8

The Colonial Legacy and the Jamaican Healthcare System

Elsada Diana Cassells, Gabriela de Carvalho,
and Lorraine Frisina Doetter

1 Introduction

Jamaica became a British colony in 1655. For the next two centuries, Jamaica's incorporation into the British Empire was as the crown jewel, the site of a very successful sugar and slavery operation. After the abolition of slavery in 1838, Jamaica became a backwater filled with the broken bodies of the formerly enslaved, and a hotbed of destitution, disease and death. In the wake of independence in 1962, Jamaican policymakers were faced with enormous social policy challenges, particularly in the area of health, while coping with the trials of political transition and severe economic constraints. In the present study, we explore the colonial

---

E. D. Cassells

Purchase College, SUNY, Purchase, NY, USA

e-mail: diana.cassells@purchase.edu

G. de Carvalho (✉) • L. Frisina Doetter

University of Bremen, Bremen, Germany

e-mail: decarvalho@uni-bremen.de; frisina@uni-bremen.de

legacy on healthcare in Jamaica, casting an eye especially to the long-term policy conditions introduced by years of foreign rule. More specifically, we ask, *how did British colonialism impact the nature of choices and challenges confronting Jamaican policymakers as they grappled with a national response to healthcare post-independence?* To answer this question, we begin by exploring a number of key insights from extant scholarship regarding the intersection between colonialism and social policy, as well as outline our main assumptions. We then trace policy developments across two time periods: The colonial-era up to independence in 1962, and post-independence to the present. Our study concludes by reflecting on the consequences of colonialism and its legacy on the trajectory of healthcare policy in Jamaica.

2 Colonialism and the Emergence of Social Policy

Classical welfare state scholarship often explains the formation and ongoing development of social policy with reference to domestic factors, such as the role of industrialisation or economic development, as well as the ideological leanings of political parties. The last decades, however, have seen the emergence of new studies that consider external factors like globalisation and the influence of international organisations as (additional) drivers of social protection and social policy reform. This has come to include a focus on the role of colonialism in explaining welfare state development. Such literature argues that, in many instances, social security can be traced back to the colonial period and that the ongoing development of social policies is directly related to this time. The French Empire, for instance, had an active role in supporting social security legislation in its colonies, shaping both the institutional framework and the way the state would behave in countries post-independence (Schmitt 2015).

Although colonial powers have pursued different paths and approaches in relation to their territories, responsibilities in social protection for colonial populations typically arose at the beginning of the twentieth century. This mainly took the form of employment-related injury benefits as a response to the expansion of labour movements (Midgley 2011;

Schmitt 2015). In contrast to the Spanish and French, the British Empire did not follow a centralised and universal approach to social policy in the colonies. The very few common responses to social affairs came about only in 1929 and 1940, decades later than in other empires, with the ratification of the Colonial Development Act (see Shriwise in this volume) and the Colonial Development and Welfare Act, respectively. These provided financial assistance in the form of grants and loans for socioeconomic programmes, such as sanitation and transport (Colonial Development Act 1929). Public health measures represented 16 percent of the total amount recommended to finance projects, totalling £1,460,388¹ for the 1929–1940 period (Colonial Development Act 1929). The amount of funds available for each territory, however, was quite limited: for instance, the total assistance for all programmes recommended by the Colonial Development Fund to Jamaica over the same period was only £219,000 (Colonial Development Act 1929).

The publication of the Beveridge Report² in 1942 and the massive impact it had in Britain encouraged the debate over social security systems across British colonies. However, colonial officials maintained their position against a universal response and indicated (a) the need to create programmes that could be integrated into pre-existing territorial structures; and (b) that colonies were responsible for financing any programmes, despite their constant economic constraints (Midgley 2011; Schmitt 2015). This led to highly heterogeneous and delayed developments in social policy for British colonies, with most social protection programmes only introduced post-independence and in select countries. By way of comparison, whereas healthcare programmes are currently in place in 94 percent of former Spanish territories and in 91 percent of former French colonies, only 58 percent of former British territories provide some form of health coverage for their populations (Schmitt 2015). Given such divergent trajectories in social policy in (former) British colonies, the question necessarily arises, what leads one country to adopt a specific response to addressing social protection versus another, or none

---

¹ All figures reported as in historical Acts.

