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The Bhore Committee: An Overview

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The countrywide experience of China has been confirmed by almost all the smaller scale health projects in our own country such as Jamkhed, Mandwa, Vadu and Munnar. All demonstrate that it is entirely feasible to provide adequate health services to all the people even under the existing socio-economic constraints in a predominantly rural society spread over a subcontinent. That health is far more than mere illness care and the preventive and promotive aspects of health depend as much or more on nutrition, water supply, sanitation, environment and education as on the medical services.

Also, there is adequate medical knowledge and technology already available for the control of the majority of the diseases that affect our people, namely communicable diseases and this knowledge and technology is simple, cheap, effective and safe. Even semiliterate and illiterate people have the capacity to absorb this knowledge and utilise the technology if it is demystified and provided to them in a manner they can understand and utilize. The role of the professionals is to teach, encourage self-help and to provide the services for the few conditions that require skills and/or facilities which are beyond the capability of the community itself. This can be achieved only through a decentralised health care system which has firm roots within the community itself.

It is indeed remarkable that such a model for the development of the health services of our country was conceptualised in the mid-forties by both the medical committees, namely the Sokhey report of the National Planning Committee appointed by the Congress as well as by the National Health Survey and Development Committee appointed by the then British rulers, a report more popularly known as the Bhore Committee report named after its Chairman, Sir Joseph Bhore, an Indian ICS officer born in the Ahmednagar district of Maharashtra. The latter was the outcome of a remarkably detailed countrywide study of existing health problems and health services conducted over a period of two years during the Second World War.

An attempt is being made in this issue of the FRCH Newsletter to review some of the more important aspects of this outstanding and remarkably farsighted document which though much quoted is seldom available and even less read, a document as relevant to India and all the need based countries of the world today as it was when written in the pre-independence period.

The scope and vision of this report has been spelt out so admirably in the foreword that it is deemed best to quote it verbatim as follows:

In this foreword an attempt is made to present, in a nutshell, the main principles underlying the Committee's proposals for the future health development in the country. These are –

1. No individual should fail to secure adequate medical care because of inability to pay for it.

2. In view of the complexity of modern medical practice, the health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment.

3. The health programme must, from the beginning, lay special emphasis on preventive work. The creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement or recreation, are essential. So long as environmental hygiene is neglected, so long as the faulty modes of life of the individuals and of the community remain uncorrected, so long as these and other factors weakening man's power of resistance and increasing his susceptibility to disease are allowed to operate unchecked, so long

will our towns and villages continue to be factories for the supply of cases to our hospitals and dispensaries.

4. The need is urgent for providing as much medical relief and preventive health care as possible to the vast rural population of the country. The debt which India owes to the tiller of the soil is immense and, although he pays the heaviest toll when famine and pestilence sweep through the land, the medical attention he receives is of the most meagre description....

5 The health services should be placed as close to the people as possible in order to ensure the maximum benefit...to the communities to be served. The unit of health administration should therefore be made as small as is compatible with practical considerations.

6. ...The idea must be inculcated that, ultimately, the health of the individual is his own responsibility and, in attempting to do so, the most effective means would seem to be to stimulate his health consciousness by providing health education on the widest possible basis as well as opportunities for his active participation in the local health programme.

7. ...Both in respect of legislation and of administration it is likely that some of the measures to be undertaken may offend existing social and religious practices, while others may involve control over the day to day life of the citizen. We therefore feel that it is only a Minister enjoying the confidence of the people who can carry such enactments through the legislature and ensure their practical application in the country.

In putting forward its proposals for a national health organisation, which incorporates these principles, the Committee has drawn up a long-term programme which, if implemented on the lines suggested, should help to provide the people with a reasonably well developed service based on the newer and expanding conceptions of modern health practice. The attainment of this objective, which may take about 40 years, is to be achieved through successive stages of intensive effort directed towards the production of the necessary trained personnel and the creation and development of the organisations and institutions which will form essential parts of the community's health service. The Committee has attempted to outline, in some detail, the first and second five-yearly stages of such development and has also suggested certain objectives to be kept in view for the next five years, leaving subsequent developments to be shaped in the light of the circumstances existing at the time.

The doctor of the future should be a "social physician protecting the people and guiding them to a healthier and happier life". He should place prevention of disease in the forefront of his programme and should so combine remedial and preventive measures as to confer the maximum benefit on the community. The Committee's proposals for the training of the `basic' doctor, the term applied to the medical graduate of the future, are designed to equip him for all such duties.

The active support of the people is sought to be secured through the establishment of Health Committees in every village and through the stimulation of local effort for the improvement of environmental sanitation, control of infectious diseases and other purposes. A wide programme of Health Education, covering all sections of the population, is also proposed, promoting the growth of such public support".

The intervening half a century has seen several reports based on the same theme, the two most quoted being the WHO Alma Ata Declaration and the joint report of the Indian Councils of Social Science and Medical Science, `Health for All: An Alternative Strategy'. Yet none of these has been based on such extensive information nor do they have the width of vision or provide the detailed recommendations as in the Bhore Committee's report.

This report provides short as well as long term plans for the organisation and administration of a `national health service for the people'. The four volumes totalling 1200 pages consist of *Vol.1 - Survey, Vol.2 - Recommendations, Vol.3 - Appendices and Vol.4 - Summary.* In these they cover almost every subject concerning health, not only hospitals and major diseases such as malaria, tuberculosis and leprosy but nutrition, general education, occupational health, maternal and child health, mental health, dental and school health, drugs, social workers, local self-government, vital statistics, water supply, sanitation, pollution, housing as well as town and village planning.

A major criticism that has been levelled against this report is the excessive financial cost of implementing such a comprehensive health system. The Committee had estimated the cost of such a health service in keeping with the percentage of the GNP incurred by some of the Western countries at that time. Even today the percentage of government health expenditure on health at about 2.5 percent of our National GNP is far lower than that of countries like UK - 6% and USA - 11% though the combined expenditure on health of the public and private sector in India is today almost 6% of our GNP or about Rs. 15,000 crore. Even half that amount would be sufficient to provide all our people with the type of health care visualised in the Bhore report. It is the skewed nature of the expenditure in the private as well as the public health sector, and not the total available resources that are responsible for the poor health care of our people. This is partly the result of the undue position and privilege provided by both the Bhore report as well as the founder fathers of our nation to the allopathic medical profession who have utterly failed to comprehend health as enunciated in this document and has converted health into an illness-based industry where they have become the

chief beneficiaries. The blame cannot be placed only on the Bhore Committee or the founders of our nation who placed their implicit trust and faith in the medical profession which has failed the country. It must lie squarely on the shoulders of the medical profession and those who support them.

Another weakness of the report is the failure to give due consideration to the indigenous systems of medicine to which the report only say "we are unfortunately not in a position to assess the real value of these systems..... We do however, say quite definitely that there are certain aspects of health protection which in our opinion can be secured wholly or at any rate largely only through the scientific system of medicine"; thus revealing the Western allopathic bias of this Committee.

That this report was implemented in China, but not in the country of its origin, reveals the pre-eminence of the political system as well as the political will (as demonstrated in Sri Lanka, a democracy) in the implementation of any programme designed for the benefit of the people at large and not merely for that of a select few.

This report needs reprinting and wide dissemination, for it should be incumbent reading for anyone concerned with the planning and implementation of the health services of our people; not forgetting the medical profession.

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A REVIEW OF THE BHORE COMMITTEE - 1946 AND ITS RELEVANCE - 1990

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The Health Survey and Development Committee, popularly known as the Bhore Committee, is now forty-four years old. We feel its relevance is not lost even today. This paper reviews the entire three volume report (the fourth volume is the summary of the report) with detailed references and quotations to highlight its wide scope and its comprehensive and progressive nature. At the end the paper discusses the need for a national health service keeping in mind the Bhore Committee recommendations which should constitute the foundation on which a national health service can be built. (The references and quotations from the report have been given in the text within brackets, for example (II.100) meaning volume two, page number 100).

The Bhore Committee was set up at a great historical juncture. It was in the midst of the Second World War and in succession to the Quit-India movement that the Government of India on 18th October 1943 announced the appointment of the Health Survey and Development Committee under the Chairmanship of Sir Joseph Bhore. It's secretary was Dr. KCKE Raja and one of the joint secretaries Dr. K.T. Jungalwala. Some of the well known members included Dr. J.B. Grant, Dr. B.C. Roy, Pandit P.N. Sapru and Dr. A.L. Mudaliar.

Why was this Committee appointed? The terms of reference were simple: (a) a broad survey of the present position in regard to health conditions and health organization in British India, and (b) recommendation for future development (I.1).

