Long Standing Weakness of the Public Health System in India

In India during British rule, state and philanthropic intervention played a significant role in healthcare, though most of these facilities were located in large towns, thus projecting a clear urban bias and neglect of the rural population. Modern medicine gradually undermined systems of Ayurveda and Unani, and those traditional practitioners who survived often concentrated in the small towns and rural areas where modern medicine had not yet penetrated. Despite the Bhore committee's recommendations at the dawn of independence towards correcting the rural-urban imbalance and suggestion of integrated planning for increasing access to health services, even post-independence the weakness of public health services in rural areas and growth of private practice continued. Public health remained a low priority in successive five-year plans and public health efforts remained focused on specific vertical programmes, of which the Family Planning programme was the most prominent. This contributed to the slow and inadequate improvement in health of the population in the period from the 1950s to the 1970s. It may be noted that until 1983 India had no formal health policy; the planning process and various committees appointed from time to time provided most of the inputs for the formulation of health programme design.

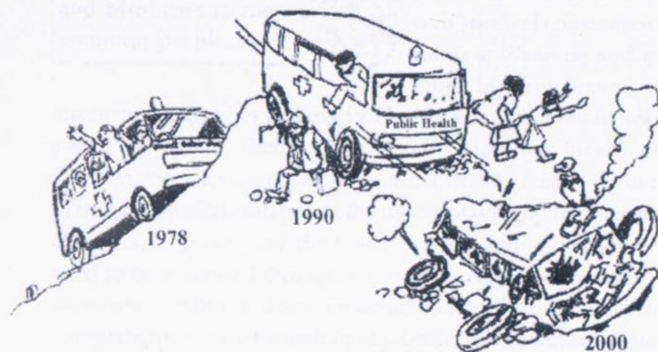
This unsatisfactory situation was recognised in the National Health Policy of 1983, which was critical of the curative-oriented western, urban-based model of healthcare, and emphasised a primary healthcare approach. There were recommendations for preventive services and a decentralised system of healthcare, focusing on low expenditure, de-professionalisation (involvement of volunteers and paramedics) and community participation. Although, significant expansion of healthcare infrastructure did take place during the 1980s, this remained grossly underutilised because of poor facilities and low attendance by medical staff, inadequate supplies, insufficient hours, lack of community involvement and lack of proper monitoring mechanisms. The Primary Healthcare Approach was never implemented in its full form, and selective vertical programmes were pushed as a substitute for comprehensive health system development.

This already unsatisfactory situation seriously worsened with the onset of globalisation-liberalisation-privatisation from 1990s onwards. In this situation of inadequate and top-down development of public health, the impact of neo-liberal policies from the 1990s has precipitated the crisis of the public health system; there has been a retreat from even the nominal universal healthcare access objectives. Guided by prescriptions from agencies such as the World Bank, public healthcare has been further constricted to certain 'cost effective' preventive-promotive services and selective interventions, paralleled by spiraling and unregulated expansion of the private medical sector. Introduction of user fees at various levels of public health facilities has also been a feature of the phase since 1990s.

A new National Health Policy was announced in 2002, which

acknowledged that the public healthcare system is grossly deficient on various fronts and resource allocations are generally insufficient. While this policy stated goals like "increase utilisation of public health facilities from current level of less than 20% to more than 75%", no corresponding large-scale measures for rejuvenating and strengthening the debilitated public health system were planned. In fact the 2002 NHP seems like a collection of unconnected statements, a dilution of the role of public health services and an unabashed promotion of the private health sector, including 'medical tourism'.

Thus the phase of privatisation-liberalisation has witnessed staggering health inequities, resurgence of communicable diseases and an even more unregulated drug industry with drug prices shooting up, adding up to the current crisis in public health. Along with the retreat from the goal of universal access, special health needs of women, children and other sections of society with special needs have become further sidelined or are inadequately addressed. A much overdue response to this situation, with certain positive features but beset with its own contradictions, was launched in the form of NRHM in 2005, which is discussed in a separate section below.



To summarise, the objective of universal access to good quality, appropriate healthcare, envisaged over half a century ago at the dawn of Independence, today remains unrealised. Public health has effectively remained a low priority for the Indian state in terms of financing and political attention. Consequently, there has been a major and growing divergence between the policy rhetoric (such as the Alma Ata Declaration) and actual implementation. Moving in to occupy the hiatus, there has been a massive growth of the private sector, which is unaffordable for a large section of the population, and which lacks any regulation and standardisation.

Closely related to this, and compounding this situation has been a Techno-managerial model of healthcare inspired by the West, with an inability to evolve effective indigenous models and appropriate technologies, or to effectively integrate modern and indigenous systems of medicine in contrast to China. The system of Health planning and decision making has remained highly centralised and top-down with minimal accountability, little decentralised planning or scope for genuine community initiatives. A prime example of this is the various communicable disease control programmes that are discussed separately in a later section.