INTERNATIONAL JOURNAL OF HISTORY

E-ISSN: 2706-9117
P-ISSN: 2706-9109
www.historyjournal.net
IJH 2025; 7(1): 85-89
Received: 06-11-2024
Accepted: 08-12-2024

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Public health and Policy in India: The changing landscape of 'Health for All'

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DOI: https://doi.org/10.22271/27069109.2025.v7.i1b.352

Abstract
This research article explores the historical evolution of the "Health for All" concept in India. It examines the key milestones and policies that have shaped India's approach to healthcare. The study analyses the impact of colonial rule, post-independence reforms, and contemporary challenges on India's pursuit of universal health coverage. It highlights the achievements and limitations of India's healthcare system and equitable access to healthcare for all citizens.

Keywords: India, World Health Organization, health for all, Bhore committee, healthcare

Introduction
"Health for All" has been a global aspiration to provide equitable access to essential healthcare services for all. In India, this aspiration has evolved over centuries and has been shaped by historical, social, economic, and political factors. This paper delves into the historical evolution of the "Health for All" concept in India, tracing its roots from the colonial era to the present day. The British period in India witnessed a focus on public health, primarily aimed at controlling epidemics and maintaining the health of the colonial population. After independence, India embarked on a journey to build a robust healthcare system, recognizing the significance of health as a fundamental human right. The National Health Policy of 1983 emerged as a pivotal moment, outlining a comprehensive framework for achieving universal health coverage.

Health in Colonial India
During colonial times, the missionaries and the government set up hospitals in various towns first to treat Europeans, and men in services and later extended to civilians [1]. The Portuguese town Goa saw a greater sign of insanitation during the last decade of the sixteenth century, the town had a 4.00,000 population which was reduced to 40,000 in 1670 due to deadly epidemics. Though the treatment of the patients was with the Portuguese physicians, it needed more manpower to treat the patients. This resulted in the remediation teaching of medicine at Royal Hospital, Goa beginning in 1703 [2]. The First British medical school set up in Kolkata was opened in October 1824. Later the First medical college was opened on February 20, 1835, in Kolkata. In Madras Presidency, a medical school was established on February 13, 1835, and was opened in 1838 for civilians. The Madras medical school came on par with the ones in Calcutta and Bombay. The name was changed to Madras Medical College in October 1850 [3]. The first English hospital at Madras was opened at was opened in 1664. A new bigger hospital was completed in 1772, which later became the Madras General Hospital. This was created to treat Europeans, native civilians, and Military personnel. A hospital was ordered to be built in 1912 by the Governor of Madras, known as Royapuram Government Hospital. It expanded rapidly and was later changed to Government Stanly Hospital in 1940 [4]. While India's independence was achieved in 1947, the concept of universal health access began to take root much earlier. Several key figures and reports during the British colonial era laid the groundwork for a more equitable healthcare system. The 1946 Bhore Committee Report was a pivotal document that outlined a comprehensive plan for a national health service in India.

It recommended a three-tiered system of primary, secondary, and tertiary care, along with preventive measures and public health initiatives [5]. Jawaharlal Nehru as a prominent leader of the Indian National Congress, recognised the importance of healthcare for the nation's development. He advocated for a publicly funded healthcare system that would be accessible to all. Mahatma Gandhi emphasised the importance of public health and sanitation. His philosophy of "Swadeshi" (self-sufficiency) encouraged local production of medicines and healthcare facilities.

