Chapter 3: Understanding Healthcare Policies of India

Public policies have been defined in many ways but the easiest way to understand would be to see it as, 'anything the government chooses to do or not to do' (Dye 1972, 3). Policies can also be perceived as acts that include goals and ways to achieve them, whether clearly stated, adequately supported, or poorly formed (Howlett and Cashore 2014). For many, the tall claims made by India's healthcare policies are seldom met in actions and the reasons for the gap are found in the low funds, absence of accountability and bad governance. A participatory democracy that has adopted welfarism has also failed to deliver since instead of simplifying things, many institutions have 'duplicated, stalled, or delayed' the process of decision making (Rao 2017, xv). An attempt has been made in the following section, to trace the development of healthcare in India through time. This section is divided into four parts: healthcare in pre-colonial India, postcolonial India till Emergency, healthcare policies during the years of turmoil, leading up to liberalisation and policies post 1991 India, till 2015.

It needs to be mentioned that modern system of medicine and healthcare is relatively a recent development. William Rosen (2017) links it to the discovery of antibiotics, Thomas Helling (2022) traces its roots to the "Great War" of 1914-1918, while for some other it had emerged after Industrial Revolution in the 18th century[1]. However, caring and healing are as old as human civilisation. Famous Anthropologist Margaret Mead, apparently in one of her classes had accepted that a healed femur bone (longest bone in the human body) some 15,000 thousand years ago was the first sign of civilization. That a human cared and nurtured another ailing human to recovery, indicates how old the practice of care and healing is[2].

3.1 Healthcare in pre-colonial India:

Atharva Veda seems to document the earliest developments in the field of medicine. The practice of medicine went in to the hands of the Brahmins by 700 B.C. and 'halls of healing' were founded between 700-600 B.C. (TNAI 2001, 1). The *Atharva Veda* talked of *Ayurveda*

[1] https://www.medicalnewstoday.com/articles/323538#infectious-diseases. Last accessed 21.3.22
[2] https://www.purdue.edu/research/life-sciences/newsletter/introduction-november-2020/. Last accessed 21.3.22.

looking into various ways of healing the human body like with the use of medicine, with the use of surgery, by resorting to Psychiatry and several other means. The healers also had the knowledge of Ophthalmology, Toxicology and were believed to cure infertility (Shah 2018). The teachings of Susruta, the famous surgeon, and Charaka, the famous physician is well-documented in treatises or *Samhitas* like *Charak Samhita, Susrut Samhita,* and the *Ashtangha Hridaya Samhita* (comprising brief works of Charaka and Susruta (TNAI 2001,1; Shah 2018). Susruta defined the relation between the doctor, patient, nurse and medicine as "the four feet upon which cure must rest" (TNAI 2001, 4). Other contributions in the field of Ayurveda, include, Vagbhatta's *Astangahrdaya* (seventh century), a few epics of Jatakas, travel accounts etc. (Saini 2016, 254).

With the rise of Buddhism, especially during the reign of Ashoka the great, lot of large hospitals were built for men and animals. Buddhists paid attention to the "bodily health" of its members and Buddha on one occasion was believed to have said, 'He who would care for me should care for the sick' (Embree 1992, 116). Various monasteries became seats of learning of medicine, like in Taxila, Nalanda and later King Buddha Das is believed to have designed a sort of state medical system where 'for every ten villages on the main roads of India' a doctor was appointed. (TNAI 2001, 5). Gangolli, Duggal and Shukla argued in their work that even in those days a rural urban divide existed. They noted that, 'structured medicine existed mostly in towns around the courts of the rulers; and in the countryside healers operated as practitioners of what we term today as "folk medicine'" (Gangolli, Duggal and Shukla 2005, 22).

With the decline in Buddhism, the practice of medicine got restored in the hands of Brahmins; the Buddhist hospitals disappeared and the practice and development of medicine suffered as the idea of "pollution" started having a determining role and the physicians did not come into contact with blood which was considered "impure". (TNAI 2001,6). The ideas of "pure" and "impure" play an important role in care even today, an issue which will be dealt in this thesis in various places. After the 10th century, with the advent of Muslim rule, the Ayurvedic system of medicine started stagnating and Unani, based on Greco-Arab system of knowledge, started gaining popularity and state patronage (TNAI 2001, 6; Alavi 2008, 855).

Modern medicine and healthcare system developed in India during the colonial times displacing the indigenous, less formal system of medicine and healthcare. Before 1800, western medicine was limited to European enclaves and port cities like Chennai, Mumbai, Kolkata (previously known as Madras, Bombay, Calcutta), etc. and Europeans took help of indigenous

medical practices as they thought that the indigenous medical practitioners would know about the diseases of the region more accurately and would know better what medicine would be better suited. It was a century later that western medicine grew in stature as 'one of the most confident expressions of British political and cultural hegemony in India' (Arnold 1993, 12). It is interesting to note here that although the Orientalists praised various ancient texts and writings on medical issues or medicine, they were critical of the decline of native medical system over time. The Anglicists on the other hand were not much impressed by vernacular works on medicine (Hochmuth 2006, 44).

As David Arnold has pointed out, the colonialism attempted to use the *body as a site* where the power of the colonial authority could be established along with its legitimacy and control (Arnold 1993, 8-10). Daniel Headrick saw medicine as a tool of the British empire, and found it necessary to study certain diseases like cholera, dysentery, leprosy, malaria etc. and their correlation with certain place or environment. As a result, many medico-topographical surveys were conducted during the colonial times (Headrick 1981). Agreeing with Arnold, that 'new' ideas of western science and medicine were "enforced", Bala argued that Indian medical science was socially and culturally "reconstituted" (Bala 2014, 4). During the colonial days two main trends could be seen. While the 'indigenous patrons', comprising the 'best educated social echelons', quickly responded to the calls for new medical policies, there was also the presence of high-caste Hindus, who were instrumental in 'restructuring traditional Indian medicine'. As the state started to emerge and take shape it was influenced by 'new' caste identities. This coupled with different types of patronages, gave direction to medical practice 'through a specific trajectory of conflict, acceptance and eventual accommodation' of both knowledge systems – western and indigenous (Bala 2014, 12).

Indigenous medicine got the support of the East India Company, when in 1832, the Native Medical Institution was established to train Indians, so that they can be employed as 'native doctors' in several establishments in the Bengal Presidency. Here knowledge about both indigenous and western medicine was imparted. However, it ceased to exist in 1835 as it was considered inadequate (Bala 2014, 14). Later the urban educated middle-class elites and members hailing from upper echelons resisted and renegotiated with modernity as it came to be represented by the colonial rulers. This necessitated them to revisit or rediscover Indian medical science as was practiced in earlier days and thus, there was a re-emergence of Ayurveda (and to some extent Unani) as a 'political and national symbol' (5).

It was along this nationalist zeal that Mahendralal Sircar had founded the Indian Association for the Cultivation of Science, which gave impetus to indigenous science and medicine. Prafulla Chandra Roy founded the Bengal Chemical and Pharmaceutical Works in 1893 for the purpose of manufacturing and selling of indigenous drugs. From the colonial government's point of view, it was important to bring women 'within the purview of medical gaze which was at the same time an imperial gaze'. Countess of Dufferin's Fund was aimed at providing medical care to native women and later separate hospitals and dispensaries for women and children enabled them to access institutionalised medical care. The nationalist project also required women to be aware of health and hygiene, which required a 'circulation of medical knowledge, ideas and objects' (Bala 2014, 14-16). Scholars like Lata Mani and Uma Chakraborty have pointed at the 'collusion' between two existing patriarchies – imperialist and indigenous, while addressing the question of women rights and role in 19th century India (Sangari and Vaid 1989). Numerous exhortative texts during this time focused on building a healthy home, which would be crucial for building the foundation of a strong nation.