² The Beveridge Report is the most influential report in the foundation of the UK's welfare state. It advocated for flat-rate universal contribution and benefits.

at all? Moreover, are such choices shaped by the policy imprint of the colonial period?

While the present study cannot provide full answers to these questions, in what follows we take a first step at exploring the role that colonialism played in the introduction of the healthcare system in Jamaica. Our working assumption is that policy developments specific to health, however embryonic, witnessed during the colonial period left an indelible mark on the policy choices subsequently made and faced by Jamaican politicians. This might have manifested in anything ranging from the full embracing of the colonial policy legacy to the absolute rejection of all social policy modelled by the former colonial power. Moreover, we assume that the experience of colonialism, with its deeply rooted social inequalities, generated long-term consequences for the health of the people. This left national policymakers post-independence to struggle with the colossal task of having to address decades' worth of systematic neglect and abuse concerning population health. This presumably created policy-making conditions that were constraining in both their urgency, and the nature and range of choices available to decision-makers at the time. Bearing these assumptions in mind, we now turn to trace the history of healthcare in Jamaica, starting pre-independence, to explore the intersections between colonialism and the birth of a healthcare system.

3 The Development of Public Health Services in Colonial Jamaica

To understand the development of healthcare in Jamaica requires an interrogation of the processes that accompanied the radical shift from a slave-based free labour economy to an independent nation state. The public healthcare system in Jamaica grew out of a turbulent and traumatic post-emancipation process during which disease and social dystopia set the framework for healthcare delivery in the period leading up to independence. This section explicates the healthcare landscape in Jamaica from the epoch of slavery through to independence in 1962.

3.1 Slavery and Post-Emancipation Dystopia

During slavery, estate infirmaries, sick bays, alms houses, lunatic asylums and the Kingston Public Hospital established in 1776 formed the totality of the institutional framework in place for healthcare provision for the majority of the population. Medical officers recruited from abroad attended to colonial administrators, civil servants, the plantocracy and military personnel. Post-emancipation access to healthcare for the newly freed former slaves and their descendants was conditioned upon their willingness to remain as labourers on the sites of their former enslavement. Most chose, instead, to disappear into the hinterland, in forested areas devoid of resources for sustainable livelihoods. This contributed to grave public health consequences. With the emergence of these informal settlements, poverty, poor housing and squalor, the island became a petri dish of tropical diseases, among them, yaws, tuberculosis, cholera, malaria, as well as high mortality and morbidity rates, especially among infants (Pemberton 2012).

It was not until the mid-nineteenth century that state considerations for public health policy would come into focus because of three significant agenda-setting events. First, the inhumane treatment of mental health patients was classified as cruel and revoltingly criminal in a report commissioned by the colonial government in 1861 (Jones 2008; Fryar 2016). Second, significant population loss as a result of the cholera epidemic of the 1850s signalled to the authorities that race-based public health strategies were ineffective and only led to the rampant spread of disease. The ravages of communicable illnesses, high death-to-birth ratios and uncontrollable waves of infection propelled the colonial government to establish the Central Board of Health, a short-lived entity (1852–1854), as a knee jerk reaction to the public health crisis (Roberts 2013).

Third, the Morant Bay Rebellion, a class-based revolt in 1865 which challenged the economic and social marginalisation of the Black population, led to a series of institutional reforms by the British Empire. This included the 1875 establishment of the Island Medical Services (IMS), an entity that brought together disparate elements of healthcare services

under one umbrella. Propelled by the need to provide care for the Asian indentured workers and the collapse of the estate-based healthcare system, the IMS centralised accessibility to the few medical practitioners who had not repatriated to Britain after emancipation. This culminated in the incorporation of parish infirmaries, asylums, ‘lying-in’ maternity centres, and dispensaries into a government medical service (Davidson 2013).