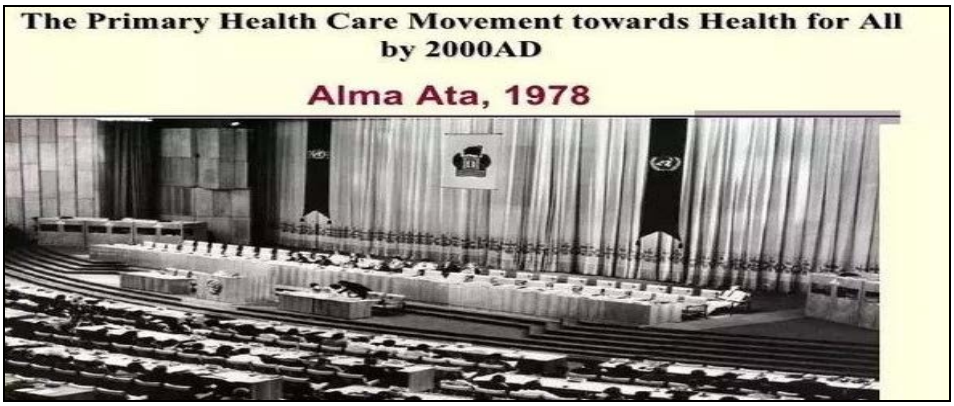
Health Care in Independent India

The development of the public health care system started in India after the Bhore Committee recommendations. This committee, known as the Health Survey & Development Committee, was appointed in 1943 with Sir Joseph Bhore as its Chairman. It emphasized the integration of curative and preventive medicine at all levels. It made comprehensive recommendations for the remodelling of health services in India. The report, submitted in 1946, had some important recommendations such as the integration of preventive and curative services at all administrative levels and the Development of Primary Health Centres in two stages: short-term measures and long-term programmes. According to the committee, the short-term measure is one Primary Health Centre (PHC) for a population of 40,000. Each PHC was to be manned by two doctors, one nurse, four public health nurses, four midwives, four trained dais, two sanitary inspectors, two health assistants, one pharmacist and fifteen other class IV employees. A secondary health centre was also envisaged to provide support to PHCs and to coordinate and supervise their functioning. A long-term programme called the 3 million plan was intended to set up primary health units with 75–bed hospitals for each 10,000 to 20,000 population and secondary units with 650–bed hospitals, again regionalised around district hospitals with 2500 beds [6]. The Third important recommendation was to bring major changes in medical education. It suggested three-month training in preventive and social medicine to prepare “social physicians”. The suggestions given by the Bhore Committee brought changes in the government's health policy. India's five-year plans have focused on health in several ways. The First Five Year Plan aimed to fight against diseases, malnutrition, and an unhealthy environment and to build up health services for the rural population and mothers and children to improve the general health status of people. A sum of Rs. 140 crores was allocated for health programmes during the first Five Year Plan which was 5.9 Percent of the total outlay (Rs. 2356 crores) for the entire development plan [7]. At the time of independence, investment in the health sector was less, especially in hospitals, dispensaries, health centres and pharmaceutical production hardly brought about any qualitative change in the health of the population at large. An outlay of Rs. 225 crores was allocated for the Second Five Year Plan (1956-1961) for health programmes which was 5.0 per cent of the entire outlay for the total development plan. As the progress towards the development at various levels was gathering momentum, another committee under the chairmanship of Dr Mudaliar was appointed in 1959 to review the progress of the development of health services. This committee felt that the norms suggested by the Bhore committee are more optimistic and it will not be possible to achieve them. It moderated the goals to be achieved in the health code and set the goal of one bed per thousand population in the country by the five-year Plan. According to the Mudaliar Committee report, it was recommended to strengthen sub-divisional and district hospitals. The committee emphasized that a Primary Health Centre (PHC) should not serve a population of more than 40,000 [8]. Additionally, it stated that all curative, preventive, and promotive services should be offered at the PHC. The Mudaliar Committee also suggested the creation of an All-India Health Service to replace the former Indian Medical Service. The main aim of the Third Five-Year Plan (1961-1966) was to remove the shortages and deficiencies which were observed at the end of the Second Five-Year Plan in the field of health. These were inadequate institutional facilities, especially in rural areas, shortages of trained personnel, supply, lack of safe drinking water in rural areas and inadequate drainage systems. An outlay of Rs. 342 crores was allocated for the Third Five Year Plan which was 4.3 per cent of the overall layout for the entire development plan [9]. Though the layout for the health plan in crores is more than the layout for the previous plan the proportionate percentage of the total layout for the development plan was much less than the previous plan. The Fourth Five-Year Plan (1969-1974) did not start soon after the Third Five-Year Plan due to some political reasons. It started in 1969 that the main aim of this plan was to strengthen the PHC network in rural areas for undertaking preventive, curative and family planning services and to take over the maintenance phase of communicable diseases. Of the total outlay of Rs. 16,774 crores on the entire development plan, Rs 840 crores were allocated to health and Rs. 315 crores to family planning [10]. The Fifth Five-Year Plan (1974-1979) was to provide a minimum level of well-integrated health. Nutrition and immunisation services to all the people with special reference to vulnerable groups especially children, pregnant women and nursing mothers. Through a network of infrastructure in all the blocks and well well-structured referral system. The emphasis of the plan was on removing imbalances concerning medical facilities and strengthening the health infrastructure in rural and tribal areas [11].

