investments, opening up of healthcare to the private sector, introduction of user fees, private investments in public hospitals, and technocentric public health interventions.33 Cutbacks in the welfare sector resulted in a direct impact on primary healthcare.34 The poor have been the worst sufferers of these reforms. As three-fourths of the Indian population subsists on less than ₹20 a day,35 access to healthcare is poor as 80% of healthcare is in the private sector36 and healthcare in the public sector has had decreasing inputs over the past few decades. Nevertheless, health sector reforms have a strong constituency among the middle- and the upper middle-income groups who have largely opted for private healthcare services.35,36

NATIONAL HEALTH POLICY (NHP) 2002
The NHP 2002 is seeped in the spirit of free market economy and does away with socialist policies in the health sector. The policy gives an important role to the private sector in the provisioning of healthcare. It says: ‘The contribution of the private sector in providing health services would be much enhanced, particularly for the population group which can afford to pay for services… In
principle, this policy welcomes the participation of the private sector in all areas of health activities—primary, secondary or tertiary... The policy also encourages the setting up of private insurance instruments for increasing the scope of coverage of the secondary and tertiary sector under private health insurance packages.' Even in respect of the poor the policy says: 'In the context of the very large number of poor in the country, it would be difficult to conceive of an exclusive government mechanism to provide health services to this category. It has sometimes been felt that a social health insurance scheme, funded by the government, and with service delivery through the private sector, would be the appropriate solution.'

As a result of this policy, a much larger and organized private healthcare system has evolved in the form of corporate hospitals, at the cost of large public subsidies, catering to the rich and health tourists, while large population groups in India do not have access to some of the most basic healthcare services.

NATIONAL RURAL HEALTH MISSION (NRHM)
The NRHM was launched in April 2005 in the backdrop of what has been described as the ‘advanced stage of decay of the health services system, particularly the rural health service system of the country’ by the Independent Commission on Health in India, set up under the aegis of the Voluntary Health Association of India. The Planning Commission also paint an equally gloomy picture. The NRHM was an attempt to improve the provision of healthcare services to the rural people of India. However, the ability of NRHM to deliver on its stated objective has been seriously questioned by some leading public health experts since the time of its inception itself, given the manner of its conceptualization.

Table I. Intrasectoral financial allocations for the health sector (in millions of rupees)

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<tr>
<td>Control of communicable diseases</td>
<td>231</td>
<td>(16.5)</td>
<td>640</td>
<td>(28.4)</td>
<td>690</td>
<td>(27.7)</td>
<td>231</td>
<td>(10.2)</td>
<td>1270</td>
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<td>Total health</td>
<td>903</td>
<td>(64.5)</td>
<td>1460</td>
<td>(64.9)</td>
<td>1500</td>
<td>(60.2)</td>
<td>939</td>
<td>(41.6)</td>
<td>4335</td>
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<tr>
<td>Family planning</td>
<td>7</td>
<td>(0.5)</td>
<td>30</td>
<td>(1.3)</td>
<td>270</td>
<td>(10.8)</td>
<td>829</td>
<td>(41.6)</td>
<td>3150</td>
</tr>
<tr>
<td>Water supply and sanitation</td>
<td>490</td>
<td>(35)</td>
<td>760</td>
<td>(35.8)</td>
<td>720</td>
<td>(28.9)</td>
<td>490</td>
<td>(21.7)</td>
<td>4070</td>
</tr>
<tr>
<td>Grand total (Health, family planning, water and sanitation)</td>
<td>1400</td>
<td>(35)</td>
<td>2250</td>
<td>(35.8)</td>
<td>2490</td>
<td>(28.9)</td>
<td>2258</td>
<td>(21.7)</td>
<td>15555</td>
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Figures in parentheses are percentages of grand total, except for communicable diseases where the figures in parentheses are percentages of total health. (Source: Health care systems in transition III. India, Part I. The Indian Experience. J Public Health Med 2000;22(25–32).

The question remains as to how to optimize and utilize resources without changing a policy that supports private (for-profit) over public healthcare, curative over preventive and promotive healthcare, urban over rural healthcare and a medical education system that continues to train doctors who aspire for careers in urban, private sector hospitals and in developed countries rather than work in rural areas and among the poor and less privileged. Even where public funds are being spent, the emphasis is increasingly on public–private partnerships and the role of ‘civil society organizations’. It is unclear how the conflicting aims of profit-oriented healthcare and publicly funded healthcare for the poor and needy will be reconciled in the public–private partnerships.

The Justice Qureshi Committee set up by the Delhi Government to look into the functioning of private hospitals in Delhi which had received large public grants in the form of free land and tax rebates, found that most of these hospitals had defaulted on their obligation towards treating poor patients free of cost. The public component of the public–private partnerships can dominate only when public healthcare occupies an indisputable upper hand in overall healthcare—a stage that has been consigned to history in India.

The NRHM has resulted in progress in some states in terms of creating additional sub-centres, PHCs, community health centres, procurement of equipment and recruitment of personnel. However, there is lack of a comprehensive vision for improving the health system and thereby the health of the people. As on 1 March 2011, there were 45 062 doctors in the public sector to serve an estimated 833 million people in rural India, i.e. approximately one doctor to every 18 488 persons (presuming that all posts were occupied).

The contradictions are glaring. The NRHM never envisioned the need to train in large numbers what Banerji has described as ‘Managerial physicians, who have the epidemiological, managerial, social and political competence to provide leadership in the administration of the health services in the country’. The important task of navigating country’s public health has instead been handed over to the ‘generalist bureaucrats’ or specialist clinicians sitting in the ministry who never had the opportunity to face the formidable challenges of rural health in India. Besides, health invariably is not a product only of efficient medical services. It is determined in the main by the social and economic condition of the people that determines their ability to earn, to eat, to afford a decent living and to access healthcare in need. Experts have estimated that rural poverty in India increased from 72% in 1973–74 to 87% in 2004–
05 as per the original nutritional norms of per capita consumption of 2400 calories and 2100 calories for rural and urban India, respectively.46 India State Hunger Index Report published in 2009 calculated the hunger index for 17 Indian states. It states that ‘not a single state in India falls in the low hunger or moderate hunger category defined by the Global Hunger Index 2008. Instead, most states fall in the alarming category, with Madhya Pradesh falling in the extremely alarming category. Four states—Punjab, Kerala, Andhra Pradesh and Assam—fall in the serious category. Punjab, which has the best hunger index score in India is placed below Gabon (in sub-Saharan Africa), Honduras and Vietnam.47 However, there is not even a hint of how these pressing issues shall be tackled in NRHM, except of course some reference to intersectoral coordination. The NRHM, in our opinion, has become focused on reducing the maternal mortality and infant mortality rates—an impression that is conveyed from the prominence given to it even in the National Review Mission Reports. Even the Sixth Joint Review Mission Report of NRHM acknowledges that the Mission is way behind in achieving its targets set for various health indicators.48

CONCLUSION

We have sketched above the trajectory of the development of the health services in India and it certainly is not the most desirable one. Have the governments since 1947 not been aware of these flaws? Governments could not possibly be as ignorant as that. There are nevertheless plausible reasons for the course of history of development of health services in India to have been what it has been post 1947. It is of utmost importance for every health worker seriously dedicated to the cause of improving the health of India’s people to understand these reasons in order to place his or her efforts in perspective. In the second part of the paper we shall seek to understand some of these crucial factors that have shaped the development of health services in India.

ACKNOWLEDGEMENT

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