



Consultation on History of Health Care in India: The Past in the Present

A Report

December 3-4, 2009

Organised by
Morarji Desai National Institute of Yoga, Dept of AYUSH
in collaboration with
WHO Country Office for India

Acknowledgements

The Consultation on 'History of Health Care in India: The Past in the Present' was possible due to the collective efforts of numerous individuals.

The support received from Dr Ishwar Basavaraddi, Director, Morarji Desai National Institute of Yoga (MDNIY) is acknowledged. The tireless efforts of the team at MDNIY - Dr Sadhana Arya, Mr Madan, Mr Mishra, the students and entire staff of MDNIY and Dr Dinesh Katoch from WHO Country Office for India are recognized.

The technical inputs received from each of the resource persons and participants, who enabled a fruitful deliberation and enriched the discussions, are placed on record. The inputs of Ms. Shelley Saha and Ms Anagha Khot in documentation are also acknowledged.

The consultation would not have been possible without the support extended by the Department of AYUSH, Ministry of Health and Family Welfare, Government of India and Dr S.J. Habayeb, WHO Representative to India.

Lastly, the genesis for organizing such a consultation grew out of the work of the Health Systems Development Cluster at the WHO Country Office for India, with inputs from individuals like Dr Helen Lambert and Dr Padma Prakash. The efforts of Ms Anagha Khot in design and conduct of the consultation, including identification of areas for deliberation, identification of subject experts and participants and co-ordination and liaison are acknowledged. The overall support provided by Mr Sunil Nandraj for conduct of the consultation is also recognized.

The Consultation on History of Health Care in India, exploring the Past in the Present was held on 3-4 December 2009 at the Morarji Desai National Institute of Yoga, New Delhi.

The Context

Any systematic enquiry into the past has value for the present and the future. Often it is the history and the historical foundations of institutions that define the manner they function and the trajectories they describe. It has been over 60 years since India gained Independence, and in these years' innumerable health programmes, schemes, policy making committees have been set up to guide and provide the health care provisions in the country. Therefore, it is time to look back and document the past for the present and the future. We need to learn from our past health care practices, identify the good ones and reinforce them in our present programmes.

There is certainly no dearth of studies in history of medicine. Even a cursory survey reveals a rich resource: on individuals who contributed to the making of public health systems, in western India, to processes and practices at times of medical emergencies, accounts of the creation of institutions, accounts of responses to epidemics, some beginnings in the emergence of disciplines, medical research to name a few areas. But one can see a disconnect between history of health care and present health policy making processes.

We need to see the history of health care from a people's perspective. For instance, how did the various medical institutions evolved during colonial times? What access did the people have to these institutions and their services? What were their own initiatives to ensure health and medical care to themselves? What were the struggles that ensued? What were the challenges? What kind of institutions emerged in contradiction and collaboration with the British rulers?

With this broad perspective this consultation was organized, with an attempt to bring together scholars from different disciplines who will examine key issues in both the provision of health care to the population and in the protection of public health in their historical and social context, thereby casting new light on current problems.

The consultation focused on the following broad themes:

- Public Health, Practice and Its Organisation
- Therapeutics and Prophylactics (Disease, Medicines, Care and Surgery)
- Medical Education and Research

The consultation was attended by representatives from academia, public health experts, historians and medical sociologists, students, researchers, health NGOs, AYUSH institutions and Councils and WHO amongst others (See Annexure 1 & 2 for Agenda and List of Participants).

Inaugural Session

The inaugural session was attended by Dr S.K. Panda (Joint Secretary, Dept. of AYUSH, MOHFW, GOI); Dr S.J. Habayeb (WHO Representative to India); Mr P.K. Jha (Director, Dept. of AYUSH, MOHFW, GOI).

Dr I. Basavaraddi, Director, MDNIY welcomed the participants followed by presentation of bouquets to the dignitaries.

In his address, Shri P.K. Jha, Director of AYUSH spoke about the various systems of health and their origin. He emphasized that the British government in India did not promote or support Indian systems of Medicine (ISM) but now Government of India is consciously supporting ISM through various initiatives.

Dr S.J. Habayeb, WHO Representative to India, in his address, stressed the need to understand the history of health care in India. He emphasized the fact that India since ancient times has several things to be proud of. He mentioned that events like famines, marginalization in society, etc have all shaped our health care provision. He said that unless present generations of health care professionals know about all these we would not be able to deliver health care properly. He shared the initiative undertaken by the Ministry of Health and Family Welfare and the WHO Country Office for India in digitizing the reports of several committees and commissions, since the 1946 to 2005.