While commenting about the beginning of Public Health Service in India, the Sokhey Report mentioned the role of Royal Commission which was appointed in 1859, after the revolt of 1857. Though the aim was to evaluate the health status of the army in India, corrective measures were targeted not only towards the army but also 'civil population' and 'Commissions of Public Health' were set up in the provinces of Bengal, Madras and Bombay in 1864. Though recommendations like deployment of trained healthcare workers for towns and several districts could not be materialized, administrative posts created at the centre and the provinces, led to the creation of the post of Sanitary Commissioners, charged with the tasks of overseeing sanitation issues and the process of vaccination. The success was limited due to limited staffing. Towards the end of the 19th century, with the outbreak of plague in India and subsequent publication of the report by the Plague Commission in 1904 highlighted the need for a strong public healthcare service system where research, laboratories, vaccines were regarded as important requirements (Bhore 1946, vol 1, 24). According to Arnold, the idea of public health triumphed (over 'enclavism'), with the prominence given to the development of tropical medicine in 1890s, which in turn depended on the germ theory of disease This phase also saw state intervention in developing medical system which reached its peak during the 1890s and 1900s following the outbreak of the Indian plague epidemic. (Arnold: 1993, 13)

Another important turn of events took place with the passing of the Government of India Act of 1919, by which health was transferred to the provincial governments. Further, the

involvement of Rockefeller Foundation, with the government in providing preventive health care programmes in Madras Presidency was a new start to rural health care expansion. Its support was extended to Mysore, Travancore, United Provinces and Delhi. The Rockefeller Foundation also supported research on malaria (Bradfield 1938, 274-275). Further, the Government of India Act, 1935, granted more autonomy to provinces to frame internal health policies and implement them. This act is important as it influenced the organisation of healthcare in India, at the centre and in provinces.

Other developments include the setting up of the National Planning Committee, under the leadership of Jawaharlal Nehru, appointed many sub committees, one of which was on National Health, under the chairmanship of Col. S.S. Sokhey, the setting up of Health Survey and Development Committee, under the chairmanship of Sir Joseph Bhore. It was set up amidst World War II and had Dr. J.B. Grant, Dr. B.C. Roy, Pandit P.N. Sapru and Dr. A.L. Mudaliar, as important members of the committee. The Bhore Committee (as it was popularly referred), had the following aims: (a) broad survey of the present position in regard to health conditions and health organization in British India, and (b) recommendations for future development (Bhore 1946, vol 1, 1).

3.2 Healthcare After Independence till Emergency:

After independence, the then Prime Minister Jawaharlal Nehru in order to deal with various existing health problems, and to deal with the organization of health care services had initiated three conferences with health ministers of various provinces (TNAI 2001, 181). During 1950s, 1960s and 1970s, three main developments in healthcare can be seen. The first one saw the government giving primacy to check the spread of contagious diseases and family planning and thus primary health became important. Due to lack of human resources, having more teaching hospitals producing doctors and nurses was a necessity. This was the second development. The third was more of a realization that attempts made at building a strong primary health system was inadequate (Rao 2017, 13). It needs to be mentioned here that concerns about health and healthcare were addressed in various five-year plans as well as expert committees set up by the central government. A detailed analysis of various such committees has been done later, in the chapter on Nurses.

Further, development of a solid system of healthcare services was interrupted by governments' focus of eradicating specific diseases like malaria, smallpox etc., which required the adoption of several costly 'vertical' programmes (Amrith 2007, 114). However, since the chief focus was on 'modern medical technology and its commodification' medical pluralism comprising various indigenous health practices that existed earlier in Indian societies, a system that sustained people because of its low- cost nature and having easy access to it was disfavoured (Sadgopal and Sagar 2007). To put it simply, Bhore Committee favoured the development of western system of medicine, while the Chopra Committee of 1946, talked of an exchange between western system and indigenous system of medicine and Sokhey committee, realizing the need of the hour being to enable better access to healthcare, favoured training of *Vaids* and *Hakims*[3].

Apart from the plans as forwarded by the above-mentioned committees, the Bombay Plan (compiled by industrialists), the People's Plan (developed by post war reconstruction committee of the Indian Federation of Labour and the Gandhian Plan as postulated by Gandhi himself, were also forwarded for perusal of leadership associated with planning. Apart from the Gandhian Plan, the other two favoured the use of big technologies and hence emphasised the need to have modern technologies and hospitals in order to control spread of diseases. While the Gandhian Plan and the People's Plan highlighted the need to improve health in rural areas, the Bombay Plan focussed on health in urban industrial areas, and while the Bombay Plan and the People's Plan upheld the role of doctors, nurses, hospitals, the Gandhian Plan focussed on 'People's role in self-care' (Qadeer 2008, 54). However, in the early days, the focus was to build a strong economy through state intervention and regulation and thus, the state's emphasis was on industrialisation, infrastructural development and reducing economic inequalities through increasing employment opportunities (Sarma 1958, 180). Health featured in plans through discussions on infrastructure like hospitals, training institutes, and discussions on manpower like training of various categories of healthcare workers, requirement, shortfall and so forth. It was not till 1982, that India could come up with a formal healthcare policy. But before discussing national health policies, a cursory look into the developments in the post-independent period till 1991, is necessary.

Following independence, the centre and the states each created their own Ministries of Health. The positions of Director General (IMC) and Public Health Commissioner (GOI) were

[3] See https://ruralindiaonline.org/en/library/resource/report-of-the-udupa-kn-committee-on-ayurveda-research-evaluation/. Last accessed 23.09.20.

combined to form Director General of Health Services, who now serves as the Union Government's primary medical and public health advisor. In several states, the positions of Director of Health Services, Surgeon General, Director of Public Health, and Inspector General of Hospitals were combined, and the post of Director of Health Services was created in 1947. In the next year India became a member of the World Health Organization on January 12, 1948, and the Employees State Insurance Act of 1948 was also passed in the same year[4].

In the next decade, the Constitution came into force (in 1950) and India got established as a Republic. Healthcare was not seen as a right of the citizen but as a duty of the state as it found place in the Directive Principles of State Policy (Article 47). The Planning Commission was set up by Government of India and in the **First Five-Year Plan (1951-56)**, it was noted that the figures for child mortality and maternal mortality were very high (around 2 lakhs maternal death occurring annually), lives were lost due cholera, smallpox, plague, fever, dysentery. It also acknowledged the problem that 75 per cent of doctors were available in the urban areas, which further widened the rural-urban divide when it came to accessing healthcare. Since communicable diseases claimed a lot of lives every year, checking the spread of diseases and providing preventive healthcare to the rural population was considered a priority. Further, providing health education, attaining self-sufficiency in drugs and equipment, increasing manpower were also concerns that required attention. In its attempts to eradicate malaria, the Central government worked in collaboration with state governments (GOI: 1951). The thrust was on preventive measures as limited resources were available back then and with the aim of improving health of the rural population, the Community Development Programme of 1952 came into force (Nayar 2014, 1401).