3.2 Rockefeller Intervention

The global influenza pandemic compounded the deleterious economic and social conditions in Jamaica at the dawn of the twentieth century. Together these threatened the economic base of the island as the indentured labour pool succumbed to disease and ill health. In response, the colonial government offered up the territory as a laboratory for the Rockefeller Foundation³ to carry out epidemiological research. Beginning in 1918, the Rockefeller International Health Commission incorporated Jamaica into its network of studies on tropical illnesses such as hookworm infestations, tuberculosis, malaria and yaws, among others. The direct policy implications of the Rockefeller intervention manifested in the 1927 establishment of a national health education bureau geared towards providing rudimentary primary health services, particularly clinics for venereal and communicable diseases (Altink 2018).

3.3 Moyne and Irvine Commissions

The turbulence occasioned by the Great Depression, the waning imperial ambitions of Great Britain and unsettled questions of Jamaican humanity under the matrix of colonialism led to widespread riots and violent labour-related actions during the 1930s. Economic contractions during the inter-war years fuelled a contentious class battle between Jamaican

---

³ The Rockefeller Foundation is a New York based philanthropic organisation established in 1913. Although it develops activities in different fields, medical and health sciences have been the focus of the foundation since its creation (Birn and Fee 2013).

workers, landless illiterate peasants and the colonial elite. Moreover, the Colonial Development Act of 1929 increased Jamaica's foreign debt, as loan repayments well exceeded the actual loan amounts (Abbott 1971). Mass unemployment, low wages, poor living and deplorable working conditions culminated in island-wide disturbances. Several categories of workers, among them dockworkers, agricultural workers, ex-servicemen and public-works labourers, engaged in generalised work stoppages and strikes. The ensuing riots and violent disruptions proved to be a watershed moment, as it led to the formation of the labour unions and affiliated political parties that would preside over the development of national health policies after independence (Dawson 2016). Accordingly, from the 1938 riots onwards and during the Second World War, Jamaican elites, the peasantry and assorted ideologues were locked in a struggle regarding the future of the nation. The nascent independence movement was viewed with distrust by the colonial authorities (Palmer 2014). This period marked the genesis of Jamaica's political divide as the political culture that was birthed during this time continued to shape social policymaking long after independence.

Britain responded by convening the Moyne Commission (1938) to assess social, economic and political conditions, and the Irvine Commission (1943) on higher education, in its Caribbean colonies. The Moyne Commission recognised the structural deficiencies that plagued the region and offered a range of recommendations that included provisions that propelled a revolutionising of the public health landscape forward. The West Indies School of Public Health inaugurated in 1943 in Jamaica as a regional training institute for public health officers and allied health works was a product of this commission. Meanwhile, the Irvine Commission advanced the idea of establishing a regional university in the Caribbean, the University of the West Indies in Jamaica, founded in 1948. In recognition of the precarious health profile of the region, the first class at this new institution consisted of thirty-three students in the faculty of medicine. Then, the institution operated as a franchise of the University of London, with curriculum and faculty imported from abroad. The rise of political autonomy, however, with Jamaica and Trinidad and Tobago gaining independence in 1962, and the dictates of national health policy ultimately led to an indigenisation of all aspects of

the institution. Notably, in the lead-up to Jamaican self-government in 1957, the British Empire sought to decolonialise district medical offices and assorted medical departments by consolidating them into a Ministry of Health in 1955 (Campbell 2013). This introduced a novel and enduring institutional landmark into the healthcare architecture of the soon to be former colony.

4 Healthcare Post-Independence

The political parties formed in response to the 1938 labour disturbances—the conservative Jamaica Labour Party (JLP), which attracted agricultural and urban workers, and the People’s National Party (PNP) with its middle-class membership—would become the two dominant political entities in the nation post-independence (Bradley 1960). Following in the footsteps of the former colonial power, Jamaican political elites opted for a Westminster style parliamentary system. The JLP, the ruling party at independence having defeated the PNP in a national referendum, withdrew Jamaica from the British-influenced West Indian Federation in 1961. This set the stage for full independence in 1962. After independence, the new government was challenged by labour–management tensions inherited from the colonial period and this delayed the implementation of many social policies (Johnson 1980), including health insurance.

