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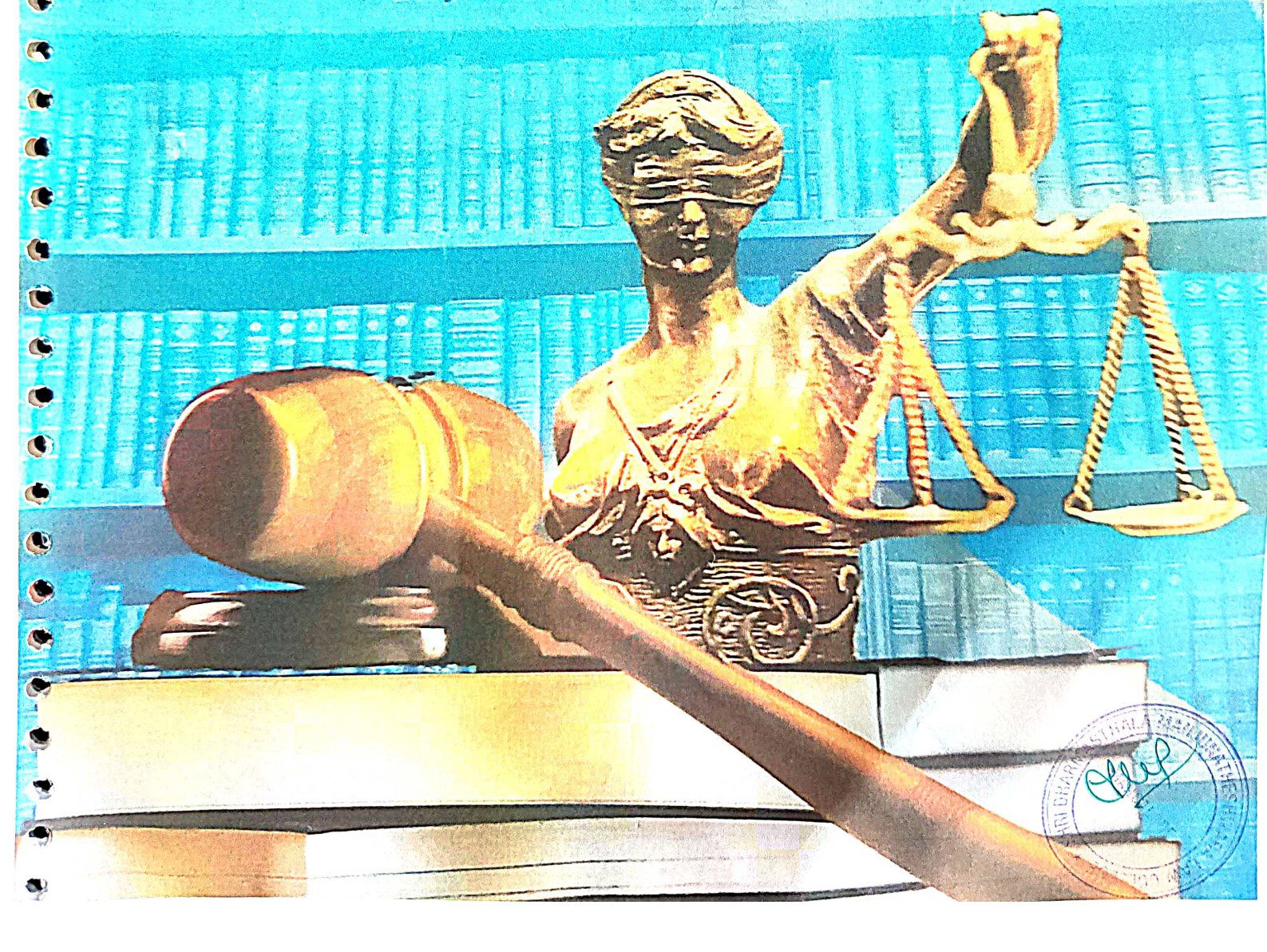

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HEALTH UNDER BRITISH INDIA AND THE COMMITTEES TO PROTECT RIGHT TO HEALTH IN INDEPENDENT INDIA

Mrs. Reshma [1]

Introduction

In shaping the public health policy in British India, the medical officers played a major role in the light of their aspirations, priorities, and grievances. But the same privileges were not enjoyed by them in British India as in Britain in the 19th century. The royal structure of the British Medical Profession rarely could go hand in hand with those of the Indian Government and the indigenous medical practice was subordinate to the colonial rule. Due to this there was an anxiety to establish a firm and gripped medical service set up in British India[2].