During this period, primary health centres (PHC) were set up and a Central Council of Health comprising the health minister at the centre with all health ministers in the states was also formed (GOI 1951). Tuberculosis was a concern for governments at both the centre and the state and as a result 1956 marked the beginning of National TB sample survey. The same year also saw another important development that indirectly affected healthcare. The Hindu Marriage Act fixed the minimum age for marriage for both boys and girls to be 18 and 15 respectively, aimed to improve the health conditions of women. However, it needs to be flagged that here women's health was seen to be associated with events like pregnancy and childbirth,

[4] See www.ilo.org/dyn/travail/docs/687/Employees%20State%20Insurance%20Act%201948.pdf. Last accessed 23.09.21.

beyond which not much was done in regard to women's health (Vibha, Laskar: 2011; Sanne A.E. Peters et.al: 2016)

The **Second Five-Year Plan** was published (the NDC [National Development Council] passed the resolution in May 1956), with the objective of establishing a "socialist pattern of society' (GOI 1956). The Plan being forwarded by Mahalanobish, considered it necessary to have more training facilities, so that the gap in terms of the availability of doctors, related medical workers, nurses, auxiliary nurses, midwives would be filled. The plan also talked of introducing short training courses for Auxiliary Nurses and Midwives (ANM), and recommended that institutions for training midwives be upgraded into auxiliary nurse-midwives' training centres and hospitals at headquarters of districts. Hospitals with fifty or more beds could also be utilised for such training (GOI 1956). The issues of paucity of health workforce and inadequate access to primary healthcare posed challenge as there were only 2800 PHCs existing by the end of 1961. Most of the PHC's were understaffed and many of them were being operated by ANM's or public health nurses in charge and doctors being trained out of public expenses, were mostly found in urban areas and in private practices (Mudaliar 1962). On another front, during this plan period National Malaria Control Programme was converted into National Malaria Eradication programme in 1959, followed by completion of the National TB survey (Chadha 1963).

The National Malaria Eradication Programme (hereafter NMEP) brought the whole state under its banner and due to the works done in undertaking various preventive measure coupled with the Community Development Programme, the average expectation of life at birth improved by about 10 years. Though health insurance got introduced through the Employees' State Insurance Scheme and the Contributory Health Service Scheme for the employees of the Central Government in Delhi, but healthcare grew in an uneven manner. The uneven growth pattern of healthcare system in India was the result of the first two five-year plans, through which urban areas got over three-fourth of medical care resources and the rural areas received 'special attention' through Community Development Programmes setting a rural -urban divide into motion. Public healthcare access in urban centres involved curative care and for rural centres it meant providing preventive services. The divide was also a result of measures taken by the Rockefeller Foundation in making rural areas, areas receiving preventive healthcare programmes or care. As a result, what they availed was public health (Duggal, 2001).

The next decade saw (**Third Five-Year Plan** 1961-66) a reduction in the government's contribution to the health sector took place. Out of Rs. 8576.50 crores, Rs. 225.90 crores (2.63 per cent) were allotted for health programmes. The Plan emphasised the need to develop or upgrade the "basic and heavy industries" and urged the need to have a public sector facilitating growth and development (GOI 1961). This period also saw the Central Bureau of Health Intelligence (CBHI) getting established in 1961, as the health intelligence wing of the Director General of Health Services in the Ministry of Health and Family Welfare, with an aim to have a "strong health management information system' throughout the country".[5] 1963 saw the launching of the Smallpox Eradication Programme and in order to facilitate work for the maintenance phase of the NMEP and family planning, introduction of multi-purpose workers was suggested (Chadha 1963).

In most of the cases women's health and reproductive health are treated as synonyms or used interchangeably. Hence, the question of women's health popped up, it did so in relation to their reproductive health as if women did not suffer from any non-reproductive comorbidity like high blood pressure, diabetes and so forth[6]. In 1964, the Central Family Planning Board had expressed concerns about "women's health", pertaining to the reported increase of illegal abortions being performed in unhygienic conditions and a committee was formed under the chairmanship of Shanti Lal Shah (the then minister of Health, Law and Judiciary of Maharashtra) and the Medical Termination of Pregnancy Act was enforced in 1972 in the whole of India, except Jammu and Kashmir (Jalnawalla 1974).

The end of sixties saw a separate department called the department of Family Planning being constituted within the Ministry of Health to coordinate family planning programmes both at the Centre and the States and the Health Minister was also appointed the Minister for Family Planning, in 1967. In 1968, the Central Council of Health recommended the levy of a health cess on patients attending hospitals 1) a minimum charge of 10 paise per patient and 2) a minimum charge of 25 paise per day of hospitalisation. Further, incentives were given to families opting for the small family norm, and practicing family planning (Rathod 2018,92).

[5]See Ministry of Health and Family Welfare. "Central Bureau of Health Intelligence". Government of India: New Delhi, for details. Available at, http://dghs.gov.in/WriteReadData/userfiles/file/Work%20allocation%20and%20channel%20of%20Submission%20(13-19).pdf.

[6] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/unlocking-opportunities-in-womens-healthcare. Last accessed 24.09.21.

The seventies saw an intensification of the fight against communicable diseases. The **Fourth Five-Year Plan** which began in 1969 after a three-year plan holiday continued on the same line as the third plan. For the period 1969-74, the Fourth Five Year Plan made a Rs. 840 crores allocation to health and Rs 315 crore to family planning, out of Rs 16774 crore budget (Rathod 2018,92). This phase also saw an increased focus on training opportunities for paramedical personnel in order to overcome the problem of scarcity of medical personnel in the rural areas. However, scholars point out that the Fourth Five Year Plan is probably the most poorly written plan document as it does not seek to probe into the socio-politico and economic upheaval during the "Plan Holiday" period (1966-1969) (Duggal: 2002).

During the above plan period, the Central Births and Deaths Registration Act (1969) was being promulgated[7] and the Population Council of India was formed in April 1970. Another important development was the initiation of Chittaranjan Mobile Hospitals (mobile-training-cum-service unit) on the birth centenary of late C.R. Das on 5 Nov, 1970. The scheme envisaged attachment of a mobile hospital to a suitable medical college in each state. Other developments included the initiation of the Family Pension Scheme (FPS) for industrial workers in 1971[8], setting up of the National Nutrition Monitoring Bureau under the Indian Council of Medical Research with the Central Reference Laboratory at the National Institute of Nutrition (NIN), Hyderabad in 1972. It also started functioning in several states like Andhra Pradesh, Gujarat, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, Uttar Pradesh and West Bengal. Its job was to create a database on the nature of diet and nutritional status of various communities.[9] Also around this time the problem of overlapping pertaining to the vertical and horizontal division of staff working on various national health programmes pertaining to health, family planning and nutrition was sought to be solved through an 'integrated services at the peripheral and supervisory level' (Kartar Singh 1973, 3).

3.3 Years of Political Turmoil and Run-up to liberalisation:

The Fifth Five -Year Plan (1974-1979) coincided with the National Emergency (1975). During this time population control and family planning topped the priority list. Total plan outlay of Rs 37250 crores was increased to Rs 39303 crores and the outlay for the next two

[7] For details see http://www.pbnrhm.org/docs/b&d_reg.pdf
[8] See http://epfindia.gov.in/site_docs/PDFs/Downloads_PDFs/EmployeesFPS1971.pdf
[9] See http://nnmbindia.org/default.html.

years was fixed at Rs 19902 crores as against a previous estimate of Rs 19401 crores in the first three years of the plan. Thus, the revised total Fifth Plan outlay for the Health Sector was Rs. 681.66 crores.[10] It should be mentioned here that the plan was framed in a time of inflation and problem of balance of payment following the rise in imported oil prices and other materials. Food grains and essential wage goods had to be imported. An 'anti-inflammatory plan' or the Annual Plan 1974-75 was formulated to bring the situation under control. The Annual Plan for 1975-76, focussed on agriculture, irrigation, power, coal etc. The Annual Plan 1976-77 provided for an outlay of Rs. 7852 crores which was 31.4% more than the original Plan allocation for 1975-76 [11].

