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Invited Article

Revisiting Perspectives in Public Health for People's Health and Wellbeing

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ABSTRACT

The paper traces the evolution of modern healthcare services on the ground and the changing concept of public health in India to see how these differ from the countries of their origin and why? It traces the transition of public health in India over three distinct periods - the colonial period, its initial welfare oriented social democracy and its drift into the contemporary neo-liberal phase. It explores the links between the shifting political ideologies and health policy and its links with international players, highlighting the structural changes brought in by the Reforms. The Health Sector Reforms have deformed the public sector healthcare system that is now fragmented and stagnating. They have allowed the private/corporate sector to take over medical care, rather than be a partner in strengthening the public sector healthcare system. The conceptual digressions within public health that rationalise the Health Sector Reforms are critiqued and the paper proposes the kind of intellectual enquiry that is required to resurrect public health and make wellbeing of the majority possible.

Keywords; Public health, healthcare system, medical care system, systems analysis, non-medical determinants of health.

INTRODUCTION

History is not just the knowledge of our past, it is a method of understanding the present to be able to visualise the future. Revisiting perspectives in public health, therefore, is an exploration of the significance given to the maze of the socio-economic context that shapes Public health - its definition, practice and its frontiers of knowledge in different times and places. Public health, social medicine, community medicine and socialised medicine[2] are the incarnations of the human desire for achieving health and of spreading the benefits of knowledge not only to individuals but to a population. In Europe the French revolution was the impetus for the emergence of social medicine and, in the United States, Community medicine emerged in academic institutions with a narrower base in local communities and not as a state response to public health problems, as in Britain.

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2 Socialised medicine evolved in the Socialist countries that built their universal healthcare and education system along with socio-economic development. Their trajectories are not discussed in this paper.

Classical public health was rooted in the individual and collective practices and regulations (both private and governmental) of the sanitary era in Britain of the 1830-1857 period when government-run dispensaries, maternity child care services, private practitioners, milk supplies, vaccination campaigns, medical policing and engaging private water supply companies (Rosen, 1958) emerged. It gained strength from the workers movement arising out of the discontent from living and working conditions. In the second half of the 19th century, Germ theory of disease causation promoted the search for diagnostic techniques and specific cures. The technological developments that could be widely used (like drugs, and antibiotics) took over from the earlier broader approach to disease control in the first half of the 20th Century.

A few interesting aspects of this historical process are important for our discussion. Firstly, over time, supremacy of medical technology overshadowed the importance of the living and working conditions that required socio-economic and structural changes. Secondly, the wealth acquisition required for development was rarely a part of the debates in public health as it came easily from the colonies and was colossal[3]. Thirdly, though in the countries of its origin, public health's progressive perspective was derived from the democratic principles of fairness, justice and equitable distribution, from the early 20th Century its content was primarily bio-medically determined. Consequently, the experiments in Universal health care (UHC) for the people, though varied, remained in the sphere of organisation of technology, manpower and materials required. States partnered with the private providers in provisioning of care using different ways of resource mobilisation. British National Health Services (NHS) came up in 1948 but mainly for medical care on the basis of differential taxation. Inspired by it, Canada developed its national health care system. Germany and France opted for the insurance system for resource mobilisation. These efforts at universal healthcare were thus rooted in social democracies that could sufficiently invest in their healthcare system and the states played a crucial role in financing and regulating the providers. However, when public health came to the poor countries it was assumed that the route through socio-economic development is too long and technological interventions will provide a short cut to development. In other words the social roots of technology were ignored assuming it to be an independent transferable resource - from one context to another.

Historically, one of the academic definitions of public health that became popular, came from Winslow in 1920, "The science and art of preventing disease, prolonging life, and promoting health of the community through organized community efforts. This calls for organization of health care services (manpower, technology, and material), for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure access to services, environmental sanitation, health education to the community and a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birth right of health and longevity" (Kemper, 2015). Over time different components of this vision were emphasised: first, scientific and technical knowledge (Institute of Medicine (U.S.) Committee, 2002); then the World Health Organisation (W.H.O.), proposed provisioning through "Public or private" agents (Marks et al., 2011). India's 12th Five Year Plan emphasised holistic care to improve the health status of the individual and health indices of the country (GoI, 2012, pp.132). Technically, 'holistic care' means physical, mental, emotional, social, and spiritual aspects of individual health as well as use of various systems of healing for individuals. Here, individuals become the focus for improving population statistics, ignoring inequalities of socio-

[3] According to Professor Utsa Patnaik, between 1765 and 1938, the drain from India amounted to £9.2 trillion (equal to $45 trillion), http://www.livemint.com/Companies/HNZA71LNVNNVXQ1eaIKu6M/British-Raj-siphoned-out-45-trillion-from-India-Utsa-Patna.html accessed on 15.8.2022

economic structures. The vision of public health has thus shrunk with time and technology and private providers have emerged as key players.