The Alma-Ata Declaration and India's Response

The Alma-Ata Declaration is a public health milestone that identified primary health care as the key to achieving "Health for All by the year 2000". The Declaration was created in 1978 at the International Conference on Primary Health Care in Alma-Ata, Kazakhstan. The conference was jointly convened by the World Health Organization (WHO) and UNICEF. The Declaration Affirmed that health is a fundamental human right. It recognized the gross inequality in health status between developed and developing countries. It stated that economic and social development are important to reducing the gap in health status. It emphasized that people have the right and duty to participate in planning and implementing their health care. The Declaration defined primary health care as "essential health care" that is based on practical, scientifically sound, and socially acceptable methods and technology. It also stated that primary health care should be universally accessible to individuals and families in the community. The Alma-Ata Declaration of 1978 was a major milestone in public health that influenced the global health landscape in several ways. It identified primary health care

(PHC) as the key to achieving "Health for All". It also defined PHC as the first level of contact with a country's health system. The Declaration shifted the focus from hospitals, doctors, and biomedical advances to include community participation, equity, and human rights. And emphasized the contribution of health to economic and individual development.



The Declaration viewed medical interventions as necessary but not sufficient for improving health. It broadened the understanding of health beyond health facilities and doctors. The Declaration of Alma-Ata, adopted in 1978, marked a significant milestone in global health policy, emphasizing primary healthcare as the key to achieving health for all [12]. India, as a developing nation, was deeply influenced by its principles and made substantial efforts to align its healthcare policies accordingly. India recognized the importance of primary healthcare in providing accessible and affordable care to its vast population. It implemented various initiatives to strengthen primary healthcare, including the establishment of rural health centres and sub-centres, Training of Primary Healthcare Workers (PHWs) and promotion of preventive and promotive healthcare services. India formulated and revised its National Health Policy to incorporate the principles of Alma-Ata. The policies emphasized universal health coverage, accessibility, affordability, and equity in healthcare.