Dr. S.K. Panda, Joint Secretary, AYUSH gave the inaugural address. He stressed on the fact that making provisions of health care does not mean providing medicines, but factors that impede on health like water and sanitation is more important and government should make provisions for that. He stressed on the fact that people should have choices of different types of medicines, from allopathy to traditional ones. He mentioned that history needs to be presented in a demystified manner and to keep ourselves open to ideas. At the end he thanked WHO for initiating this consultation.

Shri Sunil Nandraj, WHO Country Office for India, welcomed the participants and provided the background for holding such a consultative process. He mentioned that we carry baggage from our past without knowing their rationale. Therefore we need to undertake a critical review of our past practices and their relevance today. He said that this consultation would help us to look at current policies and programmes in context of historical evidence and experiences in health sector. He hoped that this consultation would suggest options and suggestions in this regard.

The vote of thanks was delivered by Mr Acharya from MDNIY

Technical Sessions

The discussions during the Consultation revolved around the following three broad aspects: Public Health; Diseases and Epidemics; and Medical / Health Research.

Public Health

The discussion of the consultation focused on the evolution of public health in British India and the history of disease prevention in the 19th and 20th century as this provides insight on how various health legislations, their implementation and disease prevention programmes were formulated and implemented.

Public health services are conceptually distinct from medical services. They have as a key goal reducing a population's exposure to disease – for example through assuring food safety and other health regulations; vector control; monitoring waste disposal and water systems; and health education to improve personal health behaviours and build citizen demand for better public health outcomes. In India public policies and programmes have focused largely on the provision of curative care and personal prophylactic interventions such as immunisation, while public health activities have been relatively neglected.

Prof. Deepak Kumar, JNU who spoke on 'Public Health Debates: Lessons from Colonial India' mentioned that in mid- nineteenth century public health usually referred to organised efforts made under the direction of medical experts for preventing disease and improving the health of the people. Environmental health included not only water, sewage, etc. but also equally important subjects like ventilations, lighting, safety, housing, town-planning and rural sanitation. The concept of public health was virtually all-embracing. He went on to say that with the advent of industrialization and with the economic depression in 1930, public spending in agriculture and public health was greatly curtailed.

If one sees the delivery of public health services in the army, one would notice that nutrition and personal hygiene were stressed among armed forces and is part of the overall health delivery. Dr Rajesh Vaidya from Armed Forces Medical Services (AFMS), while talking of 'History of Public Health in Armed Forces' pointed out the fact that Cantonment Health Officers (CHOs) are given much autonomy to decide how to provide health services in cantonment areas and that besides nutrition and personal hygiene, mental health aspect is also given importance in health care provision.

Several policy thrusts of both colonial and independent India provides evidence to show how State priority detracted from public health service provision. Dr. Derek Lobo, in his presentation 'Public Health Legislation and its Impact' critically reviewed few public health legislations in India and highlighted how they limited in their scope and does not fulfill the aim of public health. For instance from colonial India he gave the example how British policies like disabling Community Grain Banks and exporting grains and conversions of land meant for food crops to grow cash crops like cotton, opium, tea in India led to mass famines resulting in 30-60 million

deaths and lack of priority to develop public health measures led to diseases like cholera, plague and small pox.

It was articulated in the consultation that even today, India is formulating health legislations which do not address all the determinants of health like provisions of safe drinking water and sanitation. For instance the National Health Policy fails to integrate health services with wider economic & social development, and has given inadequate focus on safe drinking water, sanitation & nutrition.

Another aspect with regard to public health services delivery that was discussed was how ISM can play a huge role in developing public health services in the country. Dr V Sujatha of JNU, in her presentation 'Health care within the state and market and, without' advocated the fact that medical system should promote healthy cultures and articulated that ISM has an edge over it than allopath, which is mostly curative in nature. Through her presentation she proved that good health indicators of Kerala and Manipur is more due to people's strong belief in traditional knowledge that promote better health practices rather than the popular belief that better health indicators of these two states is because of better female literacy and political participation in case of Kerala and matrimonial social structure in case of Manipur.

Prof Biswamony Pati, Delhi University, through his presentation 'Health Care Systems - Yesterday and Today : Colonial and 21st Century Orissa' also stressed that there is a complete denial by the government or the medical system to learn from medicinal systems of the adivasi/indigenous people's experiences or to locate the problem of health holistically – poverty alleviation; employment generation; education and health. Prof V R Muraleedharan from IIT Chennai and Shirish Kavadi from NCAS also in their respective presentations highlighted the use of research and intersectoral approach adopted by colonial government in India to control epidemics like malaria and hookworm.

