The Bhore Committee and recent debates

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THE Bhore Committee report is a much-invoked document in academic, policy and activist circles when discussing the history of health services development in India. The Bhore Committee was set up in 1943 by the Viceroy of British India to assess the health conditions of the Indian population and to come up with a blueprint for health service development.

The committee gets its name from the ICS officer, Sir Joseph Bhore, who headed it. The other members of the committee were from the Indian Medical Services and several foreign experts. Given the high levels of poverty in India during that period, there was a broad consensus that the principles of universality, equity and comprehensiveness would inform the architecture of public health services. The idea of universal provisioning meant that all citizens will get equal access irrespective of the ability to pay and that the health services will integrate preventive, promotive and curative health services.

In order to ensure the latter, the Bhore Committee proposed a three tier structure consisting of primary, secondary and tertiary levels of care. Each of these levels had a specified role for health service provisioning and would support each other through a referral system. The committee debated the role of social insurance and argued that priority should be given to building strong public health services before introducing insurance schemes. This detailed report, submitted just before independence, was an invaluable reference that generated debates around policy planning for the health sector.

The ideas that shaped the approach and content of the Bhore Committee were rooted in the concept of social medicine that dominated the imagination of public health theory and practice during the early part of the 20th century. These ideas were in circulation in Western Europe and the United States during this period. Several prominent physicians who subscribed and actively advocated social medicine included Henry Siegrist, John Ryle, John Grant, Russell, Newman and Gunn to name a few.

These physicians formed an epistemic community of doctors who were advocates of the idea and practice of social medicine. They were associated with institutions that included the International Health Division of the Rockefeller Foundation, the Johns

Hopkins University and others who were engaging with China, India and several countries in Latin America. They contributed significantly to the debates on how to structure and organize health services in developed and developing countries. As Roemer observes, there were debates around the importance of the integration between preventive and curative medicine by setting up health centres as the primary level of care.

These ideas found their way into government policy soon after World War I in the UK. A committee headed by a senior physician, Robert Dawson in 1920, stated that: 'Preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical service must be brought together in close coordination. They must likewise be both brought within the sphere of the general practitioner, whose duties should embrace the work of communal as well as individual medicine.'[1]

The committee recommended a graded referral system where complex cases would be referred to secondary health centres, which would be staffed with specialist consultants and closely linked to hospitals. Similar ideas were also suggested and legislated by the Health Commissioner in New York in 1920, which was known as the Sage-Machold Bill. However, it was immediately opposed by the State Medical Society, which testified at hearings that doctors 'fear it could prove harmful to the medical profession and that it meant the establishment of "state medicine".'[2] As a result this bill was not implemented in New York and illustrated both an opportunity and resistance to the idea of social medicine in the US.

The practice of social medicine gained visibility with the experience of the Soviet Union and China with Henry Sigerist's work on Soviet medicine and John Grant's on organizing health services in pre-revolutionary China. Their experience of the theory and practice of social medicine had a global influence during this period. Sigerist was closer to the socialist ideology than John Grant, but in terms of the practice of social medicine they were in broad agreement. The work done by John Grant in China as a part of the Rockefeller Foundation's intervention in health care laid the foundation for the development of public health at the Peking Union Medical College for training public health professionals. He also initiated pilot projects for the creation of health stations in rural and urban settings.

John Grant subscribed to the view that public health was an integral part of the socio-economic development of society and therefore emphasized the need for the integration of preventive and curative services with the state playing a central role in the financing and provisioning of health services. His role as a leader of the International Health Division of the Rockefeller Foundation in China provided him ample evidence to translate the learning to other countries like India.

Even as early as 1928, in his address to the annual conference of the China National Medical Association, Grant put forth an argument for state medicine where healthcare was assured to all through a state administered machinery. Soon after the revolution in 1949, although John Grant was no longer involved in China nor could he exercise any direct influence due to the Cold War, generations of his students and colleagues whom he had interacted with occupied influential positions in the government, and the idea of social medicine found its place within a socialist state.