Technology, no doubt is critical, but is not the only component of a public health system. We therefore need to understand the complexity of sub-systems within public health system. A *medical care system* (medical technology, material, manpower and its users and providers), where technology is applied strategically with the right mix of promotive, preventive, curative and rehabilitative interventions at the primary, secondary and tertiary level institutions, ensures adequate coverage of population. It can then act as a critical instrument to change the history of diseases, as in the case of small pox or malaria – one eliminated, the other controlled. *Medical care*, on the other hand, remains a curative service to individuals without any impact on disease pattern. Strategic medical care system, when combined with selected non-medical components of health such as nutritional services, safe drinking water supply, housing, transport etc., becomes a more complex and effective *healthcare system.* The choice of these non-medical inputs is critical as livelihood, employment, wage, conditions of work and social relations of caste, class, gender, religion also influence disease prevalence and access to services and, in the context of South Asia, are the most crucial points of preventive intervention. An expanded healthcare system where these key links underlying inequalities are a part of health planning will constitute a fully evolved *public health system*.

It is with this understanding that this paper explores how public health in India lost its social and economic moorings. The paper also aims to examine the challenges in the way of health and well-being of the majority of the population today? The first part briefly sketches the field of public health over time as it evolved in the countries of its origin to set the backdrop for India. The second part explores how public health got attuned to the colonial, socialistic, liberal and neoliberal state philosophies in India and its impact on public sector health services. The third part enumerates the conceptual transgressions that distorted the democratic principles of public health. The conclusion draws lessons from history, explores the nature of academic challenges and options for broadening the frontiers of public health knowledge that may help identify the deep roots of public health embedded in the political economy of our social system.

PUBLIC HEALTH IN INDIA OVER TIME

The paper attempts to explore briefly, the journey of public health over the following three periods that reflect changing political perspectives.

Public Health in Colonial India

Only after the mutiny of 1857, public health activities of the Indian medical services (limited to medical care) were consolidated. The Indian Medical Services (IMS) was created in 1869 and a Public Health Commissioner and a Statistical Officer were appointed to the Government of India to take up the work of disease control and monitoring. The purpose was to restrain excessive deaths in the army personnel due to cholera and malaria and, to protect the British civilian populations living in the cantonment areas. Epidemics like malaria and plague were dealt with harsh and aggressive measures for the general population (Mushtaq, 2009). The impetus behind the effort to control malaria was to lay down the railway track for moving raw materials like coal, jute and food grains. The state invested little and preferred to encourage the local elite to set up medical institutions for common citizens, discouraging the traditional systems. The 1909 Morely Minto Reforms only shifted costs of maintenance to the provincial government. Rural services were paid attention to as late as 1914 (Qadeer, 2001). Even the philanthropic activities of the Funds like Dufferin and Lady Harding for training midwives, demonised local dais who continue to perform a useful function till today. The practice of variolation was rejected imposing vaccination. The handling of epidemics was

aggressive, as in plague, and drugs were always short in supply, as in the case of chloroquine. Population was often used by the experts for information, and medical knowledge steered to gain supremacy over local knowledge (Arnold, 1988).

Thus, whatever existed at the time of independence, was meagre and inadequate. The very public health that revolutionised healthcare in the west, failed the Indian people as its interphase with them was in the interest of the Raj – exclusionary and negating the social determinant of health[4].

Public Health in the New Born Socialist Democratic Republic of India

It was the ideological commitment of the leaders of the national movement and the professionals within it that inspired planning for improving health of the Indian people. Even before the First Five Year Plan, several efforts were made which include: 'The Bombay Plan' by the industrialists, 'The People's Plan' by the trade unions, 'The Gandhian Plan by a subcommittee of the National Congress Planning Committee that underlined the need to have field level workers, and the Bhore Committee's report that became a blue print for independent India (Qadeer, 2001). Broadly, all accepted the constraints of poverty and the need for a strong state infrastructure to provide basic health services.

The 2nd Plan epitomised the ideological vision of the new government and was built on what existed. It used a method of planning that was flexible and had a long term view with yearly plans to adjust for short term experiences. For a balanced growth, the activities of the private sector were to conform to the plan's framework. A feed-back loop of data flow between the Planning Commission and the field was to guide planned development under the umbrella of a constitution with a democratic vision to achieve justice and equality.