It is important to mention here that the Minimum Needs Programme (MNP) was also initiated in the first year of the Fifth Five-Year Plan which covered elementary education, rural health, nutrition, rural roads and water supply, housing, slum improvement and rural electrification. The MNP became an instrument through which only health infrastructure in the rural areas was to be expanded and further strengthened. It planned for the integration of peripheral personnel of various vertical programmes, but during the Emergency (1975–1977), the population control programme gained more momentum, and the majority of the basic health workers were drawn into the family planning programme. Amidst the ongoing political turmoil, India was pronounced smallpox-free in 1977.[12]

There were two **Sixth Five-Year Plans**. The Janata Government put forward a plan for 1978-1983, but when Congress came back to power after two years, it forwarded a different plan in 1980. The Second Sixth Five-Year Plan **focussed the need to have democracy supported by 'socialism' as it promised 'economic justice and secularism' which guaranteed social equality.** Further, "the Sixth Five-Year Plan 1980-85 – A Framework", declared the adoption of the policy –'health for all by 2000 AD', reiterating India's commitment for achieving the goals set by the **Alma Ata Declaration of 1978.**

The **Alma Ata declaration** had suggested restructuring and reorienting the healthcare system with a thrust on primary healthcare system. Proper knowledge regarding existing health problems, ways of identifying, preventing and controlling was of utmost importance along with

[10] GOI. "Plan Outlays and Programmes of Development", Fifth Five Year Plan. Available at, http://planningcommission.gov.in/plans/planrel/fiveyr/index5.html
[11] GOI. "A Review of the Economic Situation", Fifth Five Year Plan. Available at http://planningcommission.gov.in/plans/planrel/fiveyr/index5.html
[12] For details, see http://planningcommission.gov.in/plans/planrel/fiveyr/index6.html

an emphasis on basic requirements like food security, nutrition, availability of safe drinking water etc. Promotion of mental health, health of mothers and children, along with, "immunization against major infectious; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs", were considered to be crucial (Alma Ata Declaration 1978, 2). It also reiterated the need for a strong primary care system (first-level care) with strong inter-linkages between secondary and tertiary levels of care, giving rise to a strong referral system and called for "maximum community and individual self- reliance and participation in the planning, organization, operation and control of primary health care" (Ibid), with the aim of making healthcare more accessible and equitable. Apart from emphasising the need to develop a comprehensive and well-integrated healthcare system, the above declaration also stated that healthcare was the responsibility of the State and called for multi-sectoral approach as healthcare gets influenced by different sectors.

It goes without saying that the goal of attaining 'Health Care for All by the Year 2000', could not be achieved and there was a rise in inequities within and outside states or regions. The government failed to reconcile its ambition or goals set by itself in various world platforms. The central government's scheme to provide health as part of the Minimum Needs Programme proved to be inadequate, following which people in the rural areas started availing services from quacks and other private service providers as per their budget. Around this time, the private sector emerged gradually but steadily as an alternative provider of healthcare services. The welfare attitude started waning during the latter half of the eighties and was characterised by a "distinct de-politicization of health governance" (Saxena 2010, 10-17). At this juncture, the entry of Apollo (1984), managed to provide respite among the middle class as it sought to redefine quality through modern form of treatment, technologies, and corporate form of management. It paved the way for private tertiary hospitals, followed by the spread of private players to 'secondary care, medical and nursing education and diagnostic centres and laboratories' (Rao 2017, 16).

Another important incident took place with the publication of India's first, **National Health Policy** (NHP) in 1983. In tune with the Directive Principles of State Policy, the NHP stated that improving public health and guaranteeing health to all is one of the primary duties of a State. While taking stock of the existing situation, NHP pointed out that the adoption of western models, when it came to dealing with manpower and setting up of health centres, have not benefitted the people as it failed to understand the socio-economic realities of the country.

Further, it stated that the 'hospital-based disease, and cure-oriented approach', has benefitted the rich, mainly hailing from the urban areas (NHP 1983, point no. 4.2). It is also perhaps the first time that a policy document talked of private investment in offering healthcare in attempts to reduce the burden of the government (NHP 1983, 8).

The Seventh Five-Year Plan (1985-90) was formulated after the assassination of Indira Gandhi. It was acknowledged that agriculture was the core of the economy as it supported the largest section of the people and was the highest employment generator. The basic objectives of the plan were to ensure growth, modernisation, self-reliance and social justice. It laid focus on tackling poverty, by increasing scopes of employment for educated youth in the rural areas and towns by expanding services like health and education. As government was overburdened and functioned through borrowing, spread of credit institutions were considered to be helpful in making people self-reliant. Though government claimed to be committed to its investment in important industries, the need to reduce spending on others was realised. In line with the Sixth Plan, that had paved for considerable liberalization in matters of industry and import licensing, the Seventh Plan, de-licensed several important industries and had introduced broad-banding (GOI 1985). Thus, both the Sixth and Seventh Five Year Plans talked of ideas like efficiency and quality which were to be meted out by means of privatization. On top of this, the low funding in various sectors including healthcare, severely affected primary healthcare, which was essential for achieving the set target of Alma Ata. Following the economic crisis IMF's preconditions included, reducing government spending and promoting private sector (Rao, 2017,17).

Table 7 below points at the progress made in Rural Health Infrastructure, under the Sixth Plan.[13]

Table 1: Rural Health Infrastructure under the Sixth Five-Year Plan

	Number in 1979-80	Sixth Plan Target (additional	Likely achievement during 1980-85	Likely cumulative to end 1984-85
Sub-Centres	47517	4000	35509	83026
Primary Health Centres	7399	1600	3702	11101

[13] Planning Commission. "Health and Family Welfare", in Seventh Five Year Plan. GOI: New Delhi, 1985.

Community Health Centres	49	74	400	649

The Plan stated that the dearth of construction materials, ANMs and other Para-medicals had hindered the attainment of targets and in order to overcome this problem, the admission of ANMs for training had been increased and states were also allotted funds to train para-medical personnel. The Seventh Plan, perhaps in order to deal with the dearth of personnel trained in western medicine, aimed at popularising and developing Indian system of medicine like Ayurveda, Unani, Naturopathy etc (Ibid).

3.4 Post-liberalisation India till 2015:

The new decade (1990s) witnessed a lot in terms of policy changes following drastic reforms in the economic sector. The **Eighth Five-Year Plan** was postponed due to unstable government at the centre. During that time the country went through a massive economic crisis. The Plan got pushed forward by two years. But despite this no new thinking went into this plan and it kind of reframed its motto and changed "Health for All by 2000 AD" into "Health for the Underprivileged". Simultaneously it continued to support privatization, '[I]in accordance with the new policy of the government to encourage private initiatives, private hospitals and clinics will be supported subject to maintenance of minimum standards and suitable returns for the tax incentives.'

Table 2: Health Care Expenditure by Government of India

Levels of Government	Health Care Expenditure by Govt. of India in nominal terms: 1990 - 91 (Revenue and Capital accounts combined)			Health Care Expenditure by Govt. of India in nominal terms (based on conventional definition) *: 1990 - 91 (Revenue and Capital accounts combined)		
	(Rupees in million)	As % of total	As % of GDP	(Rupees in million)	As % of total	As % of GDP
Centre	16057	15.59	0.34	4441	9.12	0.09
State	83634	81.19	1.77	42922	88.08	0.91
Union Territories	3321	3.22	0.07	1365	2.80	0.03
Total	103013	100.00	2.18	48728	100.00	1.03

* Includes only expenditure on Medical, Public Health and Family Welfare (excluding interests on previous loans borrowed) by the Ministry of Health and Family Welfare at the various levels.