The National Health Policy 1983

The Alma-Ata Declaration of 1978 was a pivotal moment in global health, emphasizing the importance of primary healthcare as a key strategy to achieve "Health for all by the Year 2000." India, a signatory to the declaration, aligned its national health policies with this global vision. The National Health Policy of 1983, a direct response to the Alma-Ata Declaration, aimed to provide accessible and affordable healthcare to all Indians. It outlined a comprehensive framework for improving healthcare access, quality, and equity in the country. The policy emphasized primary healthcare as the cornerstone of the healthcare system, with a focus on preventive and promotive care. It aimed to achieve universal health coverage, strengthen health systems, develop human resources, and promote health education and promotion. Key provisions of the National Health Policy of 1983 included the importance of primary healthcare in providing accessible and affordable care to the population. It aimed to establish a network of primary healthcare centres and sub-centres, train primary healthcare workers, and promote preventive and promotive care services. The policy sought to achieve universal health coverage by ensuring that everyone had access to essential healthcare services without financial hardship. It aimed to expand public health insurance schemes and improve access to secondary and tertiary care. The policy aimed to strengthen the overall health system by improving infrastructure, human resources, and drug supply. It emphasized the need for public-private partnerships and the involvement of communities in healthcare planning and delivery. The policy recognized the importance of a well-trained and motivated healthcare workforce. It aimed to increase the number of healthcare professionals, particularly in rural areas, and improve their skills and competencies. The policy sought to ensure the availability of essential medicines at affordable prices. It aimed to promote the production of generic drugs and regulate the pharmaceutical industry. The policy emphasized the importance of health education and promotion in preventing diseases and promoting healthy lifestyles. It aimed to raise awareness about health issues and empower individuals to make informed choices. The National Health Policy of 1983 provided a roadmap for India's healthcare development. While significant progress has been made since its adoption, the country continues to face challenges in achieving universal health coverage and improving healthcare outcomes. The policy serves as a valuable reference point for ongoing healthcare reforms and discussions. The National Health Policy of 1983 articulated a vision for India's healthcare system, establishing several ambitious targets to be achieved by the year 2000 [13]. These targets were designed to enhance healthcare access, improve quality, and promote equity across the nation.

- **Infant Mortality Rate (IMR):** One of the primary goals was to significantly reduce the IMR, aiming for a target of 60 deaths per 1,000 live births by the year 2000. This initiative was crucial for ensuring healthier beginnings for infants across the country.
- **Maternal Mortality Rate (MMR):** In a similar vein, the policy sought to lower the MMR to just 3 deaths per 1,000 live births by 2000. This focus underscored the importance of maternal health and safety in childbirth, aiming to protect both mothers and their children.
- **Immunization Coverage:** Another vital objective was to achieve 80% immunization coverage for all children by the year 2000. This aimed to ensure that a majority of the child population would be protected against preventable diseases, contributing to better overall health outcomes.
- **Family Planning:** The policy also aimed to manage

population growth by targeting a total fertility rate (TFR) of 3.6 by the year 2000. This initiative sought to empower families to make informed decisions about reproduction, contributing to improved social and economic conditions.

- **Primary Healthcare Coverage:** Finally, the policy envisioned a comprehensive network of primary healthcare centers and sub-centers, intended to provide essential healthcare services to 80% of the population by 2000. This network was meant to ensure that basic healthcare was accessible, reaching even the most underserved communities. Through these targets, the National Health Policy aimed to lay a solid foundation for a more equitable and effective healthcare system in India, ultimately striving for a healthier nation [14].

Achievements in the year 2000

The National Health Policy of 1983 was a crucial milestone in India's healthcare reforms, aiming to enhance access, quality, and equity in healthcare. By the year 2000, several key achievements had been made:

Indicator	*1951*	*1981*	*2000*
Demographic Changes			
Life Expectancy	36.7	54	64.6
Crude Birth Rate	408	339	261
Crude Death Rate	25	12.5	8.7
Infant mortality rate/000	146	110	70
Epidemiological Shifts			
Malaria (cases in million)	75	2.7	2.2
Leprosy (cases per 10,000 people)	38.1	57.3	3.74
Small pox (no. of cases)	>44,887	Eradicated	
Guineaworm	n.a.	>39,792	Eradicated
Polio	n.a.	29,709	265
Infrastructure			
Primary healthcare facilities	725	57,363	163,181
Dispensaries & Hospitals (all)	9209	23,555	43,322
Beds (private + public)	117,198	569,495	870,161
Doctors (allopathy)	61,800	268,700	503,900
Nursing personnel	18,054	143,887	737,000

Source: adapted from Box 1, National Health Policy (Government of India 2002). Note that some data in column 4 is from years prior to 2000.