This intense effort at handling complex problems of integrated economic planning with distributive justice and people's consent was based on the broader perspective that Nehru offered,[5] where international aid was acceptable, provided it strengthened self-reliance. A snag here was that, though, ill health was considered to be rooted in poverty, the two efforts remained independent of each other. The specific links between health and economic reforms and welfare were neither identified nor monitored. The vision was that technology can overcome social conflicts of caste, class, and religion by achieving fair access to the gains of development for all.

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4 The deep roots of this bias are reflected in the role of Rockefeller Foundation. John Grant and Selskar M. Gunn of the Rockefeller Foundation, through their work in India and China, emphasised at the 1937 conference an integration of preventive and curative approaches to health and sought to broaden the ambit of prevention to include agriculture, food availability, drinking water, sanitation and rural reconstruction. This was turned down by Paul Russel, their leader who recommended technical support and infrastructure for rural health services in Asia and Africa (Bump, J.B. 2010: 'The Long Road to Universal Health Coverage'. Seattle, WA: PATH. 'The Long Road to Universal Health Coverage'. Seattle, WA: PATH. http://www.paho.org/forocoberturagt2014/wp-content/uploads/2014/08/DIM-The-Long-Road-toUHC.pdf accessed 20 May 2015).

5 It is argued that, Nehru dreamed of, "an ethical state endowed with the responsibility of modernising a traditional country with the help of scientists and a scientific temper. A mixed economy where the state ought to play a great role in building the economic infrastructure. Big industries (or 'temples of new India'), science labs, institutes of technology and new universities for creating a resurgent human force: rational, secular, and progressively nationalist. Strengthen the pillars of liberal democracy with periodic elections and a delicate balance of extreme political forces implicit in a country with its mind-boggling diversities" Pathak Avjit (2017), Searching for Glimpses of Nehru in a Parochial, Post-Nehruvian India, The Wire 27 May, https://thewire.in/history/searching-glimpses-nehru-post-nehruvian-india accessed on 24.10.2020.

The Plans put forward a pyramidal three-tiered infrastructure of primary secondary and tertiary care services with strong two way referral ties with tertiary care at the top and primary health centres covering the populations as close to them as possible to provide basic health care. Growth of manpower, drug industry, technology, education, National disease control programmes and monitoring mechanisms were all on the planning agenda with a 3.3 and 3.1 percent budgetary allocation in the first two plans.

On the economic front Industrial, and agricultural growth with land reforms (with higher emphasis on industrial growth), and community development was envisaged. The investments in health, out of the total budget, started receding from the 3rd Plan itself and became 2.1 and 1.9 percent in the Fourth and Fifth Plans (Sethuramalingam et al., 2011). Though the slow growth rates over these plans in the Nehruvian era is criticised, it was associated with visible distributive justice through attempts at structural change as compared to the contemporary jobless growth with shrinking welfare. The efforts at land reforms, spread of public distribution system, primary education and an impressive network of basic health care institutions with a 4 % growth rate, cannot be ignored.

There was a conflict however, between Nehru's faith in the power of knowledge and technology to overcome social conflicts of a caste and class ridden society and the will of a section of the political elite who differed on the pace and the degree of state control and interventions. There was a section which demanded more freedom from state control and a larger share of development gains for their class. The poorly implemented land reforms, economic scams, misuse of licences and distortion of priorities in health services in the long run, reflected this conflict. As they acquired access to jobs, housing, water supply, food, education and transport facilities, the nascent middle class of the 1970s joined the ruling elite in seeking international standards of medical care.

The Decades of 1970s and 80s

The Global financial bodies, in their attempt to revive capitalism, began pressurising the indebted countries to accept the neo-liberal model of capitalism in the 1970s. India's integration into the world economy started in the 1980s (Panagariya, 2005), much before the formal acceptance of Structural Adjustment Policies. Retrospectively, the 1970s and 80s were an interesting decade of contradictions reflecting compromise between efforts to move towards equity and justice and the internal and external social and economic constraints.

With the burden of the 1960's war, drought and poor agricultural output, GDP growth rates hovered around 5 percent and distributive justice lagged behind. The top ten percent population continued to own 51 percent assets as against the poorest 10 percent of the population who owned only 0.1 percent of the assets (GoI, 1980, pp8) and the economy remained under stress. The improvements experienced by the seventies were insufficient to meet the rising expectations of the working people and for public health. The alliance of different classes that faced the British could not hold for long, given their conflicting interests[6]. Added to these were the global oil crisis, price rise and a threat of the general strike that were dealt with the promulgation of Emergency, that brought the wrath of an aggressive population control upon people and also led to the political defeat of the ruling party in 1977.

[6] Bagchi argued that the ruling party's dominant bourgeois-landlord component made land reforms difficult and acquired freedom from taxation on agricultural land. While heavy industry was nurtured by the state, private industry captured the small consumer market for luxury goods at the cost of basic goods production. The slow growth of both, pushed the state into dependence on foreign aid and loans and forced it to accept economic reforms when debts became insurmountable. Bagchi Amiya (1982): The Political Economy of Under Development, Cambridge Univ. Press, Cambridge.