(Source: Combined from Reddy and Selvaraju 1994, 14 and 16)

While analysing how Narasimha Rao government could pull in what Rajiv Gandhi government failed to do, scholars argue that success lay in the fact that Rao government opted for the middle path to reform where reforms could be carried out gradually, in an incremental basis. Realizing that India could not withstand pressure from outside to open up its economy Rao entrusted Manmohan Singh (the newly inducted Finance Minister), an economist than a politician, with the job of transforming the economy. The aim was to follow the 'East Asian Miracle' model, based on more export-oriented and more globally connected strategies of development, as successfully practiced earlier by Japan and South Korea and also by the South East Asian tigers Malaysia, Singapore, Indonesia and Thailand (Wadhva 2004, 259-273).

In the mid-90s, focus was on 'Growth with equity' and it talked of concepts like cooperative federalism, self- reliance and emphasised on improving the quality of life, building regional balance and improving employment scenario of India (GOI 1997). The Ninth plan made a reference to the Bhore Committee while committing itself to improve the health status of the population. The Ninth Plan suggested that the PHCs and SCs be consolidated and brought under the Basic Minimum Services program. Dealing with the scarcity of doctors and other trained health personnel, it suggested creation of part-time positions which could be offered to local qualified private practitioners. Realising the diverse nature of India, it called for state specific strategies from primary levels to higher levels (GOI 1997). The diagram below is an attempt to make it clear as to who does what, to what effect and how, as per the Ninth Five Year Plan.

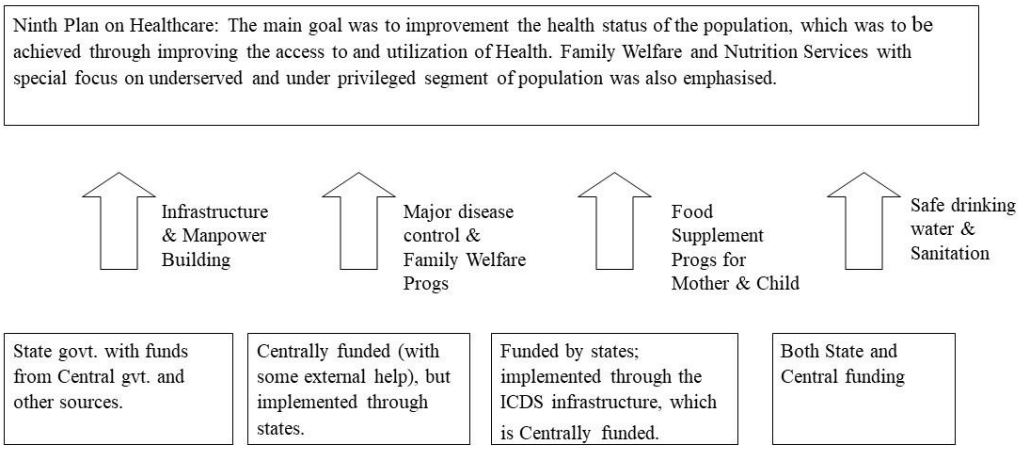

Figure 1: Flowchart of responsibility as per Ninth Five Year Plan (done by researcher)

In the meantime, the **National Population Policy** was announced in the middle of 2000 and though it made improvements from the previous one (In 1976, the first National Population Policy was formulated and tabled in Parliament, but it was neither discussed nor adopted), however the focus remained on population control and not population welfare. [14] The **National Health Policy of 2002,** which followed shortly**,** was announced, inviting public feedback for the first time. Acknowledging that the government has not been fully successful in bridging the gulf between expectation and reality when it came to issues of public health, it accepted the reality morbidity and mortality due to easily curable diseases is still high and the resource allocations are generally insufficient. Given the context that health researchers and activists have long advocated for mechanisms to build accountability within the private health sector, NHP 2002 stated an intention to regulate the private health sector through statutory licensing.

An important development that took place in the first half of the twenty first century was the implementation of National Rural Health Mission. Post 2000, the following tendencies of the government can be seen when it comes to healthcare. First, government was considered to be addressing the issue of public health by making use of the resources in the private sector. Second, it had already become an important financer of health services. Third, liberalization of

[14] For details, see www.mohfw.nic.in/showfile.php?lid=2949

the insurance sector for health financing, was a reality. It was also during this time that Congress led United Progressive Government (UPA) came to power in 2004 which was supported by the Left parties, during its first term. To design welfare programmes, it set up a National Advisory Council, which involved civil society in making welfarist policies. Apart from rights-based legislations, the Rastra Swasthya Bima Yojna [RSBY] was initiated and social sector spending as against governments total spending rose from 40 per cent in 2000 to over 50 per cent in 2012-13 (Tillin, Deshpande and Kailash 2015, 2-10).

Despite government spending going up, the gap between what was promised on paper and what was delivered remained almost the same. Due to the failure of the government's health programmes to reach out to people, now they had to rely on private operators like quacks, private hospitals depending on their need and their ability to pay and the private sector continued benefitting from such a situation (Rao 2017, 16). Here, the rise, importance and role of numerous non-government organizations (NGOs) need to be mentioned. The NGOs related to health cannot be compared to various big organizations like WHO as neither they have so much fund or backing at the international level. However, these organisations have been actively involved in improving the healthcare for all and they keep on formulating various documents in order to lobby in various platforms – governmental or non-governmental. One such initiative is the People's Health Assembly, which was held in Gonoswasthya Kendra, Bangladesh, in 2000. The Assembly saw hundreds of participants, all committed to making healthcare better, coming together. As a part of People's Health Movement, it led to the formulation of People's Charter for Health and the preamble stated clearly, that though health is a social, economic and political issue however, primarily, it is a fundamental right for all. The reason for ill-health, morbidity and eventual high mortality among the poor is due to inequality, long term poverty, exploitation, injustice and so forth (Chetley and Narayan 2002). The way forward was through guaranteeing equity, ecologically-sustainable growth and maintaining peace. The charter also highlighted that the governments in general are more bothered about the policies pertaining to the financial, industrial or agricultural sector that are driven by capitalist needs and thus, gets attention from both national governments and international agencies. The same cannot be seen in the case of healthcare (Ibid).

Earlier, in November 2000, the Indian People's Health Assembly adopted a charter in Calcutta (now Kolkata), that condemned globalization and demanded better living conditions, clean drinking water, comprehensive healthcare for all including people in transit, like migrant labourers, homeless persons and others. Indian healthcare system, as per the charter, needed to

be people-centric and not market driven. It also asked the inclusion of food security as an important pre-requisite to attain good health, the vertical programmes that affect the healthcare delivery system be reversed, health programmes initiated by the centre be treated as part of the primary healthcare system, health planning and governance be decentralised, various tiers of healthcare institutions be made accountable and be controlled by relevant Panchayati raj institutions (IPHA 2000).

Through the above-mentioned documents, important demands were made to the authorities, in order to have better healthcare services for all, without distinguishing the people as to who can or cannot avail or purchase healthcare services. Though, both these documents, like the Alma Ata declaration were powerful, they did not impact much policies of the government. The **Tenth Five-year Plan (2002-2007)** like other plans, talked of the need to reorganize and restructure the health infrastructure. In terms of increasing accountability in providing with healthcare services by the service provider, it talked of having a linked-in referral system. However, the plan seems to be contradictory as on one hand it promised free of cost services when it comes to primary health care, emergency, life-saving services and the national programmes, but on the other, it talked of charging those who belonged to Above the Poverty Line (APL). Thus, the reality became worse for the people, who were marginally APL and also for the middle class who suffer severe indebtedness for hospitalization under the private management.

