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HEALTH POLICY IN INDIA, 1946–2017: A REVIEW OF POLICY EVOLUTION

Arsha V Sathyan

RESEARCH ARTICLE

Author Details:
Research Scholar, Department of Political Science, University of Kerala, Kerala, India

Corresponding Author:
Arsha V Sathyan

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Abstract

The evolution of health policy in India reflects changing approaches to the financing, organisation, and delivery of health care, as well as persistent challenges in ensuring equitable access to health services. Beginning with the Bhore Committee Report of 1946, which envisaged comprehensive and integrated health care with a central role for the state, India's health policy trajectory has undergone substantial transformations. Before the introduction of the first National Health Policy in 1983, health-sector priorities were largely articulated through successive Five-Year Plans and different health committee recommendations. The subsequent National Health Policies of 1983, 2002 and 2017 reflected changing priorities in primary health care, public expenditure, private-sector participation, universal health coverage and financial protection. This article reviews the historical development of health policy in India, examining the major recommendations of health committees, the orientation of successive Five-Year Plans, and the objectives and limitations of the three National Health Policies. The review argues that, despite the recurring recognition of comprehensive primary health care and universal access as important policy objectives, their realisation has remained constrained by gaps between policy formulation and implementation.

Keywords: *Health policy; National Health Policy; Five Year Plans; universal health coverage; public health system in India*

Introduction

Health policy is an important instrument through which the state defines its responsibilities in protecting population health, organising health services and addressing inequalities in access to care. Tthe development of health policy in India is closely associated with the changing political, economic and social conditions. The evolution of the health sector has involved successive attempts to expand health infrastructure, control communicable diseases, strengthen primary health care, improve the availability of medical personnel and make health services more accessible to the population. However, translating these policy objectives into an equitable and adequately financed health-care system has remained a persistent challenge. The historical roots of India's public health policy can be traced to the Bhore Committee Report of 1946, formally known as the Health Survey and Development Committee Report. Its recommendations subsequently became an important reference point in discussions on the organisation and development of India's public health system. The Bhore Committee Report of 1946 marked a significant milestone in this trajectory by advocating comprehensive, integrated health care, emphasising preventive and curative services and the expansion of primary health care. Following independence, successive Five-Year Plans guided health-sector development until the introduction of the first National Health Policy in 1983. The National Health Policies of 1983, 2002 and 2017 reflect changing priorities in health-care delivery, including primary health care, private-sector participation, universal health coverage and financial protection. Despite these policy initiatives, inadequate public investment, persistent rural–urban disparities and inequalities in access to affordable and quality health care have remained significant challenges. The increasing role of private providers has also raised concerns about the relationship between public responsibility and the market-oriented delivery of health services. Against this background, this article critically reviews the historical evolution of health policy in India from the Bhore Committee Report to the National Health Policy 2017. It examines the continuities, shifts and limitations of successive policy initiatives, focusing particularly on the changing role of the state, the development of public health services and the growing involvement of the private sector. The article argues that the enduring commitment to universal and equitable health care must be assessed against the persistent gap between policy objectives and their implementation.

Historical Evolution of Health Policies in India

The public health system in India witnessed many hurdles even before independence and the same has been addressed through different policy efforts. The first national health policy was implemented in 1983. Even before that, in British India, the Bhore

committee report was identified as a primary guide for public health. Not only in British India, but in post-independence period also Bhore committee report was one of the primary references in the public health policy. The influence of Bhore committee report can be seen in all significant public health policy decisions of independent India. Until the first national health policy was formed in 1983, health policies were framed through five year plans.

Bhore Committee Report

The Health Survey and Development Committee, chaired by Sir Joseph Bhore, submitted its report in 1946 and became widely known as the Bhore Committee. It represented one of the earliest comprehensive efforts to assess the health conditions and health-care infrastructure of British India and to formulate a long-term plan for their improvement. The report is regarded as a landmark in the development of India's public health system, particularly for its emphasis on integrated health services, comprehensive health care, and the establishment of a tiered structure of health care delivery. It also articulated a vision of universal access to health services, laying an important foundation for subsequent discussions on health planning and public provision in independent India (Bhore Committee Report, 1946).