Key Issues:

- The Five-Year Plans document the rapid shift away from a public health-oriented focus in independent India. Even though little was done on sanitation in the 1950s, the plans recognised clearly its importance for controlling communicable diseases. Water and sanitation was an integral part of the chapter on health planning, and sanitary inspectors figured as an important cadre of frontline staff. By the 1960s, water and sanitation had been separated out as belonging outside the health sector, and there was little further mention of sanitary inspectors in the plans.
- The overarching policy vision emphasized developing heavy industry rather than health and education.
- Public health services were merged with the medical services in the 1950s.
- Qualifications in specialty curative skills became far better rewarded than public health qualifications, and attracted the best talent.
- The central government focuses on planning specific programmes, such as malaria eradication or family planning. This means that the bulk of the funds allocated by the central health ministry to the states are tied to specific programmes and categories of

expenditure within those programmes, and states are not free to reallocate the funds to issues that may be of higher local priority.

- Moreover, public health services which is the responsibility of the state governments, face fiscal crunch because, the constitutional fiscal provisions require states to hand over the bulk of their tax revenues to the central government. The central health authorities leverage their funds by requiring states to provide co-financing for many of their programmes. This leaves little fiscal room for states to operate programmes for which there is little support from the central government, such as assuring environmental sanitation and other core functions of a public health system.
- There is also inadequate inter-sectoral coordination, which further wastes resources. For example, the health department has limited recourse if the irrigation department generates malaria by leaving a canal half-finished and waterlogged, but once an epidemic breaks out they will be called in to step up clinical services to handle the problem.
- Unless the focus of health policies are not brought back to health promotion and address the various obstacles to health, we would continue to have high disease burden even with the largest production of health personnel in the world.
- Policies should not be made in isolation and implementing mechanism should be in place before policies are formulated.
- All policy documents should have inbuilt mechanism for implementation, enforcement and monitoring and evaluation.
- Health provision/planning/implementation suffers due to conflict between various ministries which control various aspects of health care provisions like health ministry and industry ministry (which controls drug production)
- There are some reasons to be hopeful that public health may receive more attention in the near future. Financing is available through large programmes, for example the National Rural Health Mission, through which in some areas public health system got a new impetus.

Diseases and Epidemics

During the consultation, discussions also took place on how government during colonial and recent times responded to outbreaks of epidemics. Dr. Mridula Ramanna from Bombay University in her presentation, 'Epidemics and State Responses in Colonial Bombay' said that Colonial government was concerned more with diseases that affected Europeans than diseases like malaria. She stated that there was ad-hocism in health policy making & ambivalence in attitudes of health personnel. This was reflected in the fact that the health committee, under the chairpersonship of Sokhey, the then Director of Haffkline Institute challenged the prevalent health policies and practices and advocated the strategy of formulating health programmes through community involvement and also challenged the superiority of health personnel in delivery of health care. His ideas were disregarded by the Bhole committee later in 1946.

It was also emphasized by the presenters that lack of proper sanitation has led to resurgence of epidemics in India in recent years. The consultation also discussed the importance of health practitioners from other systems of medicines to be involved in controlling public health problems. Prof Harish Naraindas of JNU in his presentation 'AYUSH and Epidemics: Responding to smallpox and chikunguniya in past and the present' gave the example how in the recent

outbreak of chikunguniya in Tamil Nadu, the state government used ayurveda medicines to control the outbreak. But it was also highlighted how the dominant allopath health care system subdued the effort of the government to use ayurveda.

Key Issues:

- Allopathy has become very dominant and it influences the scope of health care provisions of ISMs in India. This is a manifestation how the colonial government looked at ISMs.
- Need for an open mind particularly among allopath practitioners to have other systems of medicine in health care delivery for people to choose from.
- Need of alternative theoretical paradigm – collaboration between sociology and science.
- One needs to question the “scientificity” of the claim that allopath is an evidence based medicine (EBM), given the fact that there are innumerable instance where medical journals are bought over by vested groups to promote western medicine.
- To control epidemics and other communicable diseases government should focus on addressing other determinants of health care like provision of safe water and sanitation.

Health Research

The evolution of medical research institutions like Indian Council of Medical Research (ICMR) and All India Institute of Public Health (AIIPH) was another area that was discussed during the consultation because it was felt that it was important to understand the evolution of health research in India if we want our research institutions to address gaps present in the contemporary public health research.

Dr. Padma Prakash, in her presentation ‘Beginnings of Medical Research - Struggle to Find a Foothold’ highlighted the fact that in early years of its formation, ICMR felt the need to explore and use the ‘rich ancient systems’ of medicine. CG Pandit, the first Director of ICMR and the first minister of health was a strong proponent of this idea. The presentation highlighted how over the years its scope has reduced along with its autonomy to undertake health research. Dominant paradigm of western medicine by the Indian ruling classes, policy makers and funders led to the failure of integrating ISMs in medical research. Lack of finances and state support for ICMR is another issue that was highlighted during her presentation.