The **Eleventh Five-Year Plan (2007-12)** gave emphasis on dealing with the deadly disease called Cancer. It acknowledged the cancer has become an important public health problem in India. Around 7 to 9 lakh cases are reported every year and accordingly, 'the strategy under the National Cancer Control Programme (NCCP) was revised in 1984–85 and further in 2004 with stress on primary prevention and early detection of cancer cases'(GOI 2008, 65). The **Twelfth Five Year-Plan,** while talking of the role of both public and private providers of healthcare, made it clear that though the state governments offer healthcare services for free and/or at very low cost at the primary, secondary and tertiary levels, the private healthcare system ran parallel, comprising individual doctors and their clinics to general hospitals or super speciality clinics. Though much of the services are now provided by private providers, however, the situation is far from satisfactory. The Plan noted the following with regard to healthcare:

Table 3: Data on healthcare workers

Number of doctors, at the beginning of Eleventh Plan (per lakh population)	**Ideal number** (per lakh population)
45	85
Number of Nurses and Health Auxiliary Nurse and Midwifes (ANMs) available (per lakh population)	**Ideal** (per lakh population)
75	255

Thus, the gap loomed large due to the impossibility of fulfilling requirements of medical personnel as required by the population, coupled with wide geographical variation in terms of availability across the country. All these worsened the situation. Even the official reports accepted the harsh reality that the rural areas were poorly served (GOI 2013, 1). Overtime the healthcare had emerged as an important commodity that was much in demand in both rural and urban areas of India. With regard to healthcare policy making and budgetary allocations, government needed to focus on allocation of resources (money, technologies, manpower etc.) with an eye on demand, pricing and quality of healthcare as it impacts the choices or decisions of patients in general and poor patients in particular (Purohit 2013).

A High-Level Expert Group Report on Universal Health Coverage in India (HLEG) was constituted by the Planning Commission earlier in 2010, which submitted its report in November 2011. It has already been mentioned that healthcare in India, cannot be understood in isolation but as connected to world events and in this context, we have to discuss about universal health coverage. One hundred and ninety-two member states of World Health Organization (WHO) had set the goal of universal health coverage in 2005 (vide resolution WHA58:33). It was influenced by a small brief for policy makers, compiled by G. Carrin, C. James and D. Evans (Carrin, James and Evans 2005). In 2010 World Health Report urged member states to adopt the goal of UHC and bring in necessary reforms to facilitate it. Again in 2012, Margaret Chan, Director of the WHO, upheld it to be the central concept in public health, while addressing the 65th World Health Assembly. While Universal Health Care is used to describe health care reforms in high income countries, Universal Health Coverage is associated with low- and middle-income countries (LMICs). In case of LMICs universal health coverage cannot be achieved without more and more funding and investment in health, hence revenues from taxes are crucial (Stuckler et.al. 2015, 274-280).

The Twelfth Five Year Plan, acknowledging problems like unequal access to basic healthcare across regions and among different people hailing from various socio-economic backgrounds, presence of low-quality healthcare services, large private sector with minimal regulations, need for skilled manpower etc., had forwarded the goal of universal health coverage to overcome the above-mentioned crisis. The aim was to make healthcare easily *accessible*, *affordable* and to turn it into an *entitlement* for every citizen. This is in line with the goals set by the National Planning Committee, Constitution of WHO, or, Michel Foucault's analysis of the Beveridge Plan, mentioned earlier in this chapter. Though acknowledging the cost constrains, it also stated that in order to improve health status, necessary attention has to be given to other sectors as well. For instance, the Human Development discourse states that a radical improvement in Education, Health and Employment can only ensure 'development' of the society. And according to the Human Development Report (2001), although India was faring well on many other fronts, 'health' continued to be an area which needed attention, the most.

However, activists, researchers, have shown concern as to how India will fulfil its commitment of providing universal health coverage with reduced contribution to public health on the part of the central government, which meant going back on the promise of the UHC. Further, the abrogation of the Planning Commission and Five-Year Planning System raises the question as to how everything concerning health could be managed with transparency. According to scholars working in this field, the problem is neither there is anything 'universal' nor any special thing in the nature of 'care', when it comes to the UHC. They blame that it is not inclusive but exclusive in nature, therefore, does not benefit the common people who struggle every day to live a life with dignity. It is also definitely not inspired by 'care' nor has any ethical connotation of doing good for the public. It is entirely based on profit motive, which makes one wonder if we are driving away from the commitments of Alma Ata conference (Dubey 2021, viii).

3.5 Factors impacting healthcare in India and solutions through policies:

Access: At this point it is pertinent to reiterate that the idea of *access* is intrinsically linked to healthcare. Earlier, policies looked at healthcare using the lens of economics. In the 1960s, the focus was on the social factors mainly on the factors that affected healthcare access. Access still continues to be an important part in understanding the healthcare system in a country. In the Indian context, it would mean how the people of the lower socio-economic rungs get the

service of healthcare. The concept of 'access' is crucial, albeit a little vague, but essential in understanding the delivery of healthcare services. In order to understand the issue of access or availability of healthcare, R.G Beck (1973) used the idea of iceberg. The tip of the iceberg is equivalent to the medical needs of a community that are fulfilled. Greater the tip, he argued, greater would be the access.

In many cases, long distances need to be crossed in order to reach the health provider. Thus, in many instances, the distant geographic location of the health centres or institutions, act as a hindrance in India. The Bhore Committee in its recommendations suggested that healthcare services should be situated in close proximity to people they aim to serve (Bhore Committee, vol 2, 17). Second, the associated costs of availing healthcare services are important factors influencing access. Here let us remind that the idea of access in healthcare is more political than operational (Aday and Anderson 1974, 208) and can be understood through a patient's relationship with the healthcare delivery system. According to a study done in 2013, in rural India, 37% had access to IPD facilities located within a distance of around 5 kms., while 68% had access to OPD facilities in rural areas. However, in case of urban areas, the percentage was 73% and 92% for IPD and OPD facilities respectively (Aitken et al.2013, 13).

The question of negotiating distance for healthcare services are also important in the eyes of medical geography In India, it was found that people residing on the margins have limited access to healthcare. Their vulnerabilities clubbed with their geographic locations hide them from the purview of healthcare delivery from both the private and public sectors. For instance, in USA, in the seventies, in the ghettoes of African-Americans, only one-tenth of the total number of required doctors were present (De Vise 1973). Studies also revealed that there were a multitude of factors which enables 2% of African Americans to become doctors while their population percentage was 14 in the sixties (Shanon and Dever 1974).

The third factor influencing access is the general *perception* of people seeking services. General attitude and/or perception regarding the healthcare system, general perception of illness and of the service providers impact the access (Anderson and Newman 2005). Further, while doing the current study it was realized that this perception, also dictates who would be able to access private or public healthcare delivery services. Many argue that because of the general perception in India that any service which is for free is of inferior quality, even where subsidised or free healthcare services are available, they remain underutilized (Bajpai, Sachs, Dholakia 2010, 5) by the public. This point would be illustrated in detail later. The fourth

factor is the 'need' component determining healthcare access. Either the patient or the healthcare provider would feel the need to be treated or evaluated and the patient's perception of the need and the doctor's perception of that very need might not match (Anderson and Newman 2005, 218). [Re-construct the sentence] Fifthly, the nature of *delivery system* involving how resources are distributed across regions, across departments, and how the organization is set up etc. are necessary considerations as well (212) for the question of access. Sixthly, the *fear of debts/indebtedness*, further leads to unwillingness to seek care at an institution which also hinders access.