The letter of appointment of the Committee further stated that "a survey of the whole field of public health and medical relief has not hitherto been attempted. The immediate necessity for initiating such a survey has arisen from the fact that the time has come to make plans for post-war development in the health field. The Government of India consider that such plans should be based on a comprehensive review of the health problem ... one of the difficulties with which the Committee will be confronted is that of finance. Financial considerations clearly cannot be ignored. Plans based on the assumption that unlimited funds will be available for recurring expenditure will have little practical value. On the other hand it would be equally unwise to assume that expenditure on health administration will in the future be limited to the sums which were expended in the pre-war years. It is desirable, therefore, to plan boldly, avoiding on the one hand extravagant programmes which are obviously incapable of fulfillment and on the other halting and inadequate schemes which could have no effect on general health standards and which would bring little return for the expenditure involved" (I.1-2).

The Committee was thus given a completely free hand in studying the health situation and arriving at recommendations for the general benefit of the masses, especially the "tiller of the soil" (II.4-5).

To lend support to the Committee five Advisory Committees were formed from among the Committee members, and it also included selected eminent persons in the respective fields. These committees were: (i) Public Health (ii) Medical Relief (iii) Professional Education (iv) Medical Research and (v) Industrial Health (I.3, III.337-338). The Advisory Committee deliberations, tours (in all provinces except Assam and Baluchistan), interviews, observations etc. resulted in 206 background papers, memoranda and notes which formed the basis of the final report (III. 339-351). This task was accomplished in 26 months (I.4).

Historical Background

Though the Bhore Committee was the first significant attempt in understanding the health situation from a holistic perspective, it was certainly not a pioneer in this field. Some attempts had been made in the past and these were very useful to the Bhore Committee in arriving at its own understanding and recommendations.

One of the earliest known official attempt was the Royal Commission that enquired into the health (sanitary state) of the army in 1859. The British army was ravaged by disease and mortality primarily due to insanitary conditions and not so much due to wounds inflicted in the wars. The Crimean war and the Indian "Mutiny" called for a review, and as a result two Royal Commissions, one in Britain (1857) and another in India (1859) were appointed.

The analysis of mortality between 1817 and 1857 by the Indian Royal Commission indicated that of all the deaths of soldiers in this period only 6 percent were due to war. The rest were caused by four major diseases -fevers, dysentery & diarrhoea, liver disease and cholera. Clearly, therefore, the main enemy of the British soldier in India was not the Indian enemy but disease (Royal Sanitary Commission Report 1863 quoted by Radhika Ramasubban, "The Colonial Legacy and the Public Health Systems in India" in Socialist Health Review, II:1, 6-16, June 1985)

The recommendations of this Commission created the foundation for sanitary reforms and public health in India, albeit on an enclave pattern. Sanitary Commissions were set up and from then on some organised data on health and disease particularly vital statistics and disease control, was available in the annual reports of the sanitary commissions. An investigative tradition became an integral part of the sanitary movement, especially after the first Government of India (ibid).

The 1896 plague outbreak and the subsequent report of the Plague Commission in 1904 made a case to further strengthen public health administration in India, and the Commission's recommendation included the creation of a Medical Research Department and the establishment of the Indian Research Fund Association (I.24). And the Government of India Act of 1919 transferred health, among other subjects, to the provinces, and subsequently the 1935 Act further consolidated these powers to the provinces by granting a greater measure of autonomy (II.289). Between this intervening period of the two Acts the health sector, including rural areas, received much more attention. (Earlier with the establishments of Municipalities after 1870 and District Boards after 1880 urban areas and district headquarters were already benefiting from the setting up of dispensaries and hospitals). A lot of documentation took place through annual reports, special studies and medical research. The Indian Medical Gazette, Indian Journal of Medical Research, the Journal of the Association of Medical Women in India, Bradfield's Indian Medical Review - 1938, and D.G. Crawford's. A History of the Indian Medical Service 1600-1913 (2 vols.), among others, contained useful contributions in putting together the health situation in India.

Nevertheless the historical importance of the Bhore Committee still remains and its relevance to the Indian people is even greater today.

In this paper we critically review the National Health Services Scheme of the Bhore Committee and make a case for its implementation today, forty four years after it was published.

Health Situation at the Time of Bhore Committee

In defining health the Bhore Committee stated that the term 'health' implies more than an absence of sickness in the individual and indicates a state of harmonious functioning of the body and mind in relation to his physical and social environment, so as to enable him to enjoy life to the fullest possible extent and to reach his maximum level of productive capacity (I.7).

This is what one would call a definition of positive health but data regarding positive health are difficult to collect and these were not available to the Bhore Committee. What was then available was data relating to sickness and mortality which had accumulated as a result of earlier efforts as indicated in a preceding section of this paper.

The Bhore Committee begins with a comparison of the Indian Health situation with other countries. (see Table I).

Table I: Inter-Country Comparison of Mortality and Life Expectancy (I.7-8).

Country	Death Rate (1937)	IMR (1937)	Life Expectancy at Birth Males	Females		1987* Death Rate	1987* IMR	1987* Life Expectancy Male	1987* Life Expectancy Female
New Zealand	9.1	31	65.04	67.88	(1931)	9	11	72	78
Australia	9.4	38	63.48	67.14	(1932-34)	8	10	73	80
Union of S. Africa	10.1	37	57.78	61.48	(1925-27) (Europeans only)	10	72 (Blacks & Whites)	58	64
Canada	10.2	76	59.32	61.59	(1929-31)	8	8	73	80
U.S.A.	11.2	54	59.12 47.55	62.67 49.51	(whites) } (Blacks) } (1929-31)	9	10 (Blacks & Whites)	72	74
Germany	11.7	64	59.86	62.75	(1932-34)	12	8 (W. Germany)	72	78
England & Wales	12.4	58	58.74	62.88	(1930-32)	12	9	72	78
Italy	14.2	109	53.76	56.00	(1930-32)	10	10	74	80
France	15.0	65	54.30	59.02	(1928-33)	10	8	74	80
Japan	17.0	106	44.82	46.54	(1926-30)	7	6	75	81
Java	18.8	—	—	—		9	71 (Indonesia)	58	62
Palestine	18.9	153	—	—		—	—	—	—
Ceylon	21.7	158	—	—		6	33	68	73
British India	22.4	162	26.91	26.56	(1921-30)	11	99	58	58
Egypt	27.2	165	—	—		10	85	59	62

(*Source for 1987 data : World Development Report 1989, World Bank.)

Table I clearly establishes the poor state of India's health (IMR and life expectancy) in comparison to other countries, especially the developed ones. But what is more tragic is that today, fifty-three years later, India has not reached the level of health which developed countries had achieved before the start of World War II!

At the time of the Bhore Committee the health of children and women was still worse. Of all deaths in India in the pre-war years 48% was that of children below 10 years in comparison to only 10% in England and Wales, and maternal mortality was 20 per 1000 confinements in India in contrast to about 3 per 1000 in England. (I.9,63) The comparison is even worse today as in India still over 40% of the deaths continue to be in the under-10 years age group and maternal mortality is higher than 5 per 1000.

What were the causes of this low level of health in India? (It is important to note that these same causes are responsible for poor health of Indians even today - in Independent India !)

(i) **Insanitary Conditions:** The development of public health was very poor inspite of reforms that began since 1860. As stated earlier these reforms were only in enclaves where the military or civil administration resided. The concern for the "native" population was there only as far as it affected those staying in enclaves, for example, when there was an epidemic outbreak. For instance in 1936 of the 35,871 villages in 27 districts of the Punjab province only about one percent were considered as "sanitated" by the Director of Public Health i.e. those having (i) a water supply protected from surface contamination (ii) drains for removal of waste water (iii) regular removal of filth and refuse outside the village to a place prepared for their reception (I.12).

(ii) **Defective Nutrition:** Malnutrition and undernutrition reduce the vitality and power of resistance of an appreciable section of the population. An insufficient and ill-balanced diet is typical of the food consumed by millions in India. - about 80 to 90 percent of the food consumed by Indians consists of cereals and in the 1939-43 period even this fell short (in terms of availability) by 22 percent (I.12).

(iii) **Inadequacy of the existing medical and preventive Health Organizations:** The existing facilities are only a fraction of the requirement on the basis of any decent standards. A comparison of India and United Kingdom for the year 1942-43 shows the following ratios. (I.13) (Table II)

Table II : Health Facilities in India and UK in 1942-43 and India 1987.

Categories	(Population per facility) INDIA 1942-43	U.K	INDIA 1987	
Doctors (Allopathic)	1 to 6,300	1 to 1,000	1 to 2,330	(1 to 1000 including non-allopathic doctors)
Nurses	1 to 43,000	1 to 300	1 to 3,480	
Health Visitors	1 to 400,000	1 to 4,770	1 to 60,000	
Midwives	1 to 60,000	1 to 618	1 to 4,300	(1 to 2133 including ANMS)
Pharmacists	1 to 4,000,000	1 to 3,000	1 to 3,500	
Dentists	1 to 300,000	1 to 2,700	1 to 80,000	
Hospital beds	1 to 4,167	1 to 140	1 to 1,310	

(*Source for 1987 data : Health Information of India - 1987, CBHI, GOI, 1988)

It is reasonable to consider the World War II ratios of U.K. as the optimal requirement that India must have today. But, with perhaps the exception of doctors and pharmacists the other requirements, as of today, lag far behind.