There number of PHCs across the country rose from 725 in 1951 to 1,63,181 in the year 2000, which helped provide basic healthcare services in rural areas. Sub-centers were set up within the catchment areas of PHCs to improve accessibility to primary care. Existing PHCs were enhanced to offer more comprehensive healthcare services. There was an increase in training and capacity-building for Primary Health Workers, enabling them to deliver essential services effectively. More medical colleges and training programs were established to meet the growing demand for healthcare professionals. The successful implementation of immunization programs led to a significant reduction in infant mortality from 146/1000 in 1951 to 70/1000 in 2000 [15]. The Polio Virus was drastically brought under control which happened to be 29,701 in the year 1981 to 291 in the year 2000. There was a promotion of family planning services and an increase in contraceptive use, contributing to population control and improved maternal and child health. Effective measures were taken to reduce the prevalence of malaria [16].

Public health campaigns and community outreach programs also raised awareness about health issues and health education was integrated into school curricula. Partnerships between government and private sector organizations were also encouraged to enhance healthcare delivery. Despite these substantial achievements, the National Health Policy of 1983 faced challenges such as limited resources, infrastructure gaps, and inequalities in healthcare access. Nonetheless, it laid a solid foundation for future healthcare reforms and initiatives in India.

Conclusion

The historical evolution of health for all in India has been a complex journey, shaped by many factors, including historical, social, economic, and political influences. While significant strides have been made, the goal of providing equitable and accessible healthcare to all remains a work in progress. The journey began during the colonial era, characterized by limited healthcare access and a focus on public health measures. The independence of India embarked on a path of healthcare reform, culminating in the National Health Policy of 1983, which laid the foundation for a comprehensive healthcare system. Subsequent initiatives, such as the National Rural Health Mission and the National Health Mission, have further expanded healthcare access and improved health outcomes. Key achievements include a significant reduction in infant and maternal mortality rates, increased immunization coverage, and improved access to primary healthcare services. However, challenges such as inequality in healthcare access, limited resources, and infrastructure gaps persist. Addressing these challenges requires a multi-faceted approach that includes strengthening primary healthcare, addressing social determinants of health, and ensuring

equitable access to healthcare services. As India continues to evolve, it is essential to build upon the progress made and address the remaining challenges to achieve the ultimate goal of Health for All. By investing in healthcare infrastructure, human resources, and public health measures, India can create a sustainable and equitable healthcare system that benefits all its citizens.

References

1. Jaggi OP. Medicine in India: Modern Period. New Delhi: Oxford Publications, p. 31.
2. Ibid, p. 40.
3. Ibid, p. 44.
4. Ibid, p. 49.
5. Bhore Committee Report. Government of India, New Delhi; Vol. 1, 1946, p. 4.
6. Ibid, p. 20.
7. Sarma NA. Economic Development in India: The First and the Second Five Year Plans. IMF E-Library, Jan 1958. Available from: https://doi.org/10.5089/9781451949636.024.A002
8. Second Five-Year Plan Draft. Government of India, New Delhi, Feb 1956.
9. Narasimham M. India's Third Five Year Plan. IMF E-Library, Jan 1962. Available from: https://doi.org/10.5089/9781451968873.024.A005
10. India Fourth Five-Year Plan and Economic Policy Files. World Bank Group Archives Catalog. Available from: https://archivesholdings.worldbank.org/india-fourth-five-year-plan-and-economic-policy-files
11. Hans VB. Initiatives and Impact of Financial Inclusion in India. SSRN Electronic Journal, 2016 Oct. Available from: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2991428
12. Hall JJ, Taylor R. Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries. Med J Aust. 2003;178(1):17-20. DOI: 10.5694/j.1326-5377.2003.tb05033.x.
13. Grossman M. On the Concept of Health Capital and the Demand for Health. J Polit Econ. 1972;80(2):223–55. DOI: 10.1086/259880.
14. Slaughter S, Rhoades G. The Emergence of a Competitiveness Research and Development Policy Coalition and the Commercialization of Academic Science and Technology. Sci Technol Hum Values. 1996;21(3):303-339. DOI: 10.1177/016224399602100303.
15. Banerjee B. National Health Policy 2002. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd, 2017, p. 4. DOI: 10.5005/jp/books/13071_2.
16. Ibid, p. 4.