The Growth of the Indian Medical Service in British India

Ever since 1600 the number of British surgeons increased with expansion of the trading of the company. However, until the formation of the Bengal Medical Service in 1763 there was no regular medical establishment. The Bengal Medical Service fixed grades or ranks and framed definite rules for promotion in the service. Medical services were soon formed on similar lines in the other two presidencies of Bombay and Madras. In 1775 in order to administer European hospitals, the medical services were expanded, and medical boards were set up in each presidency, resulting in the expansion of the military medical service in India[3].

The wars of the eighteenth century also highlighted the need of assistance in European hospitals in India. From the very inception, the Company employed Indians and occasionally European soldiers as compounders, dressers, and apothecaries. In Bengal, in the 1760's these assistants were organised into a Military Subordinate Medical Service (SMS) and similar steps were taken in the other presidencies in the early nineteenth century. Where the strength of the SMS grew steadily from 20 to 40 men per presidency in 1848, to over 500 throughout India by 1914[4].

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[2] Harrison .M. *Public health in British India: Anglo Indian Preventive Medicine 1859- 1914*, (Cambridge University Press, 1994), pp. 7-9

[3] *Ibid*

[4] Anu Saini, "Physicians of Colonial India (1957-1900)" available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5290754/ visited on 26.05.2017

In 1857, when a commission report was submitted, the mortality rate in the British army at home was greater than among the civilian population. Two years later in the wake of mutiny, a similar commission was setup to inquire into the health of the army in India. The effectiveness of British troops during the mutiny had been severely hampered by the ravages of epidemic disease, particularly cholera, which had also claimed many lives among European civilians at Lucknow and in other north Indian towns. Medical officers noted that, after years of neglect, the East Indian Company's Board of Directors were at last taking proper interest in the health of their troops[5].

However, it was felt by the British government, that instead of rectifying the Company, its better to rectify the defects of military hygiene in India. Hygiene within military stations was sought to be regulated by the Military Cantonments Act, 1864, which established a system of sanitary police under the overall charge of military medical officers and a scheme for the registration of deaths. The provisions of the Act, which covered the Indian as well as the European populations of cantonments, were an indication of the growing conviction that the health of Europeans could not be considered in isolation.[6]

The Royal Commission on the Sanitary State of the Army in India, identified the underlying causes as inadequate sewerage and water supply, poor drainage and ill-ventilated and over- crowded barracks. In its report of 1863, the Commission recommended the creation of distinct areas of European habitation (military cantonment and civil lines) regulated by sanitary legislation similar to that in Britain[7]. In the twentieth century there was also far more attention to the subject of military nutrition. There was a practice of giving soldiers in India the same diet, regardless of the season, as in Britain. The new cantonment authorities established under the Military Cantonment Act, 1864. It was this increasing concern with sanitary conditions immediately outside of European quarters that led to the re-organisation of colonial public health administration in 1868. Any member of the Civil IMS was eligible for employment as a Sanitary Commissioner or a Health Officer. Health Officers worked under a patchwork of sanitary legislation, again modelled on British legislation, but adopted to Indian conditions. [8]

In 1870, with the construction of new barracks, under way, the Indian government ordered the supply of new pumps and filters for wells in military cantonments. Later in 1870s, the military authorities acknowledged that there was a strong link between the spread of cholera and water supplies. In the 1880s, specific measures designed to control the spread of enteric fever. In the 1900s, it was generally acknowledged that in all probability water plays only a major role in the dissemination of enteric fever (typhoid), and that the priority should be to deal effectively with the patients at the earliest. The early identification of cases was the key to this new system of military hygiene, with bacteriological diagnosis playing an important part[9].