These aggregate figures apart, the rural-urban differentials in India then (and today) are indeed alarming. For instance in 1942 urban areas of Bengal had three and a half times more doctors as a ratio to population, in comparison to rural areas and in Sind this difference was as much as 49 times. (considering the fact that 90% population lived in rural areas) (I.14). Apart from the lack of availability the quality of medical aid provided was very low, especially for the poorer classes who had to travel considerable distances and spend a whole morning before they were seen by the doctor (I.15).

(iv) **Lack of General and Health Education:** General education is a pre-condition for health education, which together helps develop civic consciousness. This deficiency is responsible for a lack of environmental hygiene (I.16-17).

It must be clarified that the Bhore Committee did not view these causes as independent of each other. They were seen as being interrelated, and overriding these causes were **unemployment and poverty** which were considered by the Committee to constitute the **social background of ill-health.** "Unemployment and Poverty produce their adverse effect on health through the operation of such factors as inadequate nutrition, unsatisfactory housing and clothing and lack of proper medical care during periods of illness.... (therefore) our survey of the causes of ill health in India will not be complete without drawing attention to the profound influence that these factors exert on the health of the community" (I.17).

The above discussion clearly indicates that the health situation in the country at the time of the Bhore Committee was quite alarming, especially when we consider U.K's pre-war level of development as a minimal human standard. The Bhore Committee fixed a much lower standard in their recommendation for India's health development programs. These we feel were not unreasonable and definitely not an over-medicalised solution, as has been made out by various post-independence health committees.

THE POLITICAL ECONOMY OF A NATIONAL HEALTH PLAN

Having made an analysis of the health situation in the country in 'volume one' of the report the Bhore Committee begins its volume on recommendations (vol.II) with the following opening statement "A study of volume I of our report cannot fail to reveal the extent and intensity of the dark shadows in the health picture of the country. It is not for us to apportion responsibility for the sombre realities which face us today. It is with the future that we are concerned and if the picture is to be substantially altered for the better with the least possible delay, a nation-wide interest must be aroused and the irresistible forces of an awakened public opinion essayed in the war against disease. Only a vivid realization of the grievous handicap which is today retarding the country's progress can help to mobilize an all-out effort in this campaign and infuse into it a driving force which will gather and not lose momentum as time goes on. If it were possible to evaluate the loss, which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency through mal-nutrition and preventible morbidity, we feel that the result would be so startling that the whole country would be aroused and would not rest until a radical change had been brought about.

"...we feel that a `nation's health', using the term to signify that positive state of well being in which mind and body are able to function to their fullest capacity, is perhaps the most potent single factor in determining the character and extent of its development and progress. Expenditure of money and effort on improving the nation's health is a gilt-edged investment which will yield not deferred dividends to be collected years later, but immediate and steady returns in substantially increased productive capacity.... We feel we can safely assert that a nation's wealth prosperity and advancement, whether in the economic or the intellectual sphere, are conditioned by the state of its physical well-being. In regarding national health as the foundation on which our plan of reconstruction must be based if it is to yield optimum results, we feel we are merely repeating an axiomatic proposition. We need no further justification for attempting to evolve a comprehensive plan which must inevitably cover a very wide field and necessarily entail large expenditure, if it is to take into account all the more important factors which go to the building up of a healthy, virile and dynamic people" (II.1-2).

Armed with this philosophy, that had emerged from a scientific understanding of the health situation in India, the Bhore Committee formulated its recommendations and evolved a national health plan.

In designing this plan the Committee clearly indicated that the national health services would be an integral part of an overall program of reconstruction." We should be failing in our duty if we omitted to stress the composite character of the problem with which we are faced and to point out that a frontal attack upon one sector alone can only end in disappointment and a waste of money and effort .... we must ensure the conditions essential for healthful living in town and countryside. Suitable housing, sanitary surrounding and a safe-drinking water supply are the primary conditions for securing such a measure of environmental hygiene as is essential to ensure the pre-requisites of a healthy life.... (and above all) the elimination of unemployment, the provision of a living wage, improvement in agricultural and industrial production, the development of village roads and rural communications, as distinct from the great national highways now projected, are all so many facets of a single problem calling urgently for attention" (II.2).

The Bhore Committee made a global review of recent trends and developments in health care services. It looked at the developments in Britain, Australia, New Zealand, Canada, USSR and the USA and found an increased role of the state in providing health care. It concluded that the ferment of ideas arising out of the World War has resulted in an increasing awareness , on the part of governments and people, of the need for measures which will ensure social security, and health protection is becoming recognized as an essential part of social security. The idea that the state should assume full responsibility for all measures, curative and preventive, which are necessary for safeguarding the health of the nation, is developing as a logical sequence.... The modern trend is towards the provision of as complete a health service as possible by the state and the inclusion, within its scope, of the largest possible proportion of the community. The need for assuring the distribution of medical benefits to all, irrespective of their ability to pay, has also received recognition" (II.7,12).

The Bhore Committee, on the basis of the above review, concluded that health care services would be available to all citizens, irrespective of their ability to pay, and that it should be a complete medical service, domiciliary and institutional, in which all the facilities required for the treatment and prevention of disease as well as for the promotion of positive health are provided. Thus there should be provision for every patient, if his condition requires it, to secure the consultant, laboratory and other special services which may be necessary for diagnosis and treatment. There should also be provision for the periodical medical examination of every person, sick or healthy, so as to ensure that his physical condition is appraised from time to time and that suitable advice and medical aid, wherever necessary, are given in order to enable him to maintain his health at the highest possible level. (II.6)

Before the Committee proceeds to delineate its plan it discusses and clarifies three issues that emerge from the trend analysis in the context of India's political economy - whether the health services should be free, whether the service should be a salaried one and whether some measure of choice can be given to the patient as regards his doctor.

(i) Whether the medical service should be free or whether it should be paid for ? We feel that a very large section of the people are living below the normal subsistence level and cannot afford as yet even the small contribution that an insurance scheme will require. We therefore consider that medical benefits will have, in any case, to be supplied free to this section of the population until atleast its economic condition is materially improved. We are averse to drawing any line of distinction between sections of the community which are and are not in a position to pay for such benefits. The application of a "means test" for this purpose is unsatisfactory and may often involve inquisitorial enquiries. Such enquiries place an unpleasant duty on the officer making them and give rise to resentment and a sense

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consider, therefore, that for the present medical services should be free to all without distinction and that the contributions from those who can afford to pay should be through the channel of general and local taxation (II.14).

(ii) A salaried service as against a service of private practitioners. The absence of certain amenities and services in the countryside has proved a deterrent to medical practitioners leaving the attraction of cities and towns and migrating to the villages. Various attempts have been made to solve the problem. One method, which has been tried in more than one province, has been the settling of medical practitioners in rural areas and giving them a subsidy which will enable them to start practice. This subsidy was intended to be supplemented by private practice among the richer sections of the community. We have had considerable evidence to show that this method has been far from being an unqualified success, partly because in many villages the income derived from private practice is too small to support the doctor in reasonable comfort. The result has been that, in many cases, the better type of such subsidized doctors have tended to gravitate back to the towns. In areas where there are greater opportunities for private practice, the more prosperous sections of the community have, we are told, generally received greater attention than the poor. We have, therefore, come to the conclusion that the most satisfactory method of solving this problem would be to provide a whole-time salaried service which will enable governments to ensure that number of representatives of medical associations, by private individuals and by several responsible medical administrators lends strong support to this proposal (II.14-15).

Further, if the poor in the rural areas must receive equal attention and if preventive work must get done then private practice by whole-time salaried doctors should be prohibited (II.5).

(iii) Freedom of choice of a doctor - theoretically the patient will be free to take treatment in any state institution. But in practice for his own convenience he would go to the nearest available. His choice would widen with the expansion of health care facilities.(II.16) Concluding this discussion the committee categorically states that "we are satisfied that our requirements can only be met satisfactorily by the development and maintenance of a state health service" (II.13).

The National Health Plan

Keeping in view the socio-economic and health conditions in India the Bhore Committee set itself the [illegible] be achieved through the plan they were formulating:

1) the services should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health;

2) these services should be placed as close to the people as possible, in order to ensure their maximum use by the community which they are meant to serve;

3) the health organization should provide for the widest possible basis of co-operation between the health personnel and the people;

4) in order to promote the development of the health program on sound lines the support of the medical and auxiliary professions, such as those of dentists, pharmacists and nurses, is essential; provisions should, therefore, be made for enabling the representatives of these professions to influence the health policy of the country;

5) in view of the complexity of modern medical practice, from the stand-point of diagnosis and treatment, consultant, laboratory and institutional facilities of a varied character, which together constitute "group" practice should be made available;

6) special provision will be required for certain sections of the population, eg., mothers, children, the mentally deficient and others;

7) no individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it and

8) the creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement or recreation, are essential (II.17).