In examining the health conditions of colonial India, the committee identified high mortality and morbidity, particularly among women and children, as major indicators of the inadequacy of existing health services. It situated these health problems within a broader context of social and environmental deprivation. Inadequate sanitation, poor nutrition, insufficient preventive and curative services, illiteracy, unemployment and poverty were identified as important factors contributing to the population's poor health. The report also recognised the influence of prevailing social practices, including early marriage and the purdah system, on health and well-being. Thus, the committee's assessment extended beyond the availability of medical facilities to consider the broader social conditions that shape population health (Bhore Committee Report, 1946).

The Bhore Committee documented inadequate sanitation, unsafe drinking water and deficient drainage facilities in both urban and rural areas. It also highlighted widespread nutritional deficiencies, noting that large sections of the population lacked access to sufficient and balanced food. The distribution of medical personnel further reflected the limitations of the public health system. Only approximately one-fourth of the doctors worked in government services, while the majority practised privately, predominantly in urban areas. The committee also reported that only around 70–80 women medical officers served in the public sector, primarily attending to maternity and child welfare, and that only a small proportion had received adequate professional training. The shortage of health personnel was evident in the reported population-to-worker ratios: one doctor for every 6,300 people, one nurse for every 43,000, one health visitor for every 400,000, and one midwife for every 60,000 people (Bhore Committee Report, 1946).

The Bhore Committee also highlighted the inadequacy of hospitals and dispensaries, particularly in rural areas, where both the availability and quality of medical services were limited. The shortage of hospital beds illustrated the extent of this infrastructural deficit: the report recorded only 0.24 beds per 1,000 population, against its stated minimum requirement of 10 beds per 1,000. The committee further identified significant shortcomings in the prevention and control of communicable diseases, including cholera, tuberculosis and malaria. Despite the long-standing practice of vaccination, smallpox continued to pose a major public health challenge in India. Taken together, these findings revealed a fundamental weakness in health administration: the failure to coordinate preventive measures with curative services. The committee consequently emphasised the need to integrate preventive and remedial interventions as essential components of an effective health system (Bhore Committee Report, 1946).

The Bhore Committee proposed both short-term and long-term programmes to address the deficiencies of India's health system. Its short-term recommendations emphasised the establishment of an integrated health-care organisation at the provincial level, bringing preventive and curative services together through primary, secondary and district health units. Specialised services were proposed for mothers and children, schoolchildren and industrial workers, alongside programmes to address major diseases, including malaria, tuberculosis, venereal diseases, leprosy and mental illness. The committee also recognised that improvements in public health required interventions beyond medical services, including better housing, town and village planning, safe water supply, drainage and sanitation (Bhore Committee Report, 1946).

Community participation constituted another important element of its recommendations. The committee proposed establishing village health committees comprising five to seven members to encourage local participation in health programmes and promote hygienic practices. It also recommended improving the availability of hospital beds, with the bed-population ratio to increase from 0.24 to 1.03 per 1,000 population over ten years. Recognising the difficulties of providing medical services in remote and sparsely populated areas, the committee advocated improvements in village communications, ambulance facilities and the provision of travelling dispensaries to supplement primary health centres. Taken together, these recommendations reflected an integrated approach to health-care development that combined medical infrastructure, disease prevention, environmental sanitation and community involvement (Bhore Committee Report, 1946).

Sokhey Committee

In 1938, the Indian National Congress had formed a committee to study the health status of India. It was set up as a sub committee of the National Planning Committee under the chairmanship of Col. S.S Sokhey. However, the report of Sokhey committee was released in 1948. The report underscored two objectives in its recommendations.

1) A fully developed health organisation should provide each individual with adequate curative and preventive care irrespective of their ability to pay
2) The rural population needed much more attention compared to the urban areas

The Sokhey Committee, identified several factors underlying India's poor health conditions, including inadequate sanitation, malnutrition, undernutrition, limited access to health services, illiteracy and prevailing social practices such as early marriage

and the purdah system. Its recommendations broadly corresponded with the principles advocated by the Bhore Committee, particularly regarding the need to expand health services and improve their accessibility. The committee placed considerable emphasis on human resource development to strengthen the health system. It advocated providing basic training to health workers to improve the delivery of health services and proposed a target of one health worker for every 1,000 people, to be achieved within five years (Sokhey Committee Report, 1948).