5, 6, 7, 8 *Ibid*

9 Mark Harrison, "Public Health and Medicine in British India : A Assessment of the British Contribution", available in http://pdfs.semanticscholar.org visited on 27.04.2016

In the early 1900s, each cantonment acquired a small laboratory in which blood samples could be tested for the presence of typhoid or the newly discovered para - typhoid bacilli. There was also greater attention to the preparation of food, since it was now thought that poor hygiene was one of the principal reasons for the high incidence of enteric fever or typhoid, in many camps[10].

The keystone in the arch of sanitation, as one health officer described it, was the registration of birth and deaths. This scheme was to provide the basis for an annual aggregate of the vital statistics of the civilian Indian population, or 'general population' as they were referred to in official reports. Village headmen were responsible for reporting deaths to the registration officer, classified according to race, religion, causes of death, age and name of village. In towns, where in some cases death registration had begun in the 1850s, officers were specially appointed by the municipality or the cantonment committee[11].

From 1898 to 1900 plague measures in most provinces of India were liberalized as a result of suspicion and hostility among lower class Indians and on a local level, medical officers and administrators began to enter into a dialogue with community leaders about how best to conduct measures against plague[12].

By 1900, given relaxations of International Quarantine Regulations, the Secretary of State no longer insisted that stringent measures be imposed on India. Following the visits of Plague Commissions from several European countries, there was general agreement that plague was not directly communicable from person to person. The influence of young medical experts, filled with enthusiasm for inoculation and coercive sanitary measures, had been destructive and in accordance with the recommendations of the Indian Plague Commission which was reported in 1999, the Indian government took steps to eradicate the unduly repressive measures still in force in India. Combined with a growing realisation of the ineffectiveness of the rat campaign, this discovery resulted in a more realistic approach to plague prevention, concentrating on the exclusion of rats from commercial and domestic premises. It was thought that such a campaign would have to go hand in hand with a program of popular sanitary education. Another important recommendation made by the Commission was the creation of a network of medical laboratories, to be engaged in investigations into the diagnosis, causation and treatment of the disease and the effectiveness of prophylactic measures like disinfection[13].

An additional equally important function was to be the production of vaccines and sera. The Commission thought that the laboratories established on an ad hoc basis during the epidemic should be made permanent, and that a new central research institute be established in Kasauli, a hill station, which from 1900 had been the location

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[10, 11] *Ibid*

[12] Sunil S Amrith, "Health in India since Independence", BWPI working paper 72, available at http:// www.hummedia.manchester.ac.uk>gdi>bwpi visited on 18.03.2016

[13] *Ibid*

of India's first Pasteur Institute.[14] The plague epidemic had demonstrated that the use of indigenous agencies and consultation with local elites, were crucial to the success of public health measures[15].

The inclusion of Indians in research work was an outgrowth of this trend, and a reflection of Morley's decision to increase the recruitment of Indians into the IMS after 1905. Until 1909 anti - malarial operations had been confined almost exclusively to military cantonments and jails or to the European quarters in Indian cities. Co-operation with the indigenous population was essential if these operations were to be extended, which seemed desirable in view of the fact that the Indians were perceived as reservoirs of malarial infection. Government attempted to encourage local and municipal boards to allot more funds for drainage, and to increase the distribution of quinine to the general population.[16]

Public Health and Local Self Government

The 1880's saw profound changes in the administration of public health in India. The reforms of the 1880's did not make a total break with the past, but accelerated the process of financial and administrative decentralization set in by the Mayor in the early 1870's. But the primary concern was to pass the responsibility for sanitation, road maintenance and other local services from central to provincial government. Administrators had come to recognise that India could be governed only with the co-operation of the Indian people, especially with regard to matters of health and hygiene. Ripon's resolution of local self-government of May 1882, established a majority elected element on each Municipal Commission although provincial governments were left to decide the exact proportion of official and non-official members in municipal bodies under their jurisdiction[17].