The Bhore Committee further recognized the vast rural-urban disparities in the existing health services and hence based its plan with specifically the rural population in mind. It's plan was for the district as a unit. "Two requirements of the district health scheme are that the peripheral units of the (health) organization should be brought as close to the people as possible and that the service rendered should be sufficiently comprehensive to satisfy modern standards of health administration" (II.22).

The district health scheme, also called the three million plan, which represented an average districts population, was to be organized in a 3-tier system "in an ascending scale of efficiency from the point of view of staffing and equipment. At the periphery will be the primary unit, the smallest of these three types. A certain number of these primary units will be brought under a secondary unit, which will perform the dual function of providing a more efficient type of health

service at its headquarters and of supervising the work of these primary units. The headquarters of the district will be provided with an organization which will include, within its scope, all the facilities that are necessary for modern medical practice as well as the supervisory staff who will be responsible for the health administration of the district in its various specialized types of service" (II.22).

This health organization would provide integrated health services curative, preventive and promotive - to the entire population. "The health organization is expected to produce a reasonably satisfactory service for rural and urban communities alike. It is based mainly on a system of hospitals of varying size and of differing technical efficiency. The institutions will play the dual role of providing medical relief and of taking an active part in the preventive campaign" (II.30).

In this paper we will discuss only the long term programme which was to be realized within a period of 30 to 40 years (II.35). That is, by the early eighties all the facets of the Bhore Committee should have been realized. We are now in the year 1990 and very well know (and it is very humiliating to know) that we are nowhere close to what the Bhore Committee had recommended in 1946 as the minimum requirements for a decent health care delivery system. This embarrassment is only enhanced when we discover that these recommendations of the Bhore Committee were far lower than the level most developed countries had reached on the eve of World War II !

What was this level of health care envisaged by the Bhore Committee? Stated in terms of ratio to a standard unit of population the minimum requirement recommended was :

567 hospital beds, 62.3 doctors, 150.8 nurses per 100,000 population.

As a contrast to this in 1942 in the United kingdom these ratios were :

714 beds, 100 doctors, 333 nurses per 100,000 population.

And in India of 1988 these ratios lagged at :

76.3 beds, 42.9 doctors per 100,000 population (100 per 100,000 if we include non-allopaths), 28.7 nurses per 100,000 population.

The three tier plan of health organizations was as follows : (II.17-34, III.3,4)

Primary Unit

Every 10,000 to 20,000 population (depending on density from one area to another) would have a 75-bedded hospital served by six medical officers including medical, surgical and obstetrical and gynecological specialists. This medical staff would be supported by 6 public health nurses, 2 sanitary inspectors, 2 health assistants and 6 midwives to provide domiciliary treatment. At the hospital there would be a complement of 20 nurses, 3 hospital social workers, 8 ward attendants, 3 compounders and other non- medical workers.

Two medical officers along with the public health nurses would engage in providing preventive health services and curative treatment at homes of patients. The sanitary inspectors and health assistants would aid the medical team in preventive and promotive work. Preferably at least three of the six doctors should be women.

Of the 75 beds 25 would cater to medical problems, ten for surgical, ten for obstetrical and gynecological (ob. & gy.), twenty for infectious diseases, six for malaria and four for tuberculosis.

This primary unit would have adequate ambulatory support to link it to the secondary unit when the need arises for secondary level care.

Each province was given the autonomy to organize its primary units in the way it deemed most suitable for its population, but there was to be no compromise on quality and accessibility. Hence, a highly dense province like Bengal may have a primary unit for every 20,000 population but a province like Sind (now in Pakistan) or Central Provinces which have a highly dispersed population may have a primary unit for every 10,000 or even less population unit. The deciding factor should be easy access for that unit of population.

Secondary Unit

About 30 primary units or less would be under a secondary unit. The secondary unit would be a 650-bedded hospital having all the major specialities with a staff of 140 doctors, 180 nurses and 178 other staff including 15 hospital social workers, 50 ward attendants and 25 compounders. The secondary unit besides being a first level referral hospital would supervise both the preventive and curative work or the primary units.

The 650 beds of the secondary unit hospital would be distributed as follows:

Medical	:	150
Surgical	:	200
Ob. & Gy.	:	100
Infectious Diseases	:	20
Malaria	:	10
Tuberculosis	:	120
Pediatrics	:	50
		650

District Hospital

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Every district centre would have a 2500 beds hospital providing largely tertiary care with 269 doctors, 625 nurses, 50 hospital social workers and 723 other workers. The hospital would have 300 medical beds, 350 surgical beds, 300 ob.& gy beds 540 tuberculosis beds, 250 pediatrics beds, 300 leprosy beds, 40 infectious diseases beds, 20 malaria beds and 400 beds for mental diseases.

A large number of these district hospitals would have medical colleges attached to them. However, each of the three levels would have functions related to medical education and training, including internship and refresher courses.

Special Services

In addition to this basic infrastructure the Committee recommended a wide range of other health programs, keeping in mind the special problems that India faced due to its economic and political conditions, that would provide support and strength to this health organization.

Certain **diseases** were singled out for special inputs that would be required to control and/or eradicate them. They were singled out because they constituted a major problem then (See box). And most of them 45 years later still constitute a major problem in the country. These diseases were malaria, tuberculosis, small pox, cholera, plague, leprosy, veneral diseases, hook-worm disease, filariasis, guineaworm disease, cancer, mental diseases, mental deficiency and diseases of the eye and blindness.

For all these diseases the Committee found that facilities are grossly inadequate and need urgent attention - proper sanitation and other public health measures are the key to eradicate or control such diseases (I.88-132). For instance in the control of cholera three measures are essential (a) provision of protected water supply (b) satisfactory disposal of nightsoil and (c) sanitary control over the production, distribution and sale of food (I.112). Similarly, inadequate sanitary measures can precipitate malaria as happened in the Sukkur Barragae and Mettur irrigation projects where the failure to make provision of adequate drainage to prevent marshy conditions resulted in large scale outbreak of malaria in regions which were previously free from it (I.91).

A review of **environmental hygiene** by the committee indicates inadequate and poor quality town

Some estimates of various diseases

Malaria : In 1935, 100 million cases recorded with a fatality rate of 8 per 1000 cases; totally about one million deaths due to malaria occur annually in endemic areas and another quarter to half million in epidemics; between the years 1932 and 1941 average annual mortality from malaria was 2.4 million or 37% of all deaths (I.90).

Tuberculosis : In 1935 about 10 to 20% of mortality from all fevers and 20% of all respiratory tuberculosis diseases are estimated to be due to pulmonary tuberculosis; on the basis of this the mortality from tuberculosis was estimated between 456,647 and 818,934 annually; for every death due to tuberculosis there were atleast 5 active cases of tuberculosis; thus, for an average of 500,000 TB deaths an estimated 2.5 million TB cases existed in India (I.97).

SmallPox : Between 1932 and 1941 average number of deaths due to small pox were 69,474 per year; the mortality among infants and children of one to ten years was very high - between 1937 and 1941 the mortality from small pox of these age groups ranged between 12.1% to 19.7% and 19.2% to 30.5%, respectively (I.109).

Cholera : Between 1877 and 1941 deaths due to cholera (5 year smoothed averages) have ranged between 141,000 to 444,000 per year (I.111-112); the 1904 epidemic, however, claimed a whopping 1.15 million deaths in a single year (I.114).

Leprosy : An estimate of one million patients in India (I.117), of which 20% were lepromatous cases (I.118); there were 95 institutions with 14,000 patient accommodation when 250,000 cases needed isolation (I.119).

Veneral Disease : In 1933 there were an estimated 5.5 million cases of syphilis and 7.6 million cases of gonorrhea (I.123).

Mental Disease : An estimated 8 lakhs to 1 million population requires hospitalization for various mental diseases whereas only 10,189 beds are presently available; the estimate for mental deficiency in addition is 1.6 million population (I.130-131).

Hookworm Disease : According to a survey in 1925-27 large endemic pockets of hookworm infection existed in India, especially in mining and plantation areas; in many of the endemic areas 60 to 80% of the population were infected with this condition (I.126-127).

and village planning, housing, water supply and general sanitation (I.133 to 146). This is a cause for concern because without this medical relief has little meaning. Hence, a social disease such as tuberculosis can be combated successfully only if ameliorative measures on an extensive scale can be undertaken so as to improve the general standard of living, including housing, nutrition and sanitation of the environment in the home, the workplace and places of public resort (I.103).

Hence the need to organize special programmes of public health especially with regard to the diseases mentioned above.

In the case of **malaria** the setting up of an anti-malaria organization was advocated which would function through the primary units under the provincial malaria organization. Malaria control units under a specially trained doctor with a complement of assistants and fieldworkers was envisaged by the committee for both preventive and curative work (II. 147-151). As indicated earlier hospital beds were provided at each level of the health organization for malaria patients who needed hospitalization.