When the Congress returned to power in 1980, it chose to centralise political power to guide policy with a firmer hand towards economic growth. Also, the populist programme for removal of poverty, initiated in 1975, was revived without disturbing the economic power balance.

In the health sector, the picture was mixed. Faith on modernisation and technical excellence meant dependence upon international experts who brought in programmes for population control, Maternal and child health, communicable disease control and medical education, all constructed on models built elsewhere. Despite the elaborate understanding expressed in the Bhore Committee Report (Bhore Committee, 1946), that ill health is rooted in poverty and recommendations of the Mudaliar Committee report (Mudaliar Committee, 1962), for rationalising resource mobilisation via differential fee or health cess to match planning with resources, priorities were distorted, privileging urban areas and tertiary care over basic healthcare institutions. The Alma Ata declaration on Comprehensive Primary Healthcare of the W.H.O. (1978) was signed but remained on paper and was replaced by Selective Primary Health care.[7]

Isolated vertical programmes for malaria eradication and Family welfare had to fail to bring home the importance of integrated approach for these services. It was then that the 8th Five Year Plan curtailed resources going to Family Welfare programme and extensively expanded the rural infrastructure adding Community health Centres as first referral units for PHCs now increased three times in number. The only link identified between poverty and ill health was development, seen as "the best contraceptive" (though it was forgotten during the emergency). These shifts however were internal to the health budget with no significant increase in overall investment. Several schemes to renew the people centred approach were introduced such as the ICDS in 1975, Rural Health Scheme of community health workers and the scheme for Reorientation of Medical Education in 1977.

From within the sector then, 1970s and 80s looked like a period of progress. Yet, the financial crunch due to the larger political economy shifts towards economic growth at the cost of removing structural inequalities, made these efforts less effective.

With the emphasis on economic growth in the 1980s, the private sector in medical care that was relatively smaller in the 1960s, came out of the shadows of public sector. Behind this was the growing global pressure for economic reforms, the weak regulatory systems in India allowing private practice to public sector doctors, diversification of agrarian capital into health sector and the return of the foreign trained specialists (specially the cardiologists) following the altered US immigration policies for professionals. A new kind of independent institution was born bringing the last two together - the corporate hospital[8].

The Shift towards Neoliberal Reforms of the Health Sector: Mid 1980s and Beyond

India's first ever National Health Policy of 1983, itself proposed the inclusion of private providers and NGOs into the health service system.

In 1991, with the formalisation of Health Sector reforms (HSR), withdrawal of state investments into welfare (the share of health came down to 0.9 percent), opening it up to

[7] Selective PHCare focused on a few vertical programmes and Family Planning and considered comprehensive socio-economic growth in the near future not possible. (Kennith 1988, The Evolution of Selective Health Care, Social Science and medicine, 26, (9), p. 891-898)

[8] In 1983 the Apollo Chain of Hospital set up by Pratap Reddy was the first corporate initiative inaugurated by President Zail Singh in Chennai, the Delhi hospital received a huge land subsidy of 50 acres of land against a symbolic rent of RS 1 per annum.

private sector, private investment into public sector, private insurance system and casualisation of personnel in the name of efficiency became the hallmark of a New Public Health.

The National Rural Health Mission initiated in 2005, promised to provide integrated quality basic services to all within a district. Actually, it only liberated the state from carrying the burden of tertiary care and, despite evidence of increased utilisation of the peripheral institutions with meagre inputs, was never provided the promised resources[9]. The shedding of the idea of even a healthcare system came from the W.H.O. when selective PHC, carrying the memory of state responsibility for strategically integrated technology based control programmes for even a few selected diseases, became discomforting. W.H.O.'s concept of 'New Public Health' (W.H.O., 1996) shifted from planning for populations to 'healthy cities' and 'communities' via local government. This was reminiscent of the colonial powers that shifted financial responsibility to provincial governments but retained control. This concept underlined the finiteness of the resources and the necessity of cut backs and unavoidable hazardous industries. It promoted individuals to protect themselves and not collectively question cut backs, hazards or social constraints on health. Technological and not social strategies, life style changes and not change of the risk- ridden environment became the dominant ideas.