The Indians were ambivalent towards European notions of sanitation and hygiene and it was already clear from the experience of the provincial capitals, where elected Indian representatives had served on municipal commissions since the early 1870's. Indigenous hostility or indifference towards western notion of public health was only a few among the several other obstacles which stood in the way of administrative decentralisation. The impact of local self-government upon sanitation is still extremely unclear[18].

As per the Rippon Reforms, the priority attached to sanitation varied enormously from one municipality to another. In Calcutta, socio-religious barriers and sectorial interests stood in the way of reform, while in Bombay, commercial factors were of

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14 Available at http://www.ijhsi.org,vol.3 issue31 March 2014 pp.09-11visited on 17.03.2015

15 *Ibid*

16 *B.B. Bandyopadyay, Dr. (Prof) Roumi Deb* "Colonial Medicine and Public Health under the British Rule- Issues with Special Reference to the United Provinces" available at http://www.ijestsr.com/images/short_pdf/1505221931_716_723-ieted263_ijetsr.pdf visited on 23.05.2017

17 See, *Supra* note 2, pp. 166- 199

18 *Ibid*

paramount importance in shaping the municipality's attitude towards public health. Since the 1860's, the city had been identified in Europe as the principal source from which cholera spread to the West, and vessels sailing from the port were subject to regular quarantine. In 1882, against the corporation's failure to take precautions against cholera, the city was overtaken by great mortality[19].

Another obstacle was the unwillingness of the provincial government to involve itself, financially in the sanitation of the city. In 1867, the Sanitary Commissioner for Bombay complained that a drainage scheme prepared by the Bombay Corporation had been scrapped because the Government of Bombay had decided that the onus of producing a financially practicable scheme would rest on the municipality. The inadequacy of Bombay's water supply was another frequent cause of complaints as was the insufficient number of subordinate sanitary staff like road-sweepers, night soil collectors etc. employed by the city's municipal commission[20].

Sanitary conditions were no better in Madras city. The city's sanitary establishment was reduced at a time when many of its European inhabitants felt that sanitary measures should be stepped up. The financial position of the Madras Corporation was such that extensions to the city's water supply were delayed, placing it at the mercy of rate payers who demanded the service they had paid for. In July 1889 the Madras government decided to intervene, in order to prevent the issue of suits against the corporation, allowing it time to complete the water supply scheme. Even advocates of sanitary reforms felt that the scheme was far too expensive in the existing condition of the municipality.[21]

The Impact of Self Government

In place of local fund circles, Ripon's resolution on local self-government established a gradation of local authorities. The smallest local board covering a tahsil, or sub-division of a district, had responsibility for sanitation, education, public works, medical services and sometimes veterinary work. The largest local board, viz. the district board, was envisaged as a supervising or coordinating body. But in all provinces except Assam, the central provinces and Madras, the District Boards were entrusted with all funds and with almost all functions of local government including the management of local charitable dispensaries[22].

In Bombay and North Western Provinces, local boards initially had only a nominal existence, with provincial government continued to levy and to disburse land revenues and with District Commissioners exercising great influence over sanitary and other arrangements. The new system came into existence in most provinces in 1885, but existing sanitary legislation, like that in the Central Provinces, remained on the statute books and was eventually extended to other provinces[23].

It is harder to gauge the impact of local self-government on sanitary activity in rural areas than in municipalities. Returns of income and expenditure from local boards

19, 20, 21, 22, 23 *Ibid*

were not always forthcoming. The total funds allotted to sanitation in both Bombay and Madras rose after 1885, reaching its peak in the mid-1890s. As a percentage of local incomes, sanitary expenditure rose steadily in Madras from 1885 to 1890. The sharp decline in allotments in Madras in 1890 may be attributed to a large rise in local revenues due to the inclusion of forty new towns into the scheme[24].