The attack on **tuberculosis,** advocated the committee, must be in two directions (a) towards an improvement of the socio-economic conditions, as mentioned in an earlier paragraph, and (b) towards an effective control of the spread of infection from patients to those who are healthy. The importance of measures to improve living conditions has been amply demonstrated in other countries where, even before anti-tuberculosis measures were instituted, the mortality from the disease began to fall as the result of a rise in the general standard of living. While such measures are no doubt important, a direct attack on the reservoirs of infection is equally necessary (II.158).

In order to provide a comprehensive and integrated service the tuberculosis organization should include (i) a domiciliary service (2) clinics (3) hospitals (4) aftercare colonies (5) homes for incurables and, in addition, (6) certain ancillary welfare services (II.159). These services would be developed as an integral part of the health organization. As far as possible the treatment should be through clinics and home isolation but where this is not possible then hospitalization should be resorted to. Special emphasis has been placed by the committee on after-care and welfare, especially for wage-earners who need an improved home and work environment after their cure, and while they are bed ridden and unable to work, then measures for their family support will need to be taken. This must be done both by the government and voluntary organizations (II.159-166).

For **small-pox** eradication it was recommended that in the first year of the implementation of the committee's plan the entire population should be covered with primary vaccination. Since this is a simple operation no special staff is needed. All paramedics of the primary units can be trained for this purpose. This operation can be repeated every five years for revaccination (II.172).

Measures needed to control **cholera** have already been referred to in an earlier paragraph. The primary units would be geared up to be in a position to tackle this problem where isolation, treatment and immunization is concerned, but ultimately wide ranging sanitary measures, protected water supply and environmental hygiene only will prevent the occurrence of cholera (II.176-180).

The same is true about **plague.** Plague control vests largely outside that of the health organization. Improved sanitary conditions and rat-proof dwellings and food godowns are the measures needed to prevent excessive breeding of rats (II.183).

As in the case of malaria the Bhore Committee recommended a separate organization for **leprosy** also. This would of course function as an integral part of the health organization. Out-patient treatment would be provided through the primariy units whereas in-patient care was envisaged at the district headquarter level where group isolation would be more feasible. The Bhore Committee also envisaged an important role of voluntary organizations in the anti-leprosy effort and recommended that they must be encouraged even further (II.190).

Syphilis and gonorrhea needed to be tackled at two levels (a) provision of medical care and (b) discouragement of promiscuity and prostitution. The former has to be tackled by the health organization but for the latter the committee recommended sex education in schools and colleges and enforcement of severe penalties on brothelkeepers (II.198,200-201). Further the Committee recognized that prostitution being a problem of poverty also needed to be tackled by providing employment opportunities for women.

Mental illness and deficiency is another wide spread problem that needs to be tackled by creating a separate mental health organization that would oversee and implement care and treatment of mental patients through the general health organization (II.211).

The other diseases, referred to earlier, like guinea worm-disease, filariasis, hookworm infestation, cancer and blindness, too would need certain special inputs in the health organization and the committee has provided for this in their national health plan.

Some of the other special considerations which the Committee has deemed necessary to spell out

separately are environmental hygiene, public health engineering, housing, health education, health services for mothers and children, health services for school children, industrial health service and the population problem.

Similarly the Committee has worked out details for medical education, medical research, vital statistics and administration.

We will not go into the details of the Committee's recommendations on all these matters. We will deal briefly with health services for mothers and children and the industrial health service only with the purpose of highlighting the fact that the Bhore Committee Plan was not only highly progressive and comprehensive but also designed to suit India's socio-economic conditions.

Health of Mothers and Children: "Our ultimate aim should be not merely to safeguard maternity but also to provide adequate health protection to all women, in order to ensure that the function of motherhood is undertaken under optimum conditions of health. Special services for the protection of maternity will no doubt be required, but these services should be developed as parts of the wider organization for providing adequate health protection to all women" (II.98). Keeping this principle in mind special services were recommended by the Committee for the health of mothers and children within the framework of general health services. The facilities available at the primary unit would enable the establishment of a maternity and child welfare centre which would have the following functions :

(1) To get in touch with as many pregnant women in the area and to persuade them to visit the clinic regularly. On the first visit a detailed examination of the expectant mothers general and obstetric, should be made and a record of her medical history kept. At subsequent visits advice in respect of the hygiene of pregnancy and instruction regarding diet will be given. Further, it should be possible to make an early diagnosis of any deviation from normal health, to give appropriate advice and timely treatment for such diseases as tuberculosis, syphilis, anaemia and toxemias of pregnancy or to refer the patient to institutions of specialists for medical attention.

(2) To provide for the skilled assistance of a midwife or trained dai at the time of delivery and for domiciliary visits by a public health nurse for two weeks thereafter. A record of the confinement and of immediate postnatal history should be added to the card of the mother and a new one opened for the infant.

(3) To keep the mother and child under observations, if possible, for a year. It is desirable to keep a weekly weight record of the infant. Advice to the mother should be given in respect of lactation, diet and exercise and, at a later stage, in respect of weaning. Treatment, where necessary should be given and extra nourishment to mother and child should be made available, if required.

(4) To teach mothercraft in all its branches with practical demonstrations, special emphasis being laid on the inculcation of sound hygienic habits in the mother and child.

(5) To keep children under observation, if possible, upto five years, weight and progress records should be kept. From the second year onwards monthly visits would suffice, but mothers should be instructed to report any illness arising between visits to the clinic and a domiciliary visit by a doctor should, in such cases, be arranged.

(6) To organize occasional talks, by suitable persons, for husbands and fathers in order to secure their cooperation,

(a) in the care of their women, especially during pregnancy,

(b) in the advisability of spacing the births of their children,

(c) in child-psychology,

(d) in aiding their wives in the maintenance of hygienic surroundings and in providing a well balanced diet for the family and

(e) in the development of the faculties of children by means of manual occupations, special toys, games etc....

(7) To give instruction on birth control (II.100).

Besides the above the Committee recommended provisions for a playground for children at the centre with adequate facilities that would make it a social activity area for mothers and children through which health and social education can be imparted by trained social workers (II.101).

The Committee also recommended the establishment of nurseries on the lines of those that had been set up in the Soviet Union. These nurseries should develop as an integral part of the child-welfare organization: Its aims would be not only to provide proper education to the mothers and children but to also provide support in child care during the mother's working hours (II. 105,106) .

And finally the Bhore Committee recommended a maternity benefit scheme that would help the pregnant and nursing woman to overcome the strain resulting from the overwork that she is invariably

subjected to. The Committee recommended compulsory abstention from work for working women six weeks prior and six weeks after delivery alongwith a grant of a maternity benefit. This could start first with industrial workers, then be gradually extended to all working women. It is heartening to note that the Bhore Committee did not forget the housewife who is "subject to undue physical strain in the discharge of (her) household duties". For such women the Committee recommended a system of 'home-help' by the public authority as was being practiced in progressive countries. (II.105)

Industrial Health Service: "It seems correct to hold that, over and above the general provision for health protection which the worker can share with the other members of the population, he has the right to claim that special measures should be taken to counteract the adverse effects of those factors which are associated with his occupation. The provision of such special health measures is the function of an industrial or occupational health service. We believe that to a greater or lesser extent, all those who are gainfully employed outside their own homes will require the services of the occupational health organization" (I.71).

The Committee reviewed the morbidity and mortality among industrial workers (I.73-74), medical relief and safety (I.74-77), working conditions (I.77-79), housing and living conditions of workers (I.80-81), nutrition of workers, hours of work, transport facilities, rest shelters, alcoholism and drug addiction (I.81- 84), special problems of women workers (I.84-85), Factories Act and Inspection, industrial zoning, unregulated factories and so on (I.85-87). Their evidence indicated deplorable conditions all over the country but it has cited a few exceptions to serve as examples in developing services for workers.

The proposed industrial health service will not minister to the general medical needs of the workers. This function will have to be performed by the service for the community as a whole. The industrial health organization is intended to meet the needs of the worker in respect to that group of factors affecting the health which are associated with the occupation he pursues. The two services are complementary to each other and will together provide him with adequate medical care. The industrial health organisation should form an integral part of the provincial health department and should be developed as such (II.125).

The aims of such an industrial health service should thus be as follows:

(a) to promote the general health of the worker by the provision of a good working environment by fitting the worker to that environment;

(b) to prevent occupational disease;

(c) to assist in the prevention of injuries at work;

(d) to organize and supervise a service for the emergency treatment and care of injured and sick workers at their place of work;

(e) to take an active part in the restoration to full working capacity of workers disabled by injury or disease and resettlement of workers suffering from permanent disability;

(f) to educate workers in the preservation of health and promotion of well being and

(g) to promote research and investigation (II.123).

The Bhore Committee also made it clear that, though this service must be the responsibility of the Provincial Health Department, the employer must be made to contribute considerably because he will gain the most out of this provision through reduced absenteeism and higher productive capacity of the workers. The Committee hence recommended that the employer and government together must be responsible for meeting the cost of the proposed industrial health service and that the worker should be exempt from being made to pay for it. However, a central health insurance fund could also be created to provide additional support and resources for such an organization (II.126-127).