Reforms in Public Sector Healthcare

The 8th and 9th Five year Plans were cautious in promoting Reforms and expressed awareness of its costs for the poor, and hence promised security nets. By the 12th Plan, all hesitations were shed and structural changes required for a neoliberal economy, were introduced as 'Reforms'- the only alternative with its focus on narrow technological approach to resolve the crisis in public health - relegating the broader approach if not rejecting it. The pace of these Reforms was hastened from 2005 by the following interventions:

i) Setting up special institutions to ease fund flows for private entrepreneurs. These were Infrastructure Financial Corporation of India and Infrastructure Project Development Fund that supplied Viability Gap Fund and Annuity Funds to promote private sector participation.

ii) Public private partnerships (PPP) in hospitals, insurances and medical education.

iii) Introduction of private and state led insurances in the name of controlling catastrophic expenditures especially for the poor. The latter could be central (Rashtriya Swasthya Bima Yojana-RSBY) or State run insurance schemes. Both empanelled public and private institutions and gave the choice to users to select one. These schemes focused on tertiary hospital care leaving out outpatient care. In 2018 a two pronged Ayushman Bharat scheme overshadowed the RSBY. It expanded the insurance cover for hospitalisation from 30,000 under RSBY to 5 lakh under the new PM Jan Arogya Yojna (PMJAY) for ten crore families (40 % of the poorest over time). In 2018 its allocation was only under 10 percent of the required resources for the hospitalisations from 10 crore families (Ghosh & Qadeer, 2019). Its other component proposed transforming Primary Health Centres and Sub Centres into 1.5 lakh Health and

[9] Against Rs. 900 per capita promised to National Rural Health Mission (NRHM) initially, only, Rs.270 per capita were given despite NRHM being the biggest component of rural PH Care infrastructure and it has been rapidly falling from 2016-17 while the PMJAY increases in its share. (Qadeer.I, 2019, UHC the Trojan Horse of Neoliberal Policies in Edit. Imrana Qadeer, K.B. Saxena, P.M. Arathi, Universalising Healthcare From Care to Coverage, p55-63, Aakar, New Delhi.).

Wellness Centres to provide care for non-communicable diseases, emergency and mental health care along with the earlier services. Without referral facilities these will again become an opening for the private first level referrals. The allocations for the two arms in 2021 was Rs 6.4 and 1.6 crores respectively showing the discrepancy between the two components as the allocation of Rs. 80,000 per centre was not enough even for the old set of services.

iv) Ayushman Bharat Scheme also proposed up-grading existing district hospitals through PPP for private medical colleges and 24 new government medical colleges and hospitals were also proposed.

v) Financial autonomy for public hospitals in the name of decentralisation forcing them into revenue generation for running the institution.

vi) Casualisation of health workers in the name of cost saving. At the primary level even doctors were engaged on part time basis.

vii) Universal health Coverage introduced through the Bill on National Health (2010) where the state was to assure coverage but not necessarily care and act as a 'steward' of the private sector ensuring its smooth expansion but not regulation.

The National Health Policy 2017 (National Health Policy, 2017) underlined India's rising economic growth and fiscal capacity, increased burden of non-communicable diseases, growing incidences of catastrophic expenditure due to healthcare costs and its emergent robust health care industry. Yet it refused to recognise health as a right since that would require further investments. Niti Aayog, in fact, produced a document in the midst of the COVID Pandemic showing the "investment opportunities in India's Healthcare Sector," arguing for privatisation, as the medical industry contributes to 6-7 percent of the GDP (Sarwal et al., 2021).

The Role of Global Agencies

Reforms were consistently encouraged by the global financial institution. The World Bank, in fact, prescribed a detailed financial Plan for Developing countries (World Bank, 1987). The International Monetary Fund appreciated India's Reforms (Panagariya, 2005), W.H.O. and the Bank together produced a report, 'Investing in health for economic development' (W.H.O., 2001) proposing that investing in health leads to economic growth, not taking into account the fact that the reforms restrict coverage. Even if coverage is possible, people must be employed to contribute to economic growth. Private funder, Bill and Melinda Gates Foundation, took over the responsibility of helping the states of UP and Bihar to implement Reforms. In 2005, W.H.O. introduced its concept note on Universal Health Care (UHC) claiming it would improve coverage, resource mobilisation, and quality of healthcare and reduction in catastrophic expenditure. These have not been validated, at least from India (Qadeer et. al., 2019). Behind these concerns is the huge interest of the USA and the European Union in trade in medical technology and medical care[10], which is beyond the considerations of this paper.