As in urban areas, rising expenditure on sanitation marked considerable regional variations. In 1886, the Sanitary Commissioner for Punjab claimed that nothing had been done to improve sanitation in rural areas in his province and highlighted many glaring sanitary defects. The Sanitary Commissioner of Berar reported in the same year that the sanitary condition of villages still continues in its primitive state and the Sanitary Code which was issued some time ago, has hitherto been almost a dead letter[25].

The obstacle to sanitary improvement in rural areas were again the lack of support from provincial government, difficulties in raising sufficient local revenues and lack of interest among the indigenous population. District Boards met infrequently, with zamindar members attending very rarely. Indian land owner viewed the elective principle as a challenge to their traditional authority and often found themselves unable to follow the unfamiliar procedures of local government. The shortage of funds available for the rural sanitation was a frequent cause of complaint among sanitary officials. Summing up the progress of rural sanitation in 1888, the Sanitary Commissioner with the Indian government recorded that progress had been poor and the cause of much of the inaction displayed by local authorities on matters of sanitation has been due to want of funds and to the very inefficient means which have hitherto existed for giving effect to suggested improvements[26].

These concerns were shared by the Indian government which for the first time in 1887 expressed its willingness to consider grants-in-aid of sanitation in local bodies. Its interest in rural sanitation attended primarily from the growing realisation that high morbidity and mortality rates among the general population constituting a serious obstacle to economic efficiency[27].

The Village Sanitary Act, 1884

The creation of Sanitary Boards was followed up in several provinces by the Indian government's passage of the Village Sanitary Act, 1884. The Act empowered villages to levy a tax in order to raise revenue for sanitary purposes. Similar legislation was introduced in Bombay and Central provinces in the same year. The Bombay Act provided for contribution from local boards and from provincial government at two sixth and one sixth respectively, the remainder to be raised from the taxation of villagers. Similar legislation was enacted in the North West Provinces in 1890 and

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[24] D McDonald, "The Indian Medical Service. A Short Account of its Achievement 1600-1947" available at https://journals.sagepub.com/doi/pdf/10.1177/003591575604900103visited on 14.03.2016

[25, 26, 27] *Ibid*

the provinces like Assam rejected it as inappropriate for sparsely populated hill and jungle areas. The narrow base of local taxation and fluctuations in economic activity also served to arrest sanitary development and this was particularly true of those provinces like Bombay and Punjab, which relied heavily on octroi and other forms of indirect taxation[28].

However, regional differences cannot be attributed solely to variations in prosperity of modes of taxation. The numerous references to the indifferent Municipal Commissioners towards sanitation which occur in official sanitary reports cannot be dismissed as simply rancour or prejudice on the part of British officials. Indian Municipal Commissioners often displayed an ambivalent, if not hostile, attitude to western concepts of hygiene and sanitary regulation, reflecting financial self-interest as much as cultural distaste for sanitary measures.[29]

Securing Right to Health in Independent India

In India evolution of health care system was beginning at the time of ancient Hindu civilization[30]. During the British period there was no clear health policy for the country. It was only after the independence, the government of India started declaring their health policy from time to time and designed programmes to meet the very object of the policies.

Starting from 1943, the Health Survey and Development Committee established by the British Government appointed various experts committees to give aid and assistance by guiding the Government of India in making of their health policy. After accepting the recommendations of these expert committees, the Government of India planned to hold a programme during each Five Year Plan declaring their aims and objectives relating to the field of health management.

To achieve their specific targets the resources were allotted by the Government. To understand the Health Policy of India clearly , it is necessary to brief the recommendations of the various expert committees and the different health programmes undertaken in India after Independence[31].