The discussion so far provides adequate evidence of not only the progressive and comprehensive nature of the national health scheme but also shows that the plan is based on a seriously studied and documented picture of the health situation of the country. We would also like to add here that the Bhore Committee's analysis and recommendations go into even very minor details and at the same time offer adequate flexibility in implementation. We have not gone into these details in this paper because the purpose here is limited to highlighting the plan and show its relevance even today.

Financing of the National Health Services

At the time of the Bhore Committee the amount of expenditure for medical relief and public health by the state was very small. It ranged from (in 1944-45) a low of 2.8 annas (or 16.8 paise per capita in Central provinces and Berar to a high of 10.9 annas (0r 65.4 paise) in the Bombay Province which was 3.1% and 4.5%, respectively, of total provincial government expenditure (II.514).

The Bhore Committee comments that in Great Britain in 1934-35 (prior to NHS) the government was spending as much as 20.4% of their total expenditure on health care services. Even the United States government spent 13.8% of its total expenditure in

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1938 on health services. It is hence obvious that governments in India have been spending an unduly small proportion of their incomes on health administration and there is therefore every justification for demanding that the ratio of expenditure under this head must be raised considerably. The government should be prepared to increase the money spent on health to atleast 15% of the total expenditure (II.514).

The development of the plan as envisaged by the Committee would cost the government as little as Re 1 and annas 14 (Rs.1.87) per-capita per year in the first ten years (1945-46 prices) on recurring expenditure and Re. 1, anna 1 and paisa 5 (Rs. 1.11) per capita per year on non-recurring expenditure. The former would be spent from state revenues and the latter from loans. (the recurring cost includes amortisation payments for non-recurring expenditure) (II.510). This would have amounted to only 1.33% of GNP. The distribution of the recurring and non-recurring expenditure as worked out by the Committee is given in Table III (III. 247-249).

Table III : Distribution of Expenditure for various Health Programs

Health Programs	(Percentages) Heads of Expenditure		Non-Recurring	Recurring
3 million unit scheme	51.34	(primary unit 26.32)	50.18	(primary units 26.54)
Central & Provincial Directorates	—		1.48	
Malaria Organisation	1.75		1.06	
Tuberculosis			2.63	
Mental Disease	1.07		2.41	
Veneral Disease	—		1.31	
Leprosy	0.78		1.57	
School Health	0.02		0.20	
Nutrition				
Professional Education	11.72	(Doctor=8.02 Nursing=2.31)	11.17	Graduate (Doctors =4.97 Nursing =3.45 Scholarships =1.10)
Water Supply & Drainage	27.55		2.29	
Health Education	—		0.05	
Industrial Health Service	—		0.29	
Medical Research	0.11		0.18	
Leave Reserve for Personnel	—		3.80	
Contribution of Centre	5.66		4.72	
Amortisation payments for non-recurring exp.	—		16.66	
TOTAL	100.00		100.00	

Note: These percentages are based on the plan's first ten years expenditure estimates. The total expenditure worked out for the rst ten years. (i.e. short term plan) was Rs. 9640 million (recurring and non recurring).

From the percentage distribution of the national health schemes expenditure it is clear that a little more than half of the total (both in case of recurring and non-recurring) would go to the three million unit schemes which forms the core of the plan; and over one-half of this would be spent on Primary units that would provide health services at virtually the doorstep of the population.

The other major head of expenditure is professional medical education which has been allocated 11% of the plan's share. Of this nearly half would be spent on the education and training of doctors and about one-third on nursing education (in the case of non-recurring cost 68% of professional education expenditure would be for training of doctors).

On the non-recurring side water supply and drainage have been allocated a major share. By its nature it is largely a capital expenditure and the recurring costs are mainly charges for maintenance of the system.

An interesting component of expenditure of the Bhore Committee's plan is provision for housing accomodation for all health staff involved in the three million unit scheme. This expenditure (on the non-recurring side) is 30% of total non-recurring expenditure and a whopping 58.52% of the three million unit non-recurring expenditure (III.253-254, 290).

Two other important items (on the recurring side) are salaries and drugs. In the three million unit scheme salaries constitute 69.39% of the total expenditure on the three million units and drugs 7.04%. (III.263-265). Of course, this is only for the 3 million units scheme. Salaries and drugs would also be important components in the other schemes of the Bhore Committee Plan.

Finally, the Bhore Committee strongly recommends that it should be a statutory obligation on governments to spend a minimum of 15% of their revenues on health activities (II.515). The plan set out by the Bhore Committee averages about 12% of government expenditure over the 1st ten year period for which the Bhore Committee has given the financial outlays. In describing financial outlays the Bhore Committee goes into minor details for each province - with details of each type of staff, equipment etc. It should suffice here to say that the plan was 'bottom-heavy' and that rural and urban areas have been dealt on an equal treatment, ofcourse with a little bias towards rural areas which had to catchup with facilities that urban areas already had.

The Bhore Committee ends its report on a clear note of urgency for implemenation of the plan in its full form. "The existing state of public health in the country is so unsatisfactory that any attempt to improve the present position must necessarily involve administrative measures of such magnitude as may well seem to be out of all proportion to what has been conceived and accomplished in the past. This seems to us inevitable, especially because health administration has so far received from governments but a fraction of the attention which it deserves in comparison with other branches of governmental activity. We believe that we have only been fulfilling the duty imposed on us by the Government of India in putting forward this health programme, which can in no way be considered as extravagant either in relation to the standards of health administration already reached in many other countries or in relation to the minimum requirements of any scheme which is intended to demonstrate an appreciable improvement in the health of the community. For reasons already set out, we also believe that the execution of the scheme should not be beyond the financial capacity of governments.

"We desire to stress the organic unity of the component parts of the programme we have put forward. Large-scale provision for the training of health personnel forms an essential part of the scheme, because the organisation of a trained army of fighters is the first requisite for the successful prosecution of the campaign against diseases. Side by side with such training of personnel, we have provided for the establishment of a health organisation which will bring remedial and preventive services within the reach of the people, particularly in the rural areas. Considerations based on inadequacy of funds and insufficiency of trained workers have naturally necessitated the suggestion that the new organisation should first be established over a limited area in each district and later extended as and when possible. Even with such limitations the proposed health service is intended to fulfil, from the beginning and in an increasing measure as it expands, certain requirements which are now generally accepted as essential characteristics of modern health administration. These are that curative and preventive work should dovetail into each other and that, in the provision of such a combined service to the people, institutional and domiciliary treatment facilities should be so integrated as to provide the maximum benefit to the community. There should also be provision in the health organisation for such consultant and laboratory services. Our proposals incorporate these requirements of a satisfactory health service.

"We have drawn attention to these aspects of the health programme because we feel that it is highly desireable that the plan should be accepted and executed in its entirity. We would strongly deprecate

any attempt, on the plea of lack of funds, to isolate specific parts of the scheme and to give effect to them without taking into consideration the interrelationships of the component parts of the programme. Our conception of the process of the development of the national health services is that it will be a cooperative effort in which the centre acting with imagination and sympathy, will assist and guide a coordinated advance in the provinces. We therefore look forward to a pooling of resources and personnel, as far as circumstances permit, in the joint task that lies before the governments" (II.516-517).

Relevance of Bhore Committee Today

Health services today are as inadequate and underdeveloped as they were during the time of the Bhore Committee. The analysis of the health situation by the Bhore Committee in the early forties would hold good if a similar enquiry is undertaken today, nearly half a century later. The enclave pattern of development of the health sector continues even today - the poor, the villagers, women and other underpriviledged sections of society, in other words the majority, still do not have access to even basic health care.

Instead of the national health care services that the Bhore Committee had envisaged, which would be available to one and all irrespective of their ability to pay, further modification of health care services took place strengthening the operation of market forces in this sector.

It is true that mortality has declined, but there is no evidence of, decline in morbidity. One suspects that the latter must have increased manifold due to mortality reduction. Infact the little evidence of classwise mortality differentials indicate that mortality decline among the poorer sections is only marginal. The aggregate figures are biased by the favourable conditions that the top 20% of the population has carved for itself. It is this improvement that reflects the aggregate improvements in all spheres of India's development.

The recommendations of the Bhore Committee were not rejected outright by the governments of Independent India. The principles were accepted in the First Five Year Plan but the contents were very selectively focused. The rest is history.

Forty years later we see that only one target of the Bhore Committee's recommendations was realised i.e., the production of doctors. But the unfortunate aspect of this development is that these doctors have been produced not for the `salaried service' in the national health plan that the Bhore Committee had envisaged but for adding to the ranks of private medical practitioners. What is even more unfortunate is that these private medical practitioners have been produced at the expense of the public exchequer and they profit from the practice of medicine without any significant state regulation of their activity.