The transformation of the W.H.O. - the trusted advisor and mentor of the developing world - also needs to be understood. The W.H.O.'s external funding was US$ 106 million less than the member countries in mid-eighties, but it exceeded by 21 million US$ by the 1990s

[10] North America and Europe medical technology market size was valued at USD 270.4 billion in 2020 and is expected to expand at a compound annual growth rate (CAGR) of 11.5%. Retrieved from, https://www.grandviewresearch.com/industry-analysis/north-america-europe-medical-technology-market-report

(Qadeer & Baru, 2016). By 1993, World Bank controlled over 54 percent of the W.H.O. funds and put forward its strategy of 'Investing in health' in its World Development report of 1993, where technology prevailed as the ultimate instrument of human welfare. The two consecutive Director Generals, Gro Harlem Brundtland and Margret Chan accepted PPPs and multi-lateral alliance with corporate medical and drug industries, private financial institutions, international NGOs and Governments to promote the medical technology markets in developing countries for the promotion of vaccines, immunisations and control of chosen diseases like aids, tuberculosis and, malaria through drug supplies.

This growing hold of the biomedical approach to healthcare has opened up areas such as digital medicine, reproductive technologies giving us designer babies, transplants of organs, stem cell therapy and new vaccines as frontiers of public health knowledge. All these fields are concentrating power in the hands of the experts.

Impact of Reforms on Public Sector Healthcare System

Inevitably, the impact of these Reforms has been drastic for the kind of public health envisaged by the initial plans or the Alma Ata Declaration - affordable, need-oriented, acceptable, equitable and rooted in their overall development. The changed vision of the government, reflected in its plans and policy, agrees with the vision of the global players and is an important reason for this let down. Resistance to meet even the promised 2.5 percent of the GDP by the Health Policy 2017, against the recommendation of 3 percent by the High Level Expert Group (HLEG-2011[11]) of the Planning Commission, and the transfer of a significant proportion of even this to private sector through state led insurances based on PPP[12], speaks of the protective attitude towards the private and corporate institutions that are freed from any social responsibility. Today the main features of the public sector health service are:

1. Stagnant, inefficient and starved of resources due to the unbridled growth of private and corporate institutions as a result of policies that support the latter and neglect regulating either sector.
2. User fees in public institutions keep the poor away and contributes no more than 3 percent of the institutional expenditure. It, in fact, becomes one of the causes of 55 million Indians being pushed into poverty in a year according to a study by PHFI (Nagarajan, 2018).
3. Loss of control and worsening of ancillary services such as food, laundry, diagnostics and services of class four employees due to out-sourcing to private agencies with poor MOUs. Another form of PPP is for diagnostic services by providing spaces on fixed returns. Both forms of partnerships show penetration of commercial values, misuse of easy access to patients and doctors for profits and loss of culture of service (Roy & Gupta, 2011).

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11 HLEG Report on Universal Health Coverage for India, Instituted by Planning Commission of India, Submitted to the Planning Commission of India, New Delhi, November, 2011.

12 Over 2019-20 and 2021-22 there was a (Annualised) rise of 3% in NRHM budget increasing from Rs. 34,660 Cr to 35,144 Cr as against a 41% and 22 % in PMJAY and PMSSY in the year 2020-21 going from Rs 3200 Cr and 4683 Cr to Rs 6,400 Cr and RS 7,000 Cr respectively. Budgets Parliament, Demand for Grants 2021-22 Analysis: Health and Family Welfare. PRS Legislative Research. Budgets Parliament, Demand for Grants 2021-22 Analysis: Health and Family Welfare. PRS Legislative Research https://prsindia.org/budgets/parliament/demand-for-grants-2021-22-analysis -health-and-family-welfare accessed 25.7.22

4. The centrality of the patient care and physician concerns are marginalised and medical care has become dehumanised by the new management techniques focusing on cost saving and economic rationalisation.
5. Autonomy granted to institutions led to delinking institutions and fragmentation of the system, weakening the referral system and forcing Primary institutions to refer patients to the private providers. Secondly, generating revenues to run institutions requires earning through paying services and deflects priorities from epidemiologically significant diseases to more remunerative demands.
6. The declines in the central investments in health sector which stayed at about two percent even in the pandemic year and the shrinking resources of NRHM, as mentioned earlier, are reflected in the short falls of the PHCs and the SHCs[13]. The number of primary health centres and Sub Centres devoid of Auxiliary Nursing Midwives (ANMs) has jumped from 4.75 per cent in 2005 to 27.16 per cent in 2021 (Rural Health Statistics (2021) (Benu & Das, 2022). In short the basic healthcare infrastructure is now denuded and fragmented and has lost its integrated character. Its consequences are reflected in the unacceptable levels of under and malnutrition among women and children with increase in anaemia since the last round in 2015-16 (NFHS- 5 (2019-2021) even though the fertility rates have declined. The neonatal mortality among the lowest quintile is three times higher (Benu & Das, 2022).

Given the bio-medical thrust and the primacy of experts at the cost of people's concerns and participation, decisions are being imposed in the name of the 'greater good.' Punitive measures like refusal to admit non immunised children to school were reported but reasons of non-acceptance and lack of access are not addressed. The Pandemic became an ultimate example of this control.