Gap between conception and implementation: Further, various ways, in which healthcare policies are conceptualised and implemented, also affects the healthcare in general. For instance, several plans reiterated, the need to restructure policies to cater to the increasing demands of healthcare, especially for the poor (target based). The need to have a decentralized system to deliver services like public healthcare leads to efforts of disease control and prevention becoming 'fragmented and disease-specific rather than comprehensive'. Thus, the programmes are often vertically structured for separate diseases and the 'vertical programmes are technology-centric and work in isolation of each other'. Banerji, in his earlier work had noted that the programme to contain malaria was not "cost effective" in the eighties. So he argued that more funding in such a programme could not have guaranteed desired results but would have given rise to more wastage of resources (Banerji 1985, 142). In several policy documents, much emphasis has been given on doctors – be it the need to have more medical colleges, or the need to have more doctors at the rural centres etc. However, there are scattered and sketchy references made to other healthcare personnel. There are plan documents like the Third Five Year Plan, which referred to health personnel involved in auxiliary healthcare services, however, no clear-cut plans were made for them. Though the need to give training to health personnel was realised time and again, but limited funds hindered the process for healthcare personnel, who were not doctors.

Funds or the lack of it: Since the very beginning India had to struggle with lack of funds, which has eventually led to the following.

First, there is a dependence on the aid of various agencies, mainly foreign donors and an understanding of healthcare in India would be incomplete without briefly reflecting on the role played by *foreign aid*, in this sector. 'No single factor has affected the policy and governance in the health sector so much as the external influence exercised by the aid and lending (donor)

agencies', (Saxena 2010, 97). It is interesting to note here that despite spending 1-3 percentage of the total expenditure on health, there are various agencies that greatly influence health policies and alter the goals of the government. Governments without addressing more pressing concerns are found to divert attention and focus to programmes for which such donor agencies are paying (Baru and Jessani 2000). For instance, before 1990s, the focus was on dealing with malaria and leprosy, then the thrust was on family planning, immunization etc., and now in post reform period, there was lot of funding to keep the spread of HIV/AIDs under control (Saxena 2010, 98).

Second, since the nineties, the World Bank has come up as an important donor for developing countries as a part of the Structural Adjustment Programmes, a move that was severely criticized by UNICEF, WHO and NORAD, whereby it (World Bank) allowed "selective state intervention", in the health sector. The discussions between health policy experts and the team from World Bank that led to the World Bank report, *India: Health Sector Financing* was not devoid of controversy as it was claimed that many of the participants, did not have sound knowledge or understanding of political, social or economic realities governing health in India nor were they aware of the basic literature related to "growth and development of public health practice in India", (Banerji 1993, 1207).

Third, this dependence on foreign aid has considerably reduced governments' spending on health, which has negatively impacted the healthcare of India and the process continues till date (Gupta and Gumber 2002).

Fourth, a shift from foreign aid to loan took place on the face of worldwide political and economic pressures that also got reflected in various policy documents of the country on various world fora. For instance, the statements presented at several UN platforms like 'Population and Development' (Cairo, 1994) and 'Women and Development' (Beijing, 1996) showed the influence on World Bank on India's policy statements (Qadeer 2000, 26). Another such instance would be the incident where the finance minister had reduced 42 per cent funding on malaria programmes in 92-93 budget. However, the allocation increased in 93-94, after World Bank had intervened (Banerji 1993, 1207). It needs to be mentioned here that, the *nature* of aid also changed since the late eighties. Whereas earlier, aids came in the form of grants, later assistance took the shape of *soft loans*. This change affected the healthcare scenario in India.

Fifth, lack of funds in India has resulted in an increase in the *out-of- pocket* expenditure when it comes to availing healthcare services, where in most of the cases, services were purchased from private sector. This practice can also be observed in government or public health institutions, where a paucity of prescribed medicines forces clients, to buy them from outside. Out-of-pocket expenditure in availing healthcare services account for almost 70 per cent of the total expenses incurred on healthcare (Joglekar 2008) which brings forth the debate regarding *health insurance*.

Based on a study related to health insurance and informal sector in Gujarat, it was found that it was a necessity for the poor working women in informal sector to have health insurance in order to escape further pauperization. It is often seen that they end up spending more than the people from other socio-economic backgrounds. (Gumber and Kulkarni 2000). Though health insurance is felt to be a necessity by many, as per the Niti Ayog Report on the 12th Five Year Plan, bulk of the out-of-pocket expenditure is incurred in availing outpatient care, in the purchase of medicines, which does not come under the coverage of existing insurance schemes.

Further, only a small percentage of the population is covered by health insurance. The coverage rate of private and public health insurance is low (not more than 10 per cent) of the Indian population is insured, comprising people working in the government sector, public sector undertakings and big private (formal) sectors (Sengupta and Nundy 2005). It might also seem like the government is trying to compensate for poor and inefficient healthcare delivery system by selling hard the benefits of health insurance. Health insurance in any case becomes redundant in a society, where medical services are not adequately available (Bhat, Maheshwari and Saha 2004). Instead of improving the quality of healthcare services offered or bridging the gap of already existent inequity, government of India took the short cut of further privatisation of healthcare (Duggal 2001).

Dearth of Manpower: In order to successfully implement the recommendations of the Bhore Committee, the total number of doctors required was 2,33,650, and the required number of nurses including public health nurses was 6,80,000. While only 47,500 doctors and 7750 nurses including health visitors were present at that time. In case of midwives the number was 5000, while the required number was 112500, for pharmacists it was 75, and the required number was 84375 (Bhore 1946, vol. 2, 31). Both the volumes of Bhore Committee, talked of the shortage of healthcare personnel. Various five-year plans, other policy documents, various studies done on health personnel by various international organisations highlight the shortage

of health personnel in India. In the first decade of the twenty first century, the aggregate density of doctors, nurses and midwives totalled to 2.08 per 1000 population in India, which fell short of WHO's critical shortage threshold of 2.28 (WHO 2006).

And to make it worse, the *rural-urban divide* had made things more difficult. According to Lancet Report, till March 31, 2015, more than 8% of 25,300 PHCs, had no doctors; 38% had no laboratory technicians; and 22% had no pharmacists. Over 60% and around 50% posts for Male Health Assistants (MHA) and Female Health Assistants (FHA) were found to be vacant respectively. The situation was worse in case of CHCs where there was an acute shortage of 83% of surgeons, 76% gynaecologists and obstetricians, 83% physicians and 82% paediatricians (Sharma 2015, 2381). In several centres, where posts were not vacant were also marked by *absenteeism*. Absenteeism in case of healthcare personnel is a common feature, not only in India but in East Asia and Pacific. In case of India, 40% absenteeism was noticed for overall healthcare workers in PHCs (Chaudhury et. al. 2006, 92; Langenbrunner and Somanathan 2011,225). Many point out the fact that persons attached with public institutions in rural areas might still continue to work in private sector or set up a private practice or do 'double practice' causing this absenteeism (Chaudhury et al 2006; Soman 2002). They are also referred to as 'ghost workers' who are present on government records, but never show up for work (Chaudhury et. al 2006, 107). Further, according to 2010 statistics, throughout India 5% posts for ANMs lay vacant in PHCs and Sub-centres as opposed to 24% vacant in case of doctors in PHCs throughout the country.[15]

When the Medical Council of India declared that one-year rural internship was mandatory for admission to PG medical courses, medical students had vehemently protested. Union health minister, Ghulam Nabi Azad, in a directive issued had urged for the rural postings, in an attempt to strengthen government's National Rural Health Mission (NDTV August 8, 2013). In August 2019, Supreme Court upheld the mandatory postings for medical students, seeking admission to PG and other courses of specialization and asked union government to frame policies in order to facilitate postings in government centres in rural areas. The Supreme Court bench comprising Justice L. Nageshwara Rao and Justice Hemant Gupta pointed that since the government invests a lot in training a medical student, such a precondition of mandatory rural posting was not 'illegal' or 'arbitrary' (*TOI* August, 2019).