Similarly Shirish Kavadi from NCAS in his presentation ‘Public Health in Colonial India: The Rockefeller Encounter and Perspective’ proved how AIIPH in early years was visualised to have great influence on the development of public health in India by undertaking research in preventive medicine. But over the years it is seen that clinical research dominated by western systems of medicine has prevented research to be undertaken in the arena of public health.

Key Issues:

- Lack of autonomy and finances in medical research, especially research on public health and preventive medicine.
- Subordination of public health administration to general administration.
- Though there has been much rhetoric on the need to encourage research in indigenous systems and revitalise them, very little has happened on the ground.

Open Discussion – Way Forward

Participants gave suggestions on how to take this initiative forward. They are enumerated below:

- Enter the subject 'History of medicine/public health' or sociology of medicine in medical curriculum initially as an optional subject. Medical Council of India (MCI) can play a role in this initiative. A course / module on history of health care to be developed.
- MBBS curriculum should also have subject on Indian Systems of Medicine (AYUSH).
- Need to institute fellowships in the area of history of health care. Further advocacy with MOHFW suggested. Alongside, there exists a need to compile a list of resource persons and institutions who could participate in such an initiative.
- MOHFW, PHFI (Public Health Foundation of India) can compile legislative debates in public health, both past and present.
- Record keeping was much better in colonial times than it is now. The participants expressed the importance of record keeping and gave suggestions with regard to that. It was suggested the NIPER could be one of the partner institutions for this initiative.
- Formulation of Society on History of Public Health and Medicine could be considered.
- For policy formulation, life style management and knowledge of health care during ancient times should be taken into account.
- Good practices in health care practices from history should be documented and advocated to bring about positive changes in health care provision and policy making.
- The concept of family physician needs to be promoted instead of the present trend of too much focus on super-specialization.
- Creation of web-space on history of health care in India
- Need to have follow-up meeting with broader audience. MOHFW and other stakeholders to be involved
- Need for focused, thematic, multi-disciplinary interaction amongst historians, policy makers, academia and public health experts amongst others.
- Sharing the list of participants

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Agenda

Day 1: December 3, 2009		
1000-1055 Registration		
1055-1200 Inaugural Session		
1055-1100	Arrival of guests	
1100-1105	Saraswati Vandana	Students of MDNIY
1105-1110	Presentation of bouquets to dignitaries	
1110-1115	Welcome address	Dr I. Basavaraddi, Director, MDNIY
1115-1120	Inauguration by dignitaries	
1120-1125	Address	Mr P.K. Jha, Director AYUSH, MOHFW, GOI
1120-1130	Address	Dr S.J. Habayeb, WHO Representative to India
1130-1140	Address	Dr S.K. Panda, Joint Secretary AYUSH, MOHFW, GOI
1140-1145	Vote of Thanks	Mr Acharya, MDNIY
1145-1200	Setting the Strategic Context	Mr Sunil Nandraj, WHO Country Office for India
1200-1215 High Tea / Coffee		
1215-1400 Technical Session 1		
1215-1240	Public Health: A Historical Perspective	Prof Deepak Kumar, JNU
1240-1305	Evolution of Public Health in Armed Forces	Dr Rajesh Vaidya, AFMS
1305-1330	Public Health Legislation and its Impact	Dr Derek Lobo, Mangalore
1330-1400	Discussion	
1400-1445 Lunch		
1445-1600 Technical Session 2		
1445-1510	Epidemics and State responses	Dr Mridula Ramanna, Mumbai
1510-1535	AYUSH and Epidemics: Responding to smallpox and chikunguniya in past and the present.	Prof Harish Naraindas, JNU
1535-1600	Discussion	
1600-1620 Tea / Coffee Break		
1620-1730 Open Discussion		
	<ul style="list-style-type: none"> • Current policies and programmes in context of historical evidence and experiences in health sector • Options and suggestions on how to 	Mr Sunil Nandraj, WHO Country Office for India

	take this initiative forward	
1730-1800	Fusion Show & Cultural Programme	Students of MDNIY
Day 2: December 4, 2009		
1030-1140 Technical Session 3		
1030-1050	Health care within the state and market and, without	Dr V Sujatha, JNU
1050-1110	Health Care Systems - Yesterday and Today: Colonial and 21st Century Orissa	Prof Biswamony Pati, Delhi University
1140-1140	Discussion	
1140-1200 Tea / Coffee Break		
1200-1315 Technical Session 4		
1200-1225	Beginnings of Medical Research Struggle to Find a Foothold	Dr Padma Prakash, TISS
1225-1250	Nature of anti-malarial policies in British India and field experiments in South India in 1930s	Prof V R Muraleedharan, IIT Chennai
1250-1310	The Rockefeller Encounter & Perspective	Dr Shirish Kavadi, NCAS
1310-1330	Discussion	
	Summing Up and Vote of Thanks	Ms Anagha Khot, WHO Country Office for India
1330 Lunch		

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