For the first quarter of the twentieth century, Jamaican life expectancy hovered around 35.5 years. At independence, this and other demographic trends steadily improved owing to public health interventions. The challenge for the nation was to decrease the prevalence of infectious diseases and to eradicate and prevent the re-emergence of communicable diseases while building up a public healthcare system (Riley 2005; Figueroa 2001). The first major piece of legislation ratified in the post-colonial period that concerned financing of healthcare services for specific segments of society was an addendum to the National Insurance Act (1966) approved in 1970, eight years after independence. Compensation for healthcare was initially introduced as part of a larger package of services which included “old age benefit, invalidity benefit, widow’s or widower’s

benefit, orphan's benefit and special child's benefit" (National Insurance Act 1966, 43). Funded by compulsory contributions (pay-as-you-go) by employers and formal employees, cash benefits for medical treatment and pharmaceuticals were provided to those beneficiaries who suffered work-related accidents or illnesses. The introduction of legislation protecting specific groups by regulating labour and industrial relations points to the segmented nature of the healthcare system at its starting point post-independence (Braveboy-Wagner and Gayle 1998). This feature mimics the colonial period's approach to providing rudimentary social protection in the area of health as a means of keeping the workforce active and avoiding social unrest.

One limitation of this first social insurance scheme was the narrow scope of coverage. The plan targeted employed persons, the self-employed and voluntary contributors, with no coverage for informal and unskilled labourers or the unemployed (Innerarity and Ridsen 2010). Given that rampant unemployment threatened real access to health services, high rates of strikes, industrial action and health-related grievances continued to plague the nation (Lacey 1977). It was not until the election of a democratic socialist government in 1972 that a more expansive national healthcare response would take off. The wide-ranging social programmes of the Michael Manley administration revolutionised welfare services for Jamaican citizens, especially for those descending from enslaved populations that were set adrift after 1838. More specifically, the government sought to expand healthcare services, exploring universalism in a green paper on the National Health System, which reached Parliament in 1974. However, prevailing economic conditions derailed the implementation of the provisions which included proposals for health sector development and a contribution-based financing scheme (Lalta 2009).

This derailment deferred any kind of comprehensive restructuring of the national healthcare system for more than a decade. In the intervening years, Jamaican healthcare policy was influenced largely by external engagements, especially within the region. This included cooperation around the aforementioned indigenisation of Caribbean medical education. Hemispheric partners such as the Pan American Health Organization (PAHO) provided technical assistance, while Cuba aided with the construction of medical facilities, and provided medicines, medical staff and

other technical professionals. Meanwhile, at the broader international level, the World Health Organization's (WHO) Alma-Ata Declaration of 1978 set in motion a greater focus on primary health services in Jamaica (WHO 1978). This period was marked by an altogether new kind of opening of the country to include a strengthening of regional ties and exposure to international policy ideas. Still, severe constraints on its economy limited the possibilities for more progressive reform.

It was not until the passing of the National Health Services (NHS) Act in 1997 and the National Health Fund (NHF) Act of 2003 that a dramatic shift in policy paradigms and a major restructuring of health services would take place. This led to the current tax-financed Public Health System (PHS). Whereas at independence Jamaica did not possess the resources to dismantle its colonial medical architecture, by 1997 health-care would come to be seen as a public good (PAHO 2001). Access to healthcare is now a government-funded enterprise with adjunct private sector financing, as well as individual out-of-pocket expenditure. An NHF Card subsidises pharmaceuticals for fifteen chronic diseases for a cross-section of the Jamaican population, while the Jamaica Fund for the Elderly Program (JADEP) provides access to medications for ten illnesses for those over the age of sixty. Another programme, the Government of Jamaica (GOJ) Health Card, provides general access to healthcare facilities and pharmaceuticals. The NHF also contains a funding mechanism for private sector institutions that engage in health education and health promotion, as well as funding for public sector health infrastructure. Beyond this, a network of 24 government-owned and administered hospitals, some 250 plus clinics, a national blood bank, a national public health lab and other allied institutions are the cornerstone of the Jamaican PHS.

Despite the successful expansion of the public healthcare system, achieving coverage for the majority of the population remains an unattainable goal in Jamaica: in the fiscal year 2018–2019, a total of 818,563 people or about 30 percent of the population were enrolled in these programmes (Chao 2013; Ministry of Health 2020). Crucially, what has emerged post-independence is a fragment or far more rudimentary version of the state-based NHS system found in Great Britain (see e.g. Grimmeisen and Frisina 2010). Based on the developments reported on

here, it is difficult to determine whether Jamaican policymakers actively looked to the former colonial power for inspiration, or, rather by chance, stumbled on a similar policy path out of necessity. What is clear, however, is that Jamaica stepped away from the social insurance model it once sought to advance in the direct aftermath of independence in favour of a tax-financed system. This coincided with the changing of political parties in power, from the conservative JLP to the socialist democratic PNP, as well as a growing and new form of international interconnectedness with the embracing of Alma-Ata principles and a substantial role for development assistance.