Five year Plans

The establishment of the Planning Commission in 1950 and the introduction of Five-Year Plans marked an important phase in the development of India's public health system. Until the introduction of the first National Health Policy in 1983, these plans served as a major framework for determining health-sector priorities and allocating resources. The First Five-Year Plan (1951–1956) allocated ₹140 crore to the health sector, while the Second Five-Year Plan (1956–1961) allocated ₹270 crore.

The First Five-Year Plan prioritised several areas, including "water supply and sanitation, malaria control, preventive health services for rural populations through health units and mobile units, maternal and child health services, health education, education and training of health personnel, self-sufficiency in drugs and medical equipment, and family planning and population control" (Planning Commission, 1951).

The Second Five-Year Plan extended these priorities by incorporating indigenous systems of medicine, including homoeopathy and nature cure, into the health-sector agenda. The initial two plans also supported efforts to control communicable diseases such as malaria, smallpox, cholera and leprosy, alongside public awareness campaigns aimed at preventing their spread (Grover & Singh, 2020).

Despite these initiatives, the early Five-Year Plans gave comparatively limited attention to improving the broader socioeconomic conditions that influenced population health. More than 55 per cent of the resources allocated under these plans were directed towards industry, power, transport and communications, while social sectors such as health, education, housing and social welfare received less emphasis (Duggal, 2001). This allocation reflected a development strategy that prioritised industrial and infrastructural growth, while insufficiently addressing the social conditions essential for improving public health. Consequently, the early planning period highlighted the limitations of expanding disease-control programmes without giving equivalent attention to the socioeconomic determinants of health.

Despite the health-sector initiatives introduced during the first two Five-Year Plans, public investment in health remained limited relative to other development priorities, and a substantial proportion of available resources was directed towards urban areas. Consequently, the public health-care delivery system underwent limited structural transformation, and disparities in health infrastructure between rural and urban populations became increasingly evident by the end of the Second Five-Year Plan. Rural areas had only one Primary Health Unit for every 140,000 people, falling considerably short of the Bhore Committee's recommended level of provision. Similarly, there was only one hospital for every 320,000 rural residents. In comparison, urban areas had a more favourable distribution of facilities, with one hospital for every 36,000 people and one hospital bed for every 440 people. These disparities illustrate the uneven development of health infrastructure during the early planning period and the limited progress made in extending health services to rural populations (Grover & Singh, 2020).

In 1959, the Ministry of Health, Government of India, appointed 'The Health Survey and Planning Committee' to evaluate the progress of the health sector following the implementation of the first two Five-Year Plans. Chaired by Dr. A.L. Mudaliar, the committee became known as the Mudaliar Committee. In its 1962 report, the committee reported significant progress in disease control programs. Previously virulent epidemics, particularly malaria, were brought under control. Deaths from malaria, cholera, and even smallpox had decreased, with overall illness and mortality rates declining (Duggal, 2001). The report concluded that health service delivery in the country was unsatisfactory. It emphasized the need to strengthen existing primary health centres (PHCs) rather than establishing new ones. The report highlighted that PHCs were understaffed and poorly equipped, with an insufficient number of health practitioners, underscoring the urgent need to improve healthcare facilities (Mudaliar, 1962).

Subsequently, the Third Five-Year Plan (1961-66) addressed the issues impacting the provision of PHCs. It highlighted the shortage of health personnel, delays in constructing PHC buildings and staff quarters, and inadequate training facilities for the various categories of staff needed in rural areas. It also recommended the establishment of medical colleges, research institutes, and training centers for doctors, nurses, and other auxiliary personnel (Planning Commission, 1961).

The Chadha Committee report of 1963, advocated for integrating health and family planning services. Their proposal involved deploying a team of one male and one female multipurpose worker per 10,000 people to deliver these combined services (Duggal, 2001). This period also saw the establishment of family planning as a separate department within the Ministry of Health. During the first two Five-Year Plans, family planning programs relied primarily on voluntary organizations. From the third five-year plan onwards, government agencies took a more proactive stance in population control initiatives.