[15] See https://www.prsindia.org/theprsblog/shortage-doctors-may-hit-rural-healthcare-delivery. Last accessed 14.06.20.

Role of private sector: Structural changes with regard to health care delivery system though began in the seventies, intensified in 1990s. It goes without saying that there existed a private sector in health care, during colonial times and it has continued. And after 1980s, the state made way for more private nursing homes and small and middle hospitals. However, it was in the '90s when the above process intensified further with a subsequent deduction in allocation to health under the union budget. Moreover, with the liberalization of foreign investment policy, in 2000, Foreign Direct Investment (FDI) in hospitals was made possible. Complimentary to it, with the introduction of third-party administrators in case of insurance, benefitted the private and corporate hospitals. The rise of private sector also led the state propagating for increase in *Public-private partnership (PPP)* model in health sector leading to outsourcing of sanitary and other services, handing over PHCs to private organizations etc. (Baru 2016; Prasad 2018). The above development happening over time has led to *commercialization* of health in India. However, though PPP model is in action in India, it cannot be said that the collaboration is always fruitful because the intention or focus of the government and private sectors might not be the same (Murray Aithen et al. 2013).

There is another side of healthcare in India, which is operating in the private, informal sphere. This part operates more in the less developed parts of the country, mainly in rural areas, trying to fill in the gap caused by factors like shortage of trained health personnel or the rural- urban divide in accessing healthcare services. This *informal sector* provides with private healthcare for the poor, mostly in developing nations. The few studies done on *informal healthcare providers* (IPs) had not been able to provide a clear-cut definition, although they pointed out some characteristic features. It can be assumed that IPs were not part of Nehru's project of building a modern India, which stood on the western concept of science, neither were they given much importance in the Bhore committee report. However, IPs bears most of the burden of primary healthcare in rural areas. IPs might have certificates based on some distance education course or diploma course on Indian systems of medicine like Ayurveda, Unani or biomedicine. These informal medical practitioners also do not have any formal training but can be trained informally through apprenticeships, workshops etc. since they are operating beyond the scope of any form of registration, regulations. Though professional associations might be absent but IPs has a strong network system (Das et al. 2016; Sudhinaraset et al. 2013). A study based on IPs in Tehri and Guntur in north and south India respectively, revealed that in Tehri one IP served a population of 2299 persons, while a professional doctor served 9599. Similarly, in Guntur, an IP serviced 1941 persons, while a professional doctor looked after 5412 persons.

Mostly, the professional doctors both in public and private service were present in high development blocs while IPs serviced the low and medium level blocks. The presence or coexistence of practitioners of western system of medicine and indigenous systems of medicine and the presence of their respective clientele has resulted in *medical pluralism* in India.

With regard to *medical pluralism*, it is observed that opting for indigenous systems of medicine might be a matter of "choice" for people in urban areas, but for rural India, it may be a major option (Sheehan 2009). However, many might believe that highlighting more on indigenous systems of medicine or informal practitioners take away public attention at the lapses of the government at providing a strong healthcare system (Banerjee 1974).

3.6 Universal Health Coverage:

A positive step, an improvement compared to other plans, was the proposal for a Universal Health Coverage (UHC), following the suggestions of the High-Level Expert Group Report on Universal Health Coverage in India (HLEG), which was constituted by the Planning Commission earlier in 2010 and which submitted its report in November 2011. It has already been mentioned that healthcare in India, cannot be understood in isolation but as connected to world events and in this context, we have to discuss about universal health coverage. One hundred and ninety-two member states of World Health Organization (WHO) had set the goal of universal health coverage in 2005 (vide resolution WHA58:33). It was influenced by a small brief for policy makers, compiled by G. Carrin, C. James and D. Evans (Carrin, James and Evans 2005). In 2010 World Health Report urged member states to adopt the goal of UHC and bring in necessary reforms to facilitate it. Again in 2012, Margaret Chan, Director of the WHO, upheld it to be the central concept in public health, while addressing the 65th World Health Assembly. While Universal Health Care is used to describe health care reforms in high income countries, Universal Health Coverage is associated with low- and middle-income countries (LMICs). In case of LMICs universal health coverage cannot be achieved without more and more funding and investment in health, hence revenues from taxes are crucial (Stuckler et al. 2015, 274-280).

The Twelfth Five-Year Plan, acknowledging problems like unequal access to basic healthcare across regions and among different people hailing from various socio-economic backgrounds, presence of low-quality healthcare services, large private sector with minimal regulations, need for skilled manpower etc., had forwarded the goal of universal health coverage to overcome

the above-mentioned crisis. The aim was to make healthcare easily *accessible, affordable* and to turn it into an *entitlement* for every citizen. This is in line with the goals set by the National Planning Committee, Constitution of WHO or Foucault's analysis of the Beveridge Plan, mentioned earlier in this chapter. Though acknowledging the cost constrains, it also stated that in order to improve health status, necessary attention has to be given to other sectors as well. For instance, the Human Development discourse states that a radical improvement in Education, Health and Employment can only ensure 'development' of the society. And, according to the Human Development Report (2001), though India was faring well on many other fronts, 'health' continued to be an area which needed attention the most.

However, activists, researchers, have shown concern as to how India will fulfil its commitment of providing universal health coverage with reduced contribution to public health on the part of the central government, which meant going back on the promise of the UHC. Further, the abrogation of the Planning Commission and Five-Year Planning System raises the question as to how everything concerning health could be managed with transparency. According to scholars working in this field, the problem is neither there is anything 'universal' nor any special thing in the nature of 'care', when it comes to the UHC. They blame that it is not inclusive but exclusive in nature, therefore, does not benefit the common people who struggle every day to live a life with dignity. It is also definitely not inspired by 'care' nor has any ethical connotation of doing good for the public. It is entirely based on profit motive, which makes one wonder if we are driving away from the commitments of Alma Ata conference (Qadeer 2013).

3.7 Where to from here?

Although it goes beyond the time frame of the present research (1990-2015), it needs mentioning that the National Health Policy of 2017, echoed India's commitments towards ensuring universality, affordability, equity, patient-centred and quality care, inclusive partnership, pluralism, decentralization of the healthcare system. It is also in tune with the sustainable development goals, which promotes the idea of healthy lives and well-being of all. In order to realize the ideas stated in the policy document and to fulfil India's international commitments, Ayushman Bharat, Government of India's flagship programme was launched, whose aim was to provide health insurance to the poor, backward sections of the society and

other vulnerable groups. [16] However, due to dearth of funding (government's expenses on health has declined over the years), the goals set could not be achieved. Despite the claims of Ayushman Bharat for not leaving anyone behind, the scheme is not inclusive and does not cover all diseases (Rajalakshmi 2019). Further, the COVID-19 pandemic revealed that India's healthcare system, which is the result of cumulative policies postulated by several governments across time, is incapable of handling a health crisis despite an overemphasis given to curative aspect of care (Gowda and Jena 2020; Dhar et al. 2021; George 2021).

While the Five-year Plans are framed at the centre, various programmes and schemes also operate at the state level through state plans, annual plans, etc. However, in this regard, the states operate within the framework of the national Five-Year Plans. That is why a thorough discussion on Five-year Plans and policies at the national level is very much required (as has been done in the previous chapter) to have a better understanding of various policy decisions at the state level. But it does not imply that all the state plans or policies are uniform in nature. The states also respond to certain local requirements giving the plans certain distinctiveness or making them unique. For instance, in the first Five-Year Plan, West Bengal government had to tackle the challenges emanating from the partition on India, followed by an influx of refugees from the then East Pakistan (now Bangladesh). The healthcare scenario in West Bengal is explored in the next chapter.

[16] See https://www.nhp.gov.in/ayushman-bharat-yojana_pg