The public sector healthcare services are thus being dismantled, medicalised and denuded of their systemic approach to be transformed into a revenue generating commodity which is costly, controlling, exclusionary and incapable of addressing issues of basic healthcare of the majority. The debunking of long term planning only adds to the chaos. The Centre increased the share of States in resources in the name of cooperative federalism but diluted it by GST in 2010. Demonetisation in 2016 destroyed purchasing capacities of small businesses and entrepreneurs. The price rise and lack of expansion of employment was visible even before the pandemic. All this weakened further the economic and welfare support essential for public health. In short, the inability of the healthcare system to play a preventive role and the lack of welfare and economic stability has destabilised public health.

CONCEPTUAL TRANSGRESSIONS TO JUSTIFY HSR

While the perspective and content of public health changed significantly over the colonial, democratic and neoliberal periods, what did not change was the professed concern of governments for peoples' welfare. Health policy, in the latter two periods, was specifically

[13] According to Rural Health Statistics 2016, there is 20% shortfall of health sub-centres, along with 22% and 30% shortage of primary health centres (PHC) and community health centres (CHC). The Bulletin on rural health statistics in India for 2018 shows that CHC and PHC deficit is the same, only Sub-centre shortage reduced by 2 percent. Within those, in 2005, 17.49 per cent of the PHCs functioned without doctors. In 2021, the proportion of such centres will be as high as 21.83 per cent, according to the same source. While less than half the Community Health Centres (CHCs) had no specialist doctors in 2005, the vacancy was a 67.96 per cent in 2021. Statistics Division, Ministry of Health & Family Welfare, https://data.gov.in/catalog/rural-health-statistics-2018?filters%5Bfield_catalog_reference%5D=6680151&format=json&offset=0&limit=6&sort%5Bcreated%5D=desc (accessed 4.8.22).

committed to universalising basic healthcare which stagnated into a political strategy to retain democratic credentials, particularly in the neoliberal phase. Thus what appeared as an unintended outcome (the distortions) had to be rationalised as an alternative process to achieve the same objectives. And this called for redefining concepts critical to public health.

The first and the foremost idea is ignoring the essential difference between the public and private services, one tuned to serving populations the other to private profit. One open to public scrutiny - both in terms of investment and earnings; and the other not for public debate, given the constitutional right of private property, privacy and profits – privileges that gave it extra freedom. Any partnership for social responsibility requires restriction of both these freedoms and effective regulation - that are entirely absent.

In the Second Five Year Plan, the concept of a system as denoted by Mahalanobis and Nehru, was of a dynamic complexity - with relationships between its components which, despite conflicts, share a common objective. Achieving that objective required compromises and self-regulation by components of the system. Today's public health, without underlining the necessity for strict regulations and restraints to achieve common objectives, distorts the very understanding of a system and misuses it.

The state which was at the commanding heights in social democracies, now acquires the role of a 'steward' for smoothening the expansion of the private sector and its penetration into the public sector. It no more remains a primary provider or a regulator.

Earlier the notion of 'efficiency' meant a combination of cost effectiveness in terms of lives saved, reduction of suffering due to morbidity, and adequate population coverage by preventive services. The neoliberal public health defines it in 'monetary' terms as cost cutting and savings with desired 'quality', or patient satisfaction as in the market framework, and coverage is ignored.

The non-contestability of public goods was redefined as the inability of certain goods to enter the market, instead of it being lack of competition between consumers. Thus, medical care was not considered a public good as hospitals were not seen as units providing uninterrupted services. Commodification and commercialisation of medical care thus became easy.

Universality of technology and its independence was re-emphasised to overshadow the concept of social roots of technology. The limits of technology transfers from very different contexts was overlooked and international standards determined technology trade, not its relevance.

These new twists in public health theory transgress the purpose, rationality and ethics of public health as we knew it. It is dominated by fragmented medical care institutions, not guided by the epidemiological priorities or systems vision. It does not highlight the limits imposed by social conditions as it become elitist and an instrument of increasing profits in the medical care market through medical tourism flourishing in the chains of corporate hospitals and trade in medical devices.

CONCLUSION

Thus, it can be concluded that the boundaries of public health are fluid as it shrinks or expands with changing political perspective of the state. Underlying the changing dynamics of public health, three critical forces appear to shape public health - the standards of living within a socio-economic context, the choices of technology and its organisation, and the influence of global forces on both. This explains variations in the nature of public health from exploitative colonial public health to welfare or liberal democracies and neoliberal states. In

western democracies where welfare capitalism flourished with easy acquisition of wealth from its colonies, prosperity, welfare services and coverage with medical care improved health of the population but clarity on the links between the three was not the basis of early health planning (Frank & Mustard, 1994). Though, it has become a major concern today.