5 Discussion and Conclusion

Throughout the colonial period, Jamaica suffered from the absence of health policy coherence. Hastily constructed, crisis-driven policy prescriptions did little to address the myriad of public health concerns that plagued the society. Health policy considerations were driven by anti-Black biases of elites, the agendas of international public health partners and regular civil unrest. A distinctive feature of the colonial health policy landscape was the institutionalisation of crisis-driven policymaking. Major policy initiatives were designed either to react to burning health issues, such as the cholera outbreak, or to address civil unrest, as seen in the Morant Bay rebellion and the 1938 labour riots. As such, colonial health policy represented piecemeal policymaking on demand.

When it was time for independence from British rule in 1962, Jamaican decision-makers were faced with the challenges of puzzling together a policy response to generations of systematic neglect of the social needs of the people. Much of Jamaican healthcare policy since then has sought to overcome this legacy. Developments in national legislation and regional coordination, the indigenisation of medical training, reform of psychiatric services, introduction of a comprehensive primary health programme and the embracing of the Alma-Ata Declaration signal a substantive delinking from its colonial past.

Still, despite progress in many areas, issues of financing continue to plague the PHS and coverage through its various schemes remains low. The problems of the healthcare system are compounded by other issues that could not be covered here but which include: *brain-drain* involving the loss of medical personnel; the macro-economic realities of debt-servicing; the challenges posed by small island environmental and climatic vulnerabilities; as well as emerging and recurring communicable diseases (Duncan et al. 2017). While many of these issues cannot be directly attributed to the role of colonialism, the historical developments traced in our case study point to severe constraints placed on the country that are deeply rooted in the colonial period. What emerged as the haphazard policy responses of a colonial power that saw health provision as a last-resort measure to quell acute circumstances would develop into a long-lasting double-bind for its social policy agenda: not only has colonialism contributed to the social conditions responsible for exacerbating the need for a comprehensive healthcare system, but it also set the country on a trajectory of development that would hamper a robust state-led response to meeting that need. Further research is needed that can unpack the complexities of the long-term impact of colonialism on social policy in present-day societies. This may be key to moving forward with policy responses to undo this legacy.

Acknowledgements This chapter is a product of the research conducted in the Collaborative Research Center “Global Dynamics of Social Policy” at the University of Bremen. The centre is funded by the Deutsche Forschungsgemeinschaft (DFG, German Research Foundation)—project number 374666841—SFB 1342.

References

- Abbott, G. 1971. A Re-Examination of the 1929 Colonial Development Act. *The Economic History Review* 24 (1): 68–81.
- Altink, Henrice. 2018. A Black Scourge? Race and the Rockefeller’s Tuberculosis Commission in Interwar Jamaica. *História, Ciências, Saúde-Manguinhos* 24 (4): 1071–1088.