The Bhore Committee, 1946

The government of India has appointed the Health Survey and Development Committee popularly known as the Bhore Committee to review the health conditions of the country. The committee submitted its report in 1946 which has special

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28 Muhammad Umair Mushtaq ,"Public health in British India: A brief account of the history of medical services and disease prevention in colonial India" available at http:// www.ijcm.org.in/article.asp?issn=09700218;2009;volume=34;issue=1;spage=6;spage34;issue=1;spage6;spage14=mushtaq visited on 30.03.2010

29 *Ibid*

30 Rakshith Sarothi Partha, *Right to Health Care for All and Health Movement in India: An Analysis*, (Public Health L:aw journal, department of law , University of North Bengal, 1998).p.53

31 Shastri Swati, *Public Health Policy during British India: Committees Introduced by the Government*, Vol. III, Issue 3(International Journal of Humanities and Social Science Invention, 2014).p.24

significance for not only revealing the health conditions of the country, but also for providing guidelines in the field of health care administration such as providing adequate medical care to everyone irrespective of financial matters, establishing consultation, laboratory and the institutional facilities necessary for proper diagnosis and treatment, special emphasis for preventive measures[32].

Providing medical relief and preventive health care to the vast rural population of the country, to avail maximum benefit, health services should be placed as close to the people as possible. The committee also thought it essential to secure active cooperation of the people in the development of the health programme. This committee was also greatly inspired by the aspiration of national movement in India. It also recommended a comprehensive proposal for the development of a national programme of health for the country[33].

The Sokhey Committee, 1948

The National Planning Committee (NPC) set up by the Indian National Congress in 1938 under the chairmanship of Colonel S. Sokhey emphasized that the maintenance of health by adopting curative and preventive measures for the people was the responsibility of the State agencies. Subsequently, in 1948, the Sokhey Committee was formulated, but the report was not as detailed as the Bhore Committee report. But it accepted the recommendations of the Bhore Committee Report and commented that it was 'of utmost significance'[34].

The Mudaliar Committee, 1959

This committee known as the Health Survey and Planning committee was appointed by the Government of India in 1959 to survey the progress made in the field of health since independence and to make proposal for further development and expansion of health services in India. The committee found the quality of service rendered by the Primary Health Centres inadequate and expressed itself to the strengthening of the already existing health centres before undertaking the establishment of the taluq and district hospitals for referral services. The committee felt that each Primary Health Centre should serve not more than 40,000 population. While favouring for integration of medical and health services as proposed by the Bhore Committee, the Mudaliar Committee stressed on the qualitative improvement of the primary health care[35].

Some of the recommendations of the Mudaliar Committee were implemented by providing better primary health care in rural areas including family planning and special training programmes for those who are working in the Primary Health Centres in various activities[36]. However, in the post-independence era i.e. in the 1950-60's

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32 *Ibid*

33 S Goel, " From Bhore Committee to National Rural Health Mission: A Critical Review" available at www.ijcm.org.in/articlevisited on 16.07.2015

34 T Bhaskara Rao, *National Health Progrmmes of India*, 1st ed, (Paras Medical Publishers 2011), p.104

35 *Ibid*

36 See, *Supra* note 30 p. 57

establishment of advanced research institutes, medical colleges, tertiary hospitals and primary health care centres emerged, while the sub centres at village level lagged behind. In the late 1960's India had raised concerns about the development model adopted so far[37].

The Chadah Committee, 1963

The National Malaria Eradication Program was examined by this committee which favoured that malaria eradication in rural areas should be the responsibility of the Primary Health Centres at the block level. Basic health workers were appointed to undertake vigilance work by monthly home visits. These workers were also entrusted with the additional duties relating to collection of vital statistics and family planning. The committee favoured the appointment of the Family Planning Health Assistants for every three or four health workers[38].

The Mukerji Committee, 1965

The committee was appointed to review all the activities of public health care. This committee along with other recommendations suggested separating the basic health workers from associating with the family planning and that the malaria eradication program should also be separated from family planning. In the very next year, 1966 this committee gave a task to work out the details of Basic Health Services being introduced at the block level and proposed to appoint one basic health worker for every 10,000 population and a Health Inspector for every four basic workers. It was also proposed that for every ten Primary Health Centres there should be one Health Supervisor[39].