In democracies like independent India, starting as welfare capitalist economies and attempting to overcome resource constraints with borrowed technologies, building public health could go only as far as state allocations, conception and regulation permitted. The strong biomedical orientation and the increasing socio-economic restrictions at the turn of the 21st Century, despite some degree of welfare inputs, could hardly build a public health system. The healthcare system that emerged was also reduced to the lowest systemic level - the medical care system. While a few disease control programmes under the public sector continued (for tuberculosis, malaria, AIDS etc.), the thrust shifted to medical care. Medical care, a public good was turned into a commodity for commercialisation at the cost of equity, by enhanced neoliberal reforms. So, the degree of universality and equity varied from the initial regulated capitalism of the Nehruvian era and beyond to the neo-liberal phase. Currently, even this healthcare system under the public sector is showing signs of cracks as its medical care shrinks and fragments, losing its referral strengths and preventive potential to become just a curing commodity.

If this direction of policy choice continues, a public health system worth its name is unachievable in India. Instead, conflicts and crisis in public health will be heightened. Corporate and large institutions retain their power to compete with small private providers, destroying whatever basic medical care services they provide, while extracting state subsidies. The handling of the COVID-19 pandemic and the introduction of a New Public Health Bill 2022[14], heralds a return to the past and not a way forward. The unbridled control over lives, proposed by the bill that unifies handling of epidemics, accidents and terrorism, formalises what we witnessed during the worst days of the pandemic.

This Medicalised, expert-dominated, centralised in its decision making and exclusionary health care system is characterised by complete insensitivity to social issues of caste, class and gender and a slow expunging of people's participation and strategies for welfare in policy making. In the process it enhances the system's potential for controlling people's health behaviour.

This trajectory matches the global vision of our well-wishers whose arrogance knows no bounds and who believed that, 'Collectively we [read they] have the financial and ever-improving technical capacity to reduce infection and child and maternal mortality' and promised, 'an enormous pay off from investing in health' claiming that 'a grand convergence in health is achievable in our [read their] lifetime;' 'we [read they] have the financial and ever-improving technical capacity to reduce infection and child and maternal mortality.' (Lancet Commission, 2013).

Indian Public health needs to move away from this borrowed vision of global experts. The majority of medical professionals trained in the biomedical tradition and much needed for their curative skills have little time to focus on this challenge. There are, no doubt, the public health activists and professionals engaged in reclaiming public health and they are increasing in numbers, yet this search needs strengthening. Public health is a challenge for

[14] Maya Valecha, (2022): Public Health Bill to be presented in the Monsoon session 2022 is Illegal, Unconstitutional and Arbitrary: BIOTECH EXPRESS May 15, http://www.biotechexpressmag.com/letter-public-health-bill-to-be-presented-in-the-monsoon-session-2022-is-illegal-unconstitutional-and-arbitrary-dr-maya-valecha/ accessed on 26.8.2022.

social scientists as well, who can explore the developmental dimensions shaping it. Interdisciplinary social sciences incorporated into systems analysis with participatory research methodologies for understanding the internal and external dynamics of the public health system must become a part of the new frontiers of knowledge in public health. They help explore the social determinants of health, their specific linkages, value of people's perceptions and knowledge, civil society engagement and global influences. Thereby, the limits of existing technological solutions and the need for suitable technologies and people's engagement can be understood.

Thus strengthened, public health can contribute to health and wellbeing. Some work in this direction helps us imagine concrete challenges.

As an example, can those living in poverty purchase medical care when the market is the instrument of distribution without a justly estimated living wage? Do we teach what a living wage[15] is and how is it to be assessed? Does the system have the capacity to generate livelihoods and employment? Similarly, we theorise social capital but not social profit. Is not health of the labour social profit that should define corporate social responsibility? If we look at the National Health Accounts' reports, only the out-of-pocket expenditure of patients is projected as private investment (Qadeer, 2020) and not the investment by the entrepreneur. But the overall revenue from this sector is used to justify privatisation and corporatisation. Where does the investment come from? Look at India's declining Recommended Dietary Allowances despite the stagnant, low or declining heights of Indians over time. The only way this can be explained is that we have accepted high physical costs (in terms of illness and growth) of physiological nutritional adaptation! These and many other complex questions await to be explored if well-being is a genuine concern and not neoliberal restructuring of the existing healthcare system.

CONFLICT OF INTEREST

The author declares that there is no conflict of interest.

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[15] Article 43 of the constitution defined living wage as a wage that ensures, conditions of work ensuring a decent standard of life and full enjoyment of leisure and social and cultural opportunities. This is relatively higher than the minimum wage which is for subsistence only not decent standard.

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