Following the Third Five-Year Plan, the Indian government implemented annual plans, also known as "plan holidays," from 1966 to 1969, covering the years 1966-67, 1967-68, and 1968-69. The disappointing performance of the Third Five-Year Plan was the primary reason for this shift. This plan encountered significant challenges due to resource constraints and setbacks such as drought. Additionally, the Indo-Pakistan War and the Sino-Indian War had a severe impact on the economy, leading to inflation and resource scarcity, which made long-term planning difficult (MoSPI, n.d.). Given the uncertain economic situation, the government opted for a more flexible approach with annual plans. This allowed them to adjust priorities and resource allocation year-to-year based on the prevailing conditions. The public health schemes initiated in the third plan and earlier continued during the annual plan period as well.

After these three annual plans and some economic recovery, the Fourth Five-Year Plan (1969-74) was introduced in 1969,

maintaining the previous methodologies and objectives. Water supply and sanitation were given separate appropriations under the Housing and Regional Development sector starting from the Fourth Five-Year Plan. Until the Third Five-Year Plan, these services were included under the health department, reflecting their direct impact on public health. The shift in responsibility to the Housing and Regional Development sector marked a strategic realignment, recognizing the need for a more integrated approach to infrastructure development and urban planning (Planning Commission, 1969).

The Fifth Five-Year Plan (1974-79) was historic in addressing the increasing health disparity between rural and urban populations across all metrics. Consequently, the Minimum Needs Programme (MNP) was introduced, focusing on the accessibility of health services in rural areas. The plan prioritized the eradication of communicable diseases and the development of health infrastructure. Other key objective of the MNP was to address chronic water scarcity by providing adequate drinking water to all affected villages. Water supply and sanitation, therefore, received greater emphasis in Fifth five year plan (Planning Commission, 1974).

A state of emergency was declared midway through the plan from 1975 to 1977. It led to a harsh shift in family planning. The program, once voluntary, became forceful and violent. The government also announced a National Population Policy with a strong focus on population control. The policy even included a recommendation for mandatory sterilization laws. However, with the end of the emergency and a new Janata government came into power in 1977, this forceful approach was abandoned (Duggal, 2001).

The new Janata government scrapped the fifth five-year plan mid-course and formulated a new draft for 1978-83. However, due to several economic and social challenges, including the aftermath of a severe drought, the government was forced to adopt the Annual Plan for the period 1979-80 instead of continuing with the five-year plan. This annual plan aligned with the international 'Health for All' movement, adopting the ambitious goal set in the 1977 Alma Ata Declaration. To achieve this, the healthcare system underwent a restructuring to prioritize both rural health initiatives and control of communicable diseases.

Consequently, the Sixth five year plan (1980-85) and Seventh Five-Year Plan (1985-90), were significantly influenced by the international declaration of 'Health for All' by the year 2000. The Sixth Plan emphasised strengthening primary healthcare, integrated rural development, and expanding health infrastructure, with a particular focus on training healthcare workers and controlling communicable diseases (Sethuramalingam, et al.,2011). While some progress was made, implementation was slower than anticipated. The first national health policy in India was introduced during this period.

The Seventh Five-Year Plan (1985) advocated for expanding specialty and super-specialty care, with an emphasis on ensuring its equitable distribution across regions (Planning Commission, 1985). The plan encouraged both public and private sectors to develop these specialized areas and training programs (Sethuramalingam, et al.,2011). Additionally, it prioritized improvements in urban health services, advancements in biotechnology and medical electronics, and initiatives to address non-communicable diseases. The Seventh Plan enhanced focus on maternal and child health, expanded immunization programs, and nutrition initiatives. Despite these efforts, health disparities between rural and urban areas remained significant, and many ambitious initiatives were only partially realized. However, these plans laid the foundation for future health sector strategies, highlighting the need for more robust and sustained efforts to achieve equitable healthcare access for all.

The period of 1990-92 went through with annual plans due to a massive economic crisis. During this period, India took two significant steps in healthcare. The Control of Acute Respiratory Infection Programme began as a pilot project in 1990. In 1992, the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act was passed (Sethuramalingam, et al.,2011).