The Jungalwala Committee, 1967

This committee was appointed for the intergration of health services in the year 1967 and made several recommendations. While the committee favoured the intergration of the organization and the personnel in the field of health from the highest to the lower level, it developed an unified approach to all problems instead of segmented approach. The committee visualized medical care and conventional public health programmes by the sole operator at all levels of hierarchy on the basis of priority[40].

The Kartar Singh Committee, 1973

The committee on multipurpose workers under Health and Family Planning was appointed by the Government of India in 1973 to suggest the structure of integrated service at the periphery and the supervisory level. The committee asked the feasibility of appointing multipurpose workers, to work out their training requirements and to

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[37] *Ibid* p. 106

[38] *Ibid.*, p. 105

[39] *Ibid*

[40] Reetu Chaudhi, "Rural Health Service in India", available at http://www.sociologydiscussion.com, visited on 25.09.2015

examine the utilization of mobile family planning unit for integrated medical and public health. Among several other suggestions the committee proposed the replacement of female and male health workers according to their multipurpose activities in the Health Care Services[41].

The Committee also recommended that multipurpose workers programme shall be introduced in areas where malaria and small pox were still a problem, that there should be a Primary Health Centre for 50,000 population, that each centre should have one male and one female health worker, that for every three to four health male workers there should be one male health supervisor, that while the female health supervisor should be in charge of four female health workers, the lady health visitors should be re-designated as female health supervisors and the doctors of the Primary Health Centre should have the overall charge of all supervisors and health workers in this area[42].

The Srivastava Committee, 1975

This group on medical education and support man power was appointed by the Government of India in 1975. The group made a number of recommendations concerning the man power requirements etc. of the Primary Health Centres.

Firstly, the committee suggested creating a team consisting of para-professionals or semi - professional workers from the community itself to provide simple, protective, preventive and curative services which are needed by the community[43].

Secondly, the group recognized two distinct cadres between the Primary Health Centres and the local community, viz. health workers and health assistants. These health workers were trained and well equipped to give simple specified remedies for day today illness. While the Health assistant's worked as intermediaries between the health workers, they were required to function in their area by possessing higher technical competence as they had to perform their primary duty of supervising the work of Health Workers[44].

Thirdly, the group recommended to provide with an additional doctor with a nurse to look after the maternal and child health services in all Primary Health Centres.

Fourthly, the possibility of utilizing the services of senior doctors to aid and assist for a short period with Primary Health Centres was sought to be explored and encouraged.

Fifthly, the Primary Health Centres were required to develop direct links with the community around as well as with other bigger hospitals around it[45].

Conclusion

A look at the history will reveal that the system of medicine developed with science. So also the awareness of the right to health grew with the advent of the British rule in

41, 42, 43, 44, 45 *Ibid*

43 See, *Supra* note 31, p. 25

India. Public health provisions in British India were developed and shaped by anxieties aroused by the Indian mutiny of 1857, practically the unhealthy status of British troops. An infrastructure of public health evolved in response to these concerns, at first within the confines of military cantonments and then, increasingly outside the camp. But the desire to sanitize the Indian population, most evident among the military and certain officers of the IMS, was held in check by financial considerations, logistic difficulties and by opposition from British humanitarians and Indian elites.

The local bodies during the British rule were cast with the responsibilities of sanitation and general medical services. The Rippon Reforms stressed the necessity of the local governance to give more attention to public health. After the independence, India also declared its health policy from time to time, by adopting the recommendations of the various committees like the Bhore Committee, 1946, the Mudaliar Committee, 1959, the Srivastava Committee, 1975, etc. Reckoning the community health care as paramount, India adopted a National Health Policy, 1983 in response to the Alma Ata Declaration to achieve ' Health for All', by considering that health is the core of development of our nation. The recent National Health Care Policy, 2017 seeks to upgrade the Indian health care system by setting up a target of 14 years, to achieve the object of universal declarations, crossing all financial barriers.

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