After his involvement with China, John Grant was deputed by the Rockefeller Foundation to set up the All India Institute of Hygiene and Public Health in Calcutta in early 1928. His presence in India as a part of the International Health Division of the Rockefeller Foundation, allowed him to participate in the Bhore Committee. Grant was formally invited by the government to join the committee as an international advisor. The others included Henry Sigerist and John Ryle. The role of these international actors and the fact that several of them were associated with the Rockefeller Foundation who advised the Bhore Committee, has not been adequately analysed. Amrith and Kavadi's scholarly writings on the Rockefeller Foundation are among the few that highlighted the role of international advisors to the Bhore Committee who were committed to the idea and practice of social medicine.[3]

The nationalist movement provided the political context where the vision for a free and fair India was a shared concern. A broad spectrum of ideological positions articulated by big business in the Bombay Plan, the Peoples Plan by the left and the Gandhian Plan, reiterated the importance of the role of the state in the economy and social sectors. Thus, the idea of social medicine resonated with the political mood of the country. However, a majority of the members of the Bhore Committee

1. M.I. Roemer, 'Resistance to Innovation: The Case of the Community Health Centre', *American Journal of Public Health* 78(9), September 1988, pp. 1234-1239.
2. Ibid.
3. S. Amrith, 'Political Culture of Health in India: A Historical Perspective', *Economic and Political Weekly* 42(2), 13-19 January 2007, pp. 114-121; S. Kavadi, The Bhore Committee, International Advisers and John Grant, August 2015. https://www.researchgate.net/publication/281287587. Accessed on 2 September 2018.

belonged to the elite Indian Medical Services (IMS) and the lobbying of doctors in private practice had a significant influence on the development of Indian health services. The fact that the Bhore Committee privileged allopathic medicine over indigenous systems was indicative of the influence of its composition.

Secondly, the committee argued for a national health service with salaried doctors. They spoke against private practice by salaried doctors but went out of their way to allay fears of private practitioners by allowing them to work outside the public services. This is indicative of the extent of influence and power that the existing private interests had even at that time. The accommodation and protection of private interests was antithetical to the idea of socialized medicine. The Bhore Committee also privileged a doctor-led model of primary healthcare. The place of nurses and other levels of health staff were subservient to the doctors.

The third aspect was on the question of insurance in the overall financing plan for health services development. There was divided opinion on the role for insurance within the committee and its advisors. There was considerable debate on the feasibility and desirability of a social insurance programmes based on the experiences of selected countries. It was felt that given the fact that a large section of the population lived below the subsistence level, an insurance scheme would not be feasible because they would be unable to make even the 'small contribution that an insurance scheme will require.'[4] So the committee opined that: 'we consider, therefore, this for the present medical service should be free to all without distinction and that the contribution from those who can afford to pay should be through the channel of general and local taxation.'[5]

The outlays earmarked for health services through general taxation was inadequate and led to its under development. A decade later the Mudaliar Committee report identified under-financing as a major reason for not being able to even fulfil the short-term goals recommended by the Bhore Committee. The subsequent developments created the distortions that were antithetical to the idea of social medicine which had influenced the recommendations of the Bhore Committee. First, the limited public funding was disproportionately spent on curative services at the tertiary level at the cost of primary and secondary levels.

The split between preventive and curative services was furthered through the introduction of vertical disease control programmes during the 1950s and 1960s. Public health services were burdened with the demands of vertical programming that further weakened their functioning. The systemic weaknesses of the public system provided space for the growth of the private sector, which consisted of individual practitioners, both formal and informal. Although the Bhore Committee had recommended that salaried doctors must not be allowed to practice privately, given the power of the medical professionals, a majority of the government doctors were in private practice and in some states they were consultants in private nursing homes. By the 1970s the boundaries between the public and private were no longer distinguishable. This marked the growth of commercialization of medical care, which became rampant through the decades of the 1980s and after.

The developments in global health like the Alma Ata declaration in the late 1970s, could not influence, check or reverse commercialization. The quick shift to Selective Primary Health Care meant that the splitting of curative and preventive care widened. By the early 1980s Indian policy gave legitimacy to the large private sector and wanted it to play a greater role in the delivery of health services.

Even before economic liberalization and the introduction of the Structural Adjustment Programme in 1992, the relevance of the Bhore Committee had ceased. The terms of debate on health sector reforms at the global level was set by the World Bank and the WHO that was an antithesis to the discourse of the 1930s and 1940s which had favoured strong public systems in the developed and developing world. Commercialization of medical care had negative consequences for both equity and affordability.