Previously, public health was lumped together with other social programs, such as education and family planning. However, the Eighth Plan (1992-97) marked a shift, making public health a distinct area of focus for the first time. It prioritized health and population control among its six key goals. The Eighth Plan adopted a new slogan, shifting from "Health for All by 2000 AD" to emphasizing "Health for the Underprivileged" (Planning Commission,1992, p.322). This plan focused on making essential services like safe drinking water and primary healthcare, including immunizations, accessible to all citizens with a focus on reaching rural areas. Additionally, it aimed for the complete eradication of the unsanitary practice of manual scavenging. Significant legislative measures were also undertaken during this time, with the Transplantation of Human Organs Bill being passed in 1994 and the Persons with Disabilities (Equal Opportunities, Protection of Rights, and Full Participation) Act enacted in 1995. A significant development during the Eighth Plan was prioritizing health education by allocating resources for the establishment of an Education Commission for Health Sciences. Several states took the initiative to create their own Universities for Health Sciences.

The Ninth Five Year Plan (1998-2002) stands out for its comprehensive review of health programs and its strategic approach to building on past achievements. It incorporates innovative ideas and draws valuable insights from the Bhore Committee report, aligning them with contemporary healthcare needs (Planning Commission,1997). Recognizing the challenge of staffing Primary Health Centers (PHCs) and Community Health Centers (CHCs), the plan proposes innovative solutions like part-time positions for local qualified practitioners and allowing them to use the facilities for private practice after-hours. It also emphasizes strengthening referral services. Another distinctive recommendation of the plan was the development of state-specific strategies, recognizing that each state has unique circumstances, varying levels of development, and different health care needs (Planning Commission, 1997).

The Ninth Five-Year Plan also thoroughly reviewed the National Health Policy of 1983 in light of its original goals. Recognizing the need for a more effective framework, the plan called for a comprehensive reappraisal and reformulation of the NHP. This revised policy was intended to serve a dual purpose: for improving healthcare delivery and establishing a reliable system for monitoring health outcomes over the next two decades. The National Population Policy introduced in 2000, marked a significant

step forward, with its focus on population control. While demographic goals remain central, the policy integrated them within a broader social context compared to previous iterations.

The Tenth Five Year Plan (2002-07) aimed to significantly improve the healthcare system. This included focusing on efficiency, quality of care, drug and diagnostics logistics, and promoting the responsible use of medication. Additionally, the plan emphasized developing, implementing, and evaluating healthcare financing systems to ensure everyone has access to affordable essential care based on their need. Reducing fertility rates, mortality rates, and overall population growth were also key objectives. The plan proposed two major initiatives during this period. 1) Revamping the Universal Health Insurance Scheme (2003), making it exclusive and more affordable for people below the poverty line. 2) Introduction of Group Health Insurance Scheme which targeted members of Self Help Groups (Planning Commission, 2002).

Finally, in 2002, the NHP document was released, aiming to achieve acceptable standards of good health for the Indian population, with a focus on decentralization, equity, accessibility of health services, and the provision of affordable private healthcare.

The Eleventh Five-Year Plan (2007-12) offers a chance to restructure policies to achieve a 'New Vision centered on broad-based, and inclusive growth'. The health sector objectives are: (i) "to ensure good health for all, particularly the poor and underprivileged, by focusing on individual healthcare, public health, sanitation, clean drinking water, access to food, and knowledge of hygiene and feeding practices; (ii) to promote convergence and development of public health systems and services that respond to the health needs and aspirations of the population; and (iii) to give special attention to the health of marginalized groups, including adolescent girls, women of all ages, children under three, older persons, the disabled, and primitive tribal groups" (Sethuramalingam, et al.,2011,p.51).

The Twelfth Five-Year Plan (2012-17), informed by public consultation, prioritized achieving Universal Health Coverage (UHC) through an Essential Health Package. It emphasized a focus on social determinants of health, aiming to reduce out-of-pocket expenses and ensure accessibility of essential services. This included vaccines, medicines, and technology, along with increased staffing levels and the integration of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy) doctors. Additionally, the plan addressed disaster management preparedness, nutrition promotion, sanitation improvement, and the provision of safe drinking water facilities (Planning Commission, 2013).