The other recommendations of the Bhore Committee have been gradually diluted and unfocussed. For instance the Primary Health Centre which we have at present is not even an apology of what the Bhore Committee had outlined - the 75-bedded Primary Health Unit with six doctors, 20 nurses, 6 public health nurses and a host of other paramedic staff catering to a 10,000 to 20,000 population then proposed, as against a six bedded primary health centre with one doctor, 1 nurse midwife, 1 public health nurse, 6 auxiliary nurse midwives and 6 Male Multipurpose Workers for a 30,000 to 80,000 population now existing. It will only add to the humiliation if we compare the other recommendations to the achievements today!

Another aspect of the health sector, besides production of doctors, which has developed considerably is the production of drug formulations, especially in the private sector. It is logical that this should develop to support the large mass of private medical practitioners. Even the production of pharmacists has increased phenomenally from 1 pharmacist to 4 million population in 1942-43 to 1 pharmacist to 3500 population in 1987. The Bhore Committee, for reasons not known, did not pay any significant attention to this aspect of the health sector, except mentioning that a combination of public & private enterprise should take responsibility of producing drugs and the former should monopolise biological products required for prevention and treatment of epidemic diseases (II. 452). What was possibly implicit in the brief discussion of the Bhore Committee regarding this issue was that drug production globally was controlled by a few companies and the development of an Indian drug industry in the near future was a difficult proposition.

To conclude this paper we will not discuss why the Bhore Committee recommendations were not implemented but will instead argue in favour of a national health service based largely on the plans of the Bhore Committee report.

Universal coverage of the population through some health plan is historically well entrenched today, whether this be through health insurance or state run health services. There is no developed country, whether capitalist or socialist, which has not ins ıred through either of the above means or a combination of a minimum standard of health care for its population. In socialist countries the state provides health care, among other `social services', as a basic right of the citizen. In capitalist countries social

security has evolved under the concept of a welfare state and health care is one of the prominant elements.

India was fortunate in having a National Health Services plan prior to independence but it missed the bus. Inadequate resources may appear to be a strong reason for not implementing the Bhore Committee plan but when resource allocations are studied carefully we clearly see that financial resources were largely committed to areas which helped the development of capitalism. The focus was clearly in that direction leaving for the `social services' like health, education and housing only residual resources. Over the years more than 80% of plan resources have been allocated to `economic services' whose benefits have been appropriated by a small class of capitalist farmers and the bourgeoisie. For instance, most of the resources expended on agriculture and irrigation have benefitted the rich and middle peasantry and agri-business (fertiliser, pesticide and modern farm implements industry). The development of power, basic or infrastructure industry, transport and communication has largely helped industrial capitalism to prosper, with the public sector industry invariably absorbing vast losses.

The same pattern of expenditure is seen in the expending of revenue resources of the state. The `Economic Services' and `non- development expenditure' (defence, police and administration) eat away more than 80% of these resources leaving only a mere lip-service worthiness for the social services sector. We will not extend this explanation further because it is very well documented by various scholors.

Given the subsistence or even below subsistence standard of life in India, the demand for a national health service assumes a great urgency, and hence resource constraint cannot be an issue. In such a socio-economic setting the state's responsibility in providing a free minimum standard of health care alongwith other `social services' becomes even more important because the majority of the households do not have a surplus, after spending on their basic necessities such as food, clothing, water and shelter to take care of their basic social needs such as education and health care. Hence the demand for a national health service is justified on just this ground, let alone other reasons.

The Bhore Committee provides a wide framework to develop a national health service. And we feel that with suitable modifications to accomodate present conditions and considerations a national health service can be evolved within a single plan period.

One of the main arguments against a national health service is that public medical institutions that presently exist are both inefficient and inadequately provided, besides being impersonal and corruption ridden. This may be true to some extent but this simple argument can be easily countered by showing that the inefficiency and inadequacy of public hospitals is largely due to the existence of the private health sector. If there was no private health sector then the public services would have no choice but to function properly and people, as well as the state, would ensure this because the alternative private health sector would not be there.

It is well established that state monopolies function quite smoothly and efficiently and many also make huge profits that even large private corporations envy. The public sector petroleum industry (ONGC, Indian Oil etc.), for instance, make whopping profits. Similarly public services like railways, electricity supply, water supply, telephones, public road transport, banking etc. function quite efficiently and provide people a fairly adequate services where they exist. We are not saying that they don't have problems or they are running at optimal efficiency. All we want to point out is that a public sector monopoly can deliver goods, provided the private sector doesen't have vested interests attached to it. For example, a large number of state infrastructure industry make heavy losses not because they are inefficient but because they provide subsidised inputs to the private industrial sector. We would like to round off this argument by saying that today most of the large and medium private corporations are thriving with resources of public financial institutions like UTI, LIC, public sector banks etc. Thus there should be no constraint on finances for setting up a national health service.

The support for privatisation has gained strength in the last one year with perestroika and glasnost in the socialist countries. In India the health sector too has got caught in this wave and beginnings have been made with the introduction of user-charges in public health institutions. The small mercies that the underpriviledged had in the form of free public health services too seem to be getting out of their reach. This must be prevented and countered, and the demand for a national health service must become vociferous before the corporate and HMO type of `health revolution' takes over in India and uproots the small legacy of public health services we already have. We have to demand that health becomes a right which the state must provide for unconditionly from the revenues it collects from citizens. The Bhore Committee report, though nearly half a century old, gives us the basic foundation from which we can build the apparatus of a national health service.

Resolutions of the National Planning Committee
on the Report of the Sub-Committee on National Health

An Extract:

The Interim Report of the Sub-Committee on National Health was presented by the Chairman, Col. S.S. Sokhey, on the 30th and 31st August, 1940 where the following Resolutions were adopted:-

1. For the purpose of raising the standards of public health in the country, and for the prevention of disease, it is essential that dietary standards should be substantially raised and made adequate and better balanced. In this connection, the N.P.C. notes the specific recommendations of the Sub-Committee, and resolves that they be placed before the National Planning Commission.

Note:- The specific recommendations are that the dietary standards laid down by the technical Commission of the Health with a permissible reduction of 8 per cent, be accepted for India. These provide a basic diet of 2,400 calories for an average adult, with suitable additions proportioned to the nature and strain of the work.

2. India should adopt a form of health organisation, in which both curative and preventive functions are suitably integrated, and administered through one agency.

3. Such an integrated system of health organisation, can be worked only under State control. It is, therefore, recommended that the preservation and maintenance of the health of the people should be the responsibility of the State.

4. For the proper functioning of such an organisation, medical and health research in the widest possible field is essential. This research should, therefore, form an important function of a Health Organisation; and this should include the application of the scientific method for the investigation of the indigenous and other methods for the maintenance of health, and the prevention and cure of diseases.

5. In view of the paucity of qualified medical men and women in the country, it is necessary to increase rapidly and substantially their number. For this purpose it is necessary to organise a large number of training centres.

6. In addition to the above, and as an immediate step in order to meet the special conditions prevailing in India, we recommend the training of large numbers of Health Workers. These Health Workers should be given elementary training in practical, community, and personal hygiene, first-aid, and simple medical treatment, stress being laid on the social aspects and implications of medical and public health work. There should be one Health Worker for every thousand of the population, and this number should be attained within five years. Selected Health Workers should be given further training at suitable intervals so that they might be better trained for this service.

7. There should be ultimately one qualified medical man or woman for every 1000 of population, and one bed for every 600 of the population. Within the next ten years the objective aimed at should be one medical man or woman for every 3,000 of population, and a bed for every 1,500 of population. This should include adequate provision for maternity cases.

8. The medical and health organisation should be so devised and worked as to emphasise the social implications of this service. With this object in view the organisation should be made a free public service, manned by whole-time workers trained in scientific method. To give effect to this aim, a Chair should be established in every medical school for special training in the social or service aspect of Medicine and National Health.

9. Adequate steps be taken to make India self-sufficient as regards the production and supply of drugs, biological products, scientific and surgical apparatus, instruments and equipment, and other medical supplies.

10. A Pharmacopoeia Committee should be appointed to draw up an Indian pharmacopoeia. In order to carry out this object adequately, research should be particularly intensified to determine the action of drugs traditionally used in India.

11. No secret remedies, or remedies whose exact composition is not stated on the labels of the containers in the clearest possible terms, should be allowed to be sold.

Proprietary remedies whose composition is clearly indicated, may, however, be allowed to be sold under proper State supervision.

12. No individual or firm, Indian or foreign, should be allowed to hold patent rights for the preparation of any substances useful in human or veterinary medicine.

The State should encourage and endow research and suitably recognise and reward those who achieve successful results.

Note:- Mr Ambalal Sarabhai is of opinion that such patents

should be treated on the same basis as copyright in books or industrial patents.

13. An attempt should be made to absorb the practitioners of the Ayurveda and Unani systems of medicine into the State health organisation by giving them further scientific training where necessary. Medical training in every field should be based on scientific method.

Note:- Mr Nanda was of opinion that other systems , such as homoeopathy and naturopathy, should also be included in this by addition of the words "and other systems." It was pointed out, however, that no exclusion was intended in the resolution but stress was laid on the necessity of the scientific method and training.