- Birn, Anne-Emanuelle, and Elizabeth Fee. 2013. The Rockefeller Foundation and the International Health Agenda. *The Lancet* 381 (9878): 1618–1619.
- Bradley, C. 1960. Mass Parties in Jamaica: Structure and Organization. *Social and Economic Studies* 9 (4): 375–416.
- Braveboy-Wagner, Jacqueline, and Dennis Gayle. 1998. *Caribbean Public Policy: Regional, Cultural, and Socioeconomic Issues for the twenty first 21st Century*. London: Routledge.
- Campbell, A. 2013. *The Abolition of User Fees in the Jamaican Public Health System: Impact on Access, Care Provided and the Work of the Professional Nurse [thesis]*. Wellington: Victoria University of Wellington.
- Chao, Shiyan. 2013. *Jamaica's Effort in Improving Universal Access within Fiscal Constraints*. Working Paper Series 75005, The World Bank.
- Davidson, Winston. 2013. Review of Healthcare in Jamaica. *Jamaica Gleaner*, The Gleaner Company.
- Dawson, Andrew. 2016. Political Violence in Consolidated Democracies: The Development and Institutionalization of Partisan Violence in Late Colonial Jamaica (1938–62). *Social Science History* 40 (2): 185–218.
- Duncan, Jacqueline, Kelly-Ann Gordon-Johnson, Marshall Tulloch-Reid, et al. 2017. Chikungunya: Important Lessons from the Jamaican Experience. *Rev Panam Salud Publica* 41 (60).
- Figueroa, J. 2001. Health Trends in Jamaica. Significant Progress and a Vision for the twentyfirst Century. *The West Indian Medical Journal* 50 (4): 15–22.
- Fryar, Christienna. 2016. Imperfect Models: The Kingston Lunatic Asylum Scandal and the Problem of Postemancipation Imperialism. *Journal of British Studies* 55 (4): 709–727.
- Government of Jamaica. 1966. *The National Insurance Act*. Kingston.
- . 1970. *National Insurance Employment Injuries Benefit Regulations*. Kingston.
- Government of the United Kingdom. 1929. *Colonial Development Act*. Source. <http://www.legislation.gov.uk/ukpga/Geo5/20-21/5/enacted>. Accessed 15 April 2020.
- Grimmeisen, Simone, and Lorraine Frisina. 2010. The Role of the State in the British Healthcare System—Between Marketization and Statism. In *The State and Healthcare: Comparing OECD Countries*, ed. Heinz Rothgang, Mirella Cacace, Lorraine Frisina, Simone Grimmeisen, Achim Schmid, and Claus Wendt, 75–118.

- Innerarity, Faith, and Colette Ridsen. 2010. Social Safety Net Reform in Jamaica Experience of the Programme of Advancement Through Health and Education (PATH). *Social and Economic Studies* 59 (1/2): 181–209.
- International Conference on Primary Health Care. 1978. Declaration of Alma-Ata. *WHO Chron* 32 (11): 428–430.
- Johnson, C. 1980. Political Unionism and Autonomy in Economies of British Colonial Origin: The Cases of Jamaica and Trinidad. *The American Journal of Economics and Sociology* 39 (3): 237–248.
- Jones, Margaret. 2008. The Most Cruel and Revolting Crimes: The Treatment of the Mentally Ill in Mid-Nineteenth-Century Jamaica. *The Journal of Caribbean History* 42 (2): 290–309.
- Lacey, Terry. 1977. *Violence and Politics in Jamaica, 1960–70: Internal Security in a Developing Country*. Manchester: Manchester University Press.
- Lalta, Stanley. 2009. *The Design of National Health Insurance: Evaluation of Options for Jamaica*. PhD thesis. London School of Hygiene & Tropical Medicine.
- Midgley, James. 2011. Imperialism, Colonialism and Social Welfare. In *Colonialism and Welfare*, ed. James Midgley and David Piachaud, 36–54. Cheltenham: Edward Elgar.
- Ministry of Health of Jamaica. 2020. *National Health Fund*. Source. <https://www.nhf.org.jm/>. Accessed 15 April 2020.
- Palmer, Colin. 2014. Challenging Power and Facing the Consequences. In *Freedom's Children: The 1938 Labor Rebellion and the Birth of Modern Jamaica*, ed. Colin Palmer, 230–279. Chapel Hill: University of North Carolina Press.
- Pan American Health Organization. 2001. Health System and Services Profile of Jamaica. https://www.paho.org/hq/dmdocuments/2010/Health_System_Profile-Jamaica_2001.pdf. Accessed 17 May 2020.
- Pemberton, Rita. 2012. Dirt, Disease and Death: Control, Resistance and Change in the Post-Emancipation Caribbean. *História, Ciências, Saúde-Manguinhos* 19 (1): 47–58.
- Riley, James. 2005. *Poverty and Life Expectancy: The Jamaica Paradox*. Cambridge: Cambridge University Press.
- Roberts, George. 2013. *The Population of Jamaica*. Cambridge: Cambridge University Press.
- Schmitt, Carina. 2015. Social Security Development and the Colonial Legacy. *World Development* 70: 332–342.

Open Access This chapter is licensed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.