National Health Policies

The National Health Policies represented a pragmatic response to the challenges of a rapidly evolving healthcare landscape in India. These policies, formulated over several decades, aim to improve healthcare access, quality, and outcomes for the diverse Indian population. They reflect changing priorities, from the initial focus on primary healthcare for all in the first national health policy of 1983 to the more recent emphasis on universal health coverage and a multi-stakeholder approach in the 2017 policy. The NHPs have also grappled with issues such as the growing role of the private sector the need for increased public health spending, and persistent rural-urban health disparities.

The health policies and programmes during the post-independence era were strategically oriented toward vertical disease control programmes. These targeted initiatives concentrated on critical public health objectives, such as the comprehensive eradication of smallpox, polio, and robust family planning interventions. This programmatic approach continued for several decades following independence, reflecting a strategic prioritization of specific disease management and population control strategies (Grover & Singh, 2020). Notably, the promotion of primary care services was not a high-priority policy agenda during this period. The hospital sector in India predominantly controlled by public sector facilities until the early 1980s. These healthcare institutions were primarily tax-funded, with the private sector playing a relatively limited and peripheral role in the national healthcare system (Selvaraj et al., 2022).

India's first National Health Policy, announced in 1983, followed the 1978 Alma-Ata Declaration, emphasizing primary healthcare with a focus on preventive, promotive, and rehabilitative care. However, this policy deviated significantly from the Bhore Committee report of 1946, which advocated for government-funded healthcare as a public good. The National Health Policy 1983 (NHP1983), conversely, sought to reduce government spending by involving the private sector, voluntary organizations, and community health workers for cost-effective primary care (Chokshi et al., 2016). While the Minimum Needs Programme initially increased primary care investment with the introduction of Auxiliary Nurse Midwives and Community Health Workers, it declined in the late 1980s due to structural adjustment policies (Selvaraj et al., 2022). This shift in approach, from a government-centric model to incorporating private and voluntary sectors, marked a significant change in healthcare delivery strategy.

From the 1980s onward, India witnessed significant growth in its private healthcare sector, driven by limited public funding, policies that favored privatization, and a rise in household incomes (Bajpai, 2014) . This expansion of private healthcare services created a dual impact: while it increased the availability of healthcare options, it also deepened disparities in access and affordability (Sengupta & Nundy, 2005). A key factor behind this trend was the persistent underfunding of the public healthcare system. Insufficient investment limited the capacity of government health facilities to provide comprehensive and quality care, prompting many individuals to turn to private providers for their healthcare needs. Simultaneously, policy measures during this period encouraged the privatization of healthcare, leading to the proliferation of private hospitals, clinics, and diagnostic centers (De Costa & Johannson, 2011). Rising incomes among certain segments of the population further fueled the demand for private healthcare services, as wealthier individuals sought specialized and advanced treatment options (Sengupta & Nundy, 2005). However, the rapid expansion of the private health sector came at a cost. Economic inequalities in India meant that a large portion of the population, particularly those living below or near the poverty line, struggled to access quality healthcare (Sengupta &

Nundy, 2005). High out-of-pocket expenditures in private facilities became a significant financial burden for low-income families, often pushing them deeper into poverty. Additionally, the private sector's profit-driven approach sometimes prioritized profitable services over equitable healthcare delivery.

The rural-urban divide in healthcare access also widened during this period. Urban areas, with their higher purchasing power and better infrastructure, attracted a greater concentration of well-trained healthcare professionals and advanced medical facilities, both public and private (Selvaraj et al., 2022). In contrast, rural areas, where a majority of the population resides, were left underserved. The shortage of qualified healthcare providers in rural regions exacerbated health inequities, leaving rural populations reliant on under-equipped facilities or unqualified practitioners . This growing reliance on the private sector, coupled with economic and regional disparities, highlighted the challenges of achieving universal healthcare in India (Hunter et al., 2022). A more balanced approach was required to address these issues, including increased public investment in healthcare, targeted policies to reduce rural-urban disparities, and measures to regulate and integrate private sector services into the broader health system to ensure equity, accessibility and affordability for all.