CHRONOLOGY OF HEALTH COMMITTEES 1940 - 1981

***Compiled by Manish Mankad**

This article attempts to give a brief note on some of the selected committees set up in the field of health since 1940 in India.

1) **The Health Survey and Development Committee.** – Sir Joseph Bhore (Chairman); Oct. 1943.

It undertook the following tasks :

a) a broad survey of the present position in regard to health conditions and health organisations in British India, and

b) recommendations for future development.

2) **National Health** (National Planning Committee Series), Col. S.S. Sokhey (Chairman), 1948.

This document on national health is the report of one of the various subcommittees set up by the national planning committee of the Congress in 1938.

The terms of reference of the subcommittee on public health were:

(i) Prescribing standards of dietary and nutrition for all classes of population.

(i) Consideration of the nature and incidence of the various epidemics which take a heavy toll of life and suggesting ways and means of guarding against these.

(iii) Investigation into the volume and cause of infant mortality as well as mortality among women, and suggesting ways and means of reducing such mortality.

(iv) Provision of the necessary health units comprising physicians nurses, surgeons hospitals and dispensaries, sanitoria and nursing homes.

(v) Health insurance.

vi) Medical training and research

(vii) Compilation of vital statistics including those of birth and death rates.

(viii) Cultivation of the necessary drugs and production of medicines to provide the necessary preventive or curative aid, scientific and surgical appliances and accessories to the National Health Services and,

(ix) any other connected questions.

3) **Committee on Indigenous System of medicine**–

Col. Sir, R.N. Chopra (Chairman), Ministry of Health 1948.

The committee was set up partly to counter the criticism about the Bhore Committee's lack of attention to indigenous systems.

4) **The environmental hygiene committee**, Dr. B.C. Das Gupta (Chairman), Ministry of Health, 1949.

This committee discussed the problems of housing, water supply, general sanitation including conservancy and drainage, prevention of river and beach pollution, control of insect vectors, disposal of trade wastes etc.

Terms of reference were:

(i) to recommend provisions for research and the application of scientific methods for investigation of indigenous systems.

(ii) to suggest measures to improve facilities for training.

(iii) to consider the desirability of state control and other measures to increase the usefulness of the system.

(iv) to investigate whether the three systems Ayurveda, Unani and modern cannot be combined into one comprehensive system.

5) **The Homeopathic Enquiry Committee** – J.N. Mukherji (Chairman), Ministry of Health, 1949.

Terms of reference were:

(i) to report on the place of homeopathy in relation to medicine in all its aspects including treatment, prevention and control of diseases;

(ii) to survey the existing facilities for the teaching of homeopathy in India, the extent to which this system of treatment is practised in the country, and the manner in which such practice is carried on, i.e. whether by people adequately trained or not; and

(iii) to make recommendations to the Government on (a) the measures to be taken to improve facilities for training in homeopathy and to regulate such training and (b) the desirability of state control of the practice of homeopathy.

6) **Committee to advise on the steps to be taken to establish a research centre in the indigenous systems of medicine and other cognate matters** – Dr. C.G. Pandit (Chairman), 1949.

The terms of reference were :

To work out and submit to the government a detailed scheme for the development of a centre of research in Ayurvedic and Unani systems of medicine on as broad a basis as possible along the lines indicated in the Chopra committee.

To investigate and define in what manner special training in Ayurvedic and Unani system can be incorporated during the last year or so of the under-graduate course in modern medicine for those who would like to qualify in these systems or alternately how these systems can be fitted into the modern medical course.

To make recommendations regarding the policy for evaluating and assessing the performance of existing institutions imparting instruction in indigenous systems.

7) **Advisory Committee on social and moral hygiene** –

Central Social Welfare Board, 1954.

The advisory committee on social and moral hygiene was constituted under the central social welfare board to study the extent of the problem of immoral traffic in women and children and to suggest remedial measures.

8) **The committee to study the question of formulating uniform standards in respect of education and regulation of practice of vaidyas, hakims and homeopaths, 1955.**

9) **The committee to assess and evaluate the present status of Ayurvedic system of medicine** – Dr. K.N. Udupa, 1960.

Terms of reference were :

To evaluate and assess the work already done; existing facilities for training and research in Ayurveda; nature, volume and standard of pharmaceutical products and practice and recognition of the ayurvedic system of medicine.

10) Report of the health survey and planning committee. -

Dr. A.L. Mudaliar (Chairman), Ministry of Health - 1961.

The terms of refernece were:

(i) The assessment of developments in the field of medical relief and public health centres, submission of the report;

(ii) Review of the Second Five Year Plan health projects;

(iii) Formulation of all the recommendations for the future plan of health development in the country.

11) **Special Committee on the preparation for entry of the National Malaria Eradication Programme into the maintenance phase** – Dr. M.S. Chadha, Ministry of Health, 1963.

12) **Report of the committee on Integration of Health Services**– Dr. N. Jungalwala.

This committee made an overview of the development of medical and health services in India and abroad, and noted changing concepts in health administration with particular reference to :

(a) broadening outlook on social welfare,
(b) centralization and decentralization,
(c) specialization,
(d) changing concept of preventable diseases,
(e) integration of curative and preventive care services,
(f) mental health services,
(g) growing emphasis on health education,
(h) biostatistical approach,
(i) international collaboration,
(j) organisation, and
(k) undesirable trends like fragmentation and multiplicity of agencies providing services for different sections of the population.

13) **Report of the Study group on medical case services** – A.P. Jain (chairman), 1966.

Terms of reference were:

Future pattern of development of hospital services of regional, district, peripheral levels in terms of size and facilities to be provided; the requirements of specialised hospital facilities such as for infectious diseases. P.336

14) Committee on multi-purpose worker – Shri Kartar Singh (Chairman), 1966.

Terms of reference were:

i) The structure for integrated services at the peripheral and supervisory levels.

ii) Feasibility of having bi/multi-purpose workers in the field.

iii) Training requirements.

iv) Utilisation of mobile service units set up under family planning programmes. (p.217)

15) **Review of staffing pattern and financial provisions under Family Planning** – Dr. B. Mukherjee, 1966.

16) **Health services and medical education : a programme for immediate action. Report of the group on medical education and support manpower** – Dr. J.B. Shrivastav (Chairman), 1975.

This committee was constituted to restructure medical education following from the Fifth Plan requirement for reorienting it towards community care rather than hospital oriented care and to accomodate the new emphasis on family planning. The committee was charged with the responsibility of devising a suitable curriculum for training a cadre of health assistants to serve as a link between the qualified medical practitioners and the multi-purpose workers, thus forming an effective team to deliver health care, family welfare and nutritional services to the people. It was also required to suggest suitable ways and means for implementing the recommendations of the earlier committees on medical education, especially the Medical Education Committee of 1968, and the Medical Education conference of 1970, and to suggest steps for improving the existing medical education processes.

17) **Report of the Committee on drugs and pharmaceutical industry** – Shri Hathi Jaisukhlal (Chairman); Ministry of Petroleum and Chemicals, 1975.

The terms of reference were as under :

i) To enquire into the progress made by the industry and the status achieved by it.

ii) To recommend measures necessary for ensuring that the public sector attains a leadership role in the manufacturing of basic drugs and formulations, and in research and development.

iii) To make recommendations for promoting the rapid growth of the drugs industry and, particularly, of the Indian and Small Scale Industries Sector keeping in view a balanced regional dispersal of the industry.

iv) To examine the present arrangements for the flow of new technology into the industry, and make recommendations thereof.

v) Measures for effective quality control of drugs, and for rendering assistance to small-scale industries.

vi) To examine the measures taken so far to reduce the prices of drugs for the consumer, and to recommend further measures as may be necessary to rationalise the prices of drugs and formulations.

vii) To recommend measures for providing essential drugs and common house-hold remedies to the general public, especially in the rural areas.

viii) Arrangements to ensure equitable distribution of basic drugs and raw materials especially to the small scale sector.

18) **Working group on health for all by 2000 A.D**– Dripa Narain (Chairman), Ministry of Health and Family Welfare, 1981.

The terms of reference were :

To review the current health status keeping in view the plan programmes; to evolve Plan outlines for 1980-81 and 1984-85 for the health sector and suggest measures so that foundation is laid for achieving Health for All; and to suggest specific programmes to benefit rural and other weaker sections and to review health components of the Minimum Needs Programme.

*(Manish Mankad is a Library & Documentation officer at FRCH)

VACANCY AT LOCOST

Post : Co-ordinator

Function : To interpret and visualise the broad scope of LOCOST'S activities for demystificaton of medicines and medical knowledge. Specific duties include coordination of production, supply and distribution of drugs as well as related educational efforts in rational therapy.

Qualifications : A science or pharmacy graduate with a minimum of two years working experience in a similar organisation. Should be in touch with general developments. Should be able to work in a team and be able to achieve specific goals.

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