Several studies have shown rising out-of-pocket expenditures for both out patient and in patient care and an increasing reliance on the private sector. These studies have also commented on the increasing OOPs as an important contributor to indebtedness and a driver of poverty especially among the lower middle and working classes. Even before the debate on universal health coverage, several state governments had introduced medical insurance schemes to address the rising OOPs.

The forerunner of such schemes, Rajiv Aarogyasri, was launched in 2007 for families below the poverty line, on a pilot basis, in erstwhile Andhra Pradesh. The then chief minister, Rajasekhar Reddy, introduced this scheme as a public-private partnership between a state sponsored insurance

4. Government of India, Report of the Health Survey and Development Committee (Bhore Committee) Vol.2. Manager of Publications, 1946.

5. Ibid.

programme partnering with the private sector for provisioning. It was a populist scheme that helped the Congress party to gain electoral mileage and thus health insurance schemes gained political visibility that motivated other state governments to emulate the Andhra model.

It is not a coincidence that the first set of states to adopt this model had a large private sector with considerable power and political influence. I would argue that in Andhra Pradesh, the introduction of the Aarogyasri was partly a populist measure and mostly based on the need of the private sector to improve their sagging profit margins. The rapid expansion of the private sector in Andhra Pradesh led to a competition to attract patients. Post the introduction of the scheme, 80 per cent of empanelled hospitals were from the private sector.

It was, therefore, quite clear that the private sector was the key beneficiary of public subsidies. For the private sector this was much needed in order to maintain their viability with the increase in patient volume. The experience of the Central Government Health Scheme showed that it could provide a steady and assured volume of patients in empanelled private hospitals, especially the corporate hospitals. Therefore, a public insurance scheme that could reach out to a substantial proportion of the population below the poverty line would add to the patient load – essential for the profit margins in private hospitals.

These state-led initiatives also informed the central government scheme of the Rashtriya Swasthya Bima Yojana (RSBY), an insurance scheme for the poor. Amongst all major political parties, medical insurance schemes and curative services became the face of universal health coverage. The experience of RSBY and the state-led insurance schemes pointed to the many anomalies of design and implementation. An analysis of the Aarogyasri showed that it benefited the corporate hospital and focused on specialist services. Studies of the RSBY have shown corruption in the empanelment of private hospitals, unnecessary testing, patients incurring out of pocket expenditures to cover the additional costs, and more. The insurance schemes were implemented in the context of an unregulated private sector that resulted in lack of accountability. The government was complicit in this process.

The design and content of the Ayushman Bharat was derived from the experiences of the state-led schemes and an expansion of the RSBY. Its announcement before the 2019 elections is a response to the distress of a large percentage of households due to rising costs of medical care and a growing reliance on private provisioning. Going by the experience of Andhra Pradesh, a populist gesture may contribute to an increase in votes for the BJP. The implementation of the scheme will only take off, if at all, after the elections. Hype and hope for improved access and a relief from indebtedness due to medical care, is being cashed on by the BJP with the introduction of Ayushman Bharat.

The introduction of medical insurance schemes is a culmination of a gradual dismembering of the recommendations of the Bhore Committee. The lack of adequate public investment over the first few decades of independence meant that the public sector could not be in a commanding position. Subsequently, the aggressive growth of the private sector and later, the health sector reforms of the 1980s and 1990s, resulted in rising inequities and a fragmented health service. The separation of curative and preventive services was split between the private sector for the former and the government for the latter. The introduction of targeted medical insurance schemes was seen to address the increasing cost of medical care, reducing inequities and improving accessibility for curative services.

These developments clearly show how the recommendations of the Bhore Committee are redundant for the present government. It has negated the idea of comprehensive health services by expanding an insurance-led model. There has been an active effort by the present government to erase and rewrite a history that is closely intertwined with the Nehruvian era. The Bhore Committee and the ideas it represents, does not resonate with the present political dispensation. While the Bhore Committee may be ignored by policy planners, there is a larger civil society that is concerned with social justice and health and will continue to emphasize its relevance in dealing with healthcare challenges today.

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