The National Health Policy 2002 (NHP 2002) came as response these issues, addressing critical systemic challenges and proposing transformative strategies to bridge rural-urban health disparities (Grover & Singh, 2020). It emerged in the context of economic liberalisation, changing disease patterns and persistent deficiencies in the public health system. It sought to improve access to health care, increase public health expenditure, strengthen infrastructure and encourage collaboration between public and private providers. It also recognised the importance of decentralisation, human resource development and the growing burden of non-communicable diseases. While the NHP 1983 focused on equity and universal access through state-driven initiatives, the NHP 2002 recognized the need to adapt to the changing socio-economic and epidemiological landscape.

The NHP 2002 aimed to achieve an acceptable standard of 'health for all' by strengthening public healthcare systems and integrating the private sector into national health strategies. Recognizing the growing role of private healthcare providers, the NHP 2002 proposed frameworks for collaboration, particularly in secondary and tertiary care, while recommending regulatory measures to ensure accountability and equity.

A key emphasis was on addressing rural health disparities by expanding the reach of primary healthcare services to underserved areas. It underscored the need to increase public health expenditure from 0.9% to 2% of GDP (NHP, 2002). The overarching objective was to dramatically improve public health infrastructure and substantially increase public sector health service utilization. Specifically, the policy set an aspirational target of expanding outpatient service utilization in public facilities from less than 20% to over 75% by 2010 (NHP, 2002).

The NHP 2002 stressed the prevention and control of both communicable and non-communicable diseases, given the rising prevalence of the latter due to lifestyle changes. To address demographic challenges, the policy included goals for population stabilization through family planning and maternal health services. Additionally, it highlighted the importance of human resource development by proposing strategies to address the shortage of trained healthcare workers, especially in rural areas. Decentralization emerged as another cornerstone, with the policy advocating for greater involvement of Panchayati Raj Institutions (PRIs) and community-based organizations in health planning and implementation (NHP,2002).

The NHP 2002 contributed to a greater awareness of critical public health challenges, laying the foundation for programs like the National Rural Health Mission (NRHM), launched in 2005. Disease-specific programs gained momentum under the guidance of NHP 2002, particularly those aimed at controlling HIV/AIDS and eradicating polio. The policy's acknowledgment of non-communicable diseases (NCDs) was another significant step, leading to targeted initiatives such as the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke (NPCDCS).

Despite its achievements, the NHP 2002 was constrained by underfunding, inequitable implementation, and systemic inefficiencies. The policy's recommendation to increase public health expenditure to 2% of GDP was not realized, limiting the scope and reach of many proposed initiatives. The integration of the private sector, while beneficial in expanding healthcare options, often prioritized profit-driven models, exacerbating inequities in access to quality and affordable care for marginalized populations (Chokshi et al., 2016). Rural-urban disparities persisted, as healthcare resources and skilled providers continued to be concentrated in urban areas, leaving rural populations underserved. Although the policy emphasized decentralization, many states lacked the institutional capacity and political will to implement these measures effectively. Furthermore, the policy paid insufficient attention to addressing the social determinants of health, such as education, housing, and sanitation, which play a critical role in improving health outcomes.

However, compared to the NHP 1983, the 2002 policy demonstrated a more realistic approach to addressing India's health needs, but its failure to fully realize its goals underscores the need for a stronger, more inclusive framework. The subsequent National Health Policy 2017 (NHP 2017) built on these lessons, aiming to bridge the gaps left by its predecessors.

The NHP 2017 marked a significant milestone in India's healthcare reforms, addressing the gaps in access, quality, and financial protection that persisted despite earlier policies. Introduced 15 years after the NHP 2002, this policy reflected the changing healthcare priorities of a rapidly evolving nation, with a vision to achieve Universal Health Coverage (UHC). It aimed to provide affordable and quality healthcare services to all, with a particular focus on underserved and vulnerable populations. The policy emphasized preventive, promotive, curative, rehabilitative, and palliative care through a robust and inclusive healthcare system (NHP, 2017).

A distinctive feature of NHP 2017 was its strong focus on strengthening public health and preventive care. The policy proposed the establishment of health and wellness centers (HWCs) to deliver comprehensive primary healthcare services, including screening and management of non-communicable diseases (NCDs), which have become a significant health burden in India.

Unlike its predecessors, this policy prioritized allocating two-thirds of health expenditure to primary care, reflecting the growing recognition of its role in improving health outcomes. Additionally, the policy set ambitious targets, including increasing public health expenditure to 2.5% of GDP by 2025 and reducing out-of-pocket expenditure to protect citizens from financial hardship caused by healthcare costs.

NHP 2017 underscored the importance of addressing social determinants of health, such as nutrition, water, sanitation, and education, through a multi-sectoral approach. It recognized the critical role of digital health in enhancing service delivery and proposed initiatives like telemedicine, electronic health records, and health information systems. Furthermore, the policy highlighted the urgent need to address the shortage of healthcare professionals in rural areas and proposed strategies to improve their availability and distribution. In addition, it advocated for greater collaboration with private healthcare providers, particularly for secondary and tertiary care, while emphasizing the need for regulation and accountability to ensure equity and quality (NHP,2017).

The policy has laid the groundwork for several transformative initiatives, most notably Ayushman Bharat, launched in 2018. Ayushman Bharat introduced Health and Wellness Centers (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PM-JAY), which provides financial protection through government-funded health insurance, targeting vulnerable populations. These initiatives have expanded access to primary healthcare and reduced out of pocket expenditure for millions (Dholakia, 2020). However, PM-JAY enables eligible patients to obtain covered hospital services from empanelled public and private hospitals. PM-JAY uses public funds to purchase specified hospital services for eligible beneficiaries. This can improve access to hospital treatment where public facilities lack the required services or capacity. However, when private hospitals become major recipients of public reimbursements, government financing also supports the expansion and operation of private health-care provision.

A critical review of PM-JAY identifies concerns about fraudulent claims, upcoding, potentially unnecessary medical procedures and the risk that hospital-centred financing may divert attention from primary care. The review also notes that robust evidence on the programme's overall impact remains limited. These concerns should not be interpreted as proof that all participating private hospitals engage in such practices; rather, they demonstrate why public financing must be accompanied by transparent monitoring, independent evaluation and enforceable accountability (Kamath and Brand, 2023)

NHP 2017 has faced several challenges. Public health expenditure remains below the targeted 2.5% of GDP, limiting the scope and reach of many programs. Human resource shortages, particularly in rural areas, continue to hinder equitable healthcare access. While the policy's reliance on the private sector has increased healthcare options, it has also raised concerns about affordability and accountability. Implementation disparities across states, due to differences in governance and resources, have further limited the policy's impact (Dholakia, 2020; Gopal, 2019).

The success of NHP 2017 in achieving its ambitious goals will depend on the government's sustained political commitment for healthcare reforms, as well as effective implementation and monitoring at the ground level.

Conclusion

The historical evolution of health policy in India shows a continuing effort to expand health services, improve population health and address inequalities in access to health care. From the Bhore Committee Report of 1946 to the National Health Policy of 2017, successive committees, planning frameworks and policy documents have recognised the importance of primary health care, preventive services, health infrastructure and wider access to medical care. Nevertheless, the persistence of many of the challenges identified in the early years of health planning indicates that the formulation of policy commitments has not consistently translated into their full realisation.

Despite the shifts in policy priorities in different durations, several concerns have remained unresolved. Inadequate public investment, shortages of trained health personnel, rural–urban disparities and unequal access to affordable and quality services continue to constrain the performance of the health system. The growing role of private health-care providers has expanded the range of available services but has also raised concerns about affordability, accountability and equitable access.

A significant lesson emerging from this historical review is that the achievement of universal health coverage cannot be assessed solely through the objectives articulated in policy documents or the introduction of new programmes. It also depends on the state's capacity to mobilise and sustain public resources, strengthen public health institutions, ensure an equitable distribution of health personnel and regulate the provision of health services. Addressing the social determinants of health, including nutrition, sanitation, housing and education, is equally important because health inequalities cannot be resolved through medical interventions alone.

The historical trajectory from the Bhore Committee to the 2017 policy therefore reveals not simply a succession of policy initiatives, but an enduring tension between the aspiration for universal and equitable health care and the structural constraints affecting its provision. Moving forward, strengthening the public health system and ensuring that health care is accessible, affordable and responsive to the needs of disadvantaged populations remain essential to realising the longstanding goal of health for all in India.

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