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Social Change 2011 41: 215
DOI: 10.1177/004908571104100202

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For a Realistic Assessment: A Social, Political and Public Health Analysis of Bhore Committee

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Abstract
The Government of India set up the ‘Health Survey and Development Committee’, popularly known as the ‘Bhore Committee’ in 1943 to draw up the scheme of health services for the newly emerging independent India. The recommendations made by the committee remain a landmark in the development of health services in the country and continue to inspire the health workers in the country in their struggle for developing pro-people health system. This article makes an attempt to analyse the positives and the negatives in the recommendations of the committee by tracing their roots in the social and political conditions, nationally and internationally, at the time of the deliberations of the committee. An attempt has also been made to trace the consequences of these recommendations and draw appropriate lessons for health policy formulation in the country. The article identifies the continuance of the colonial governance paradigm even after 1947 as the biggest threat to evolving and implementing a health policy framework favourable to the interests of the poor masses of the country.
Keywords
Bhore Committee, report, NRHM, colonial, health

Introduction

Even as the move for transfer of power from the British to the nationalist leaders of India were afoot, the then British government of India was faced with the challenge of setting up the framework of governance for different functions of the new independent Indian state that was to come into being; provision of health care being one of such important functions. Needless to say that the challenges being confronted by India towards improving the condition of health of her people were quite overwhelming to say the least, with there being little infrastructure to match the task at hand. Under the circumstances the Government of India set up the ‘Health Survey and Development Committee’ in 1943, popularly known as the Bhore Committee deriving from the name of its Chairman—Sir Joseph Bhore. The committee was charged with the task of making:

1. ‘A broad survey of the present position in regard to health conditions and health organization in British India’; and
2. ‘Recommendations for future developments’.

The committee finally submitted its report in 1946 in four volumes. It suggested a short-term plan to be achieved over a period of 10 years and a long-term plan to be put in place over a period of 40 years with regard to the development of health services in the country.

Even though, till date, the country has failed to achieve fully even the objectives of the short term plan, yet the very idea of Bhore Committee remains the most enduring idea in the struggle of development of health services in India because of the comprehensiveness of the committee’s vision. The recommendations made by the committee are great. The present disarray in the health services system of the country makes them appear greater still. Just as the Beveridge Committee of England led to the formation of the National Health Service (NHS) in England (Abel-Smith, 1992), the Bhore Committee recommendations laid down the scheme for the development of health services system in India. The difference is that while in Britain all from the Queen to the pauper seek the services of the NHS; in India we have accomplished a surgical division between the costly private health care for the rich and a poor public health care service for the poor.

Bhore Committee was not without its specific historical and political context. Its recommendations came in the background of the World Capitalism’s greatest crisis of the 20th century—the Second World War, which had announced the emergence of Soviet Union as a new super power along with almost one half of Europe turning red and the Communist movement in Asia making great strides in China. In India as well there was a great resurgence of the nationalist as well as the left movement.
All these developments had reverberations in the hearts and minds of the working people of the West as also the oppressed people of the colonised countries, forcing the governments to reckon with the rising aspirations of their people. Added to this was also the fear that the rising tide of Communism would take India in its sweep.

The Beveridge Committee in Britain identified five great social evils—squalor, ignorance, want, idleness and disease that were required to be dealt with on priority. In conjunction with the Keynesian model of economic development, it heralded the emergence of ‘welfare state’ in Britain, while the leaders of the Indian National Congress in India modeled themselves as the forbearers of socialism in the subcontinent. There was considerable confluence of interest between the British ruling classes and the leaders of the Indian National Congress, which in 1928 had demanded merely a ‘dominion status’ under the British Crown (Wikipedia, 2010). The British on their part were keen to keep India within the ‘British Commonwealth’ (Singh, 1985) and hence the urge to secure India for the Congress leadership.

It has been widely argued that what happened in 1947 was a mere transfer of power from the British to the Indian hands; with little if any change in the structure of the Indian state or any radical redistribution of resources in the society. Even the constitutional and the legal arrangement that was to guide the scheme of things in ‘independent India’ was virtually retained ipso facto as was under the British rule, with several portions of the ‘Government of India Act’ of 1935 being copied verbatim in the Indian Constitution (Indian Courts, 2009; Pylee, 2002). Most importantly the colonial construct of the defense forces (Globalsecurity.org, 2010) and the police was retained as such (Das and Varma, 1998).

Continuance of the colonial paradigm implies not just the continuance of the formal structure of governance, but also its attitude towards the people.

This background of the conditions obtaining in the period around the time of Bhore Committee give us an idea of the kind of influences that shaped the outcome of the committee. The rising aspirations of the people, the collaboration between the British ruling classes and the Indian leadership and the continuance of the colonial governance paradigm, all helped shape the recommendations made by the committee.

The Positives of the Committee

It shall only be in the fitness of things that we begin by acknowledging the most positive contributions made by the committee; and it is in these that we find an acknowledgement of the rising aspirations of the people of India from the government of a country that was about to gain independence after 200 years of colonial rule. The British were conscious of these and it was in their political and economic interests to lay the framework that would help the Indian leadership address these aspirations.
Foregrounding the Role of the State in Provision of Health

It is here that the ideological trends in the international and the national politics seem to have had maximum impact on the committee. In the post-Second World War scenario, the state had come to occupy a position of prominence across countries in the developed world. The committee very consciously did not make the emerging Indian Republic an exception to this trend and argued for free ‘universal health care’ to be provided by the state. It stated:

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. (Government of India, 1946, Vol. II, pp. 7, 12)

Giving primacy to the needs of India’s poor, in the plan for building of health services the committee proposed entirely free health services (ibid., Vol. II, p. 14) to be provided by a full-time cadre of salaried government doctors as against private practitioners (ibid., Vol. II, pp. 14–15).

Foregrounding of Health in Policy Framework

Emphasising the need for ‘health programme’ to occupy ‘high priority’ in the allocation of available resources, the committee said:

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…

… 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 health, virile and dynamic people. (ibid., Vol. II, p. 2)

The report further stated:

To shut our eyes to the consequences which a halting, ineffective and timid health policy imposes on the country can only result in perpetuating a tragedy which is as poignant on the national as on the individual side.

Little would the committee have thought that the entire experience of governance post 1947 would bear their prophecy with such force. Going by the way ‘Health’ has been privileged in the state policy post 1947, elevates these quotes way above being a matter of good semantics.
An Epidemiological Approach to Public Health Diagnosis and Health Planning

That the report is a very well written document is well recognised. However, its salience lies in the epidemiological method adopted in diagnosing the real issues confronting India in the area of health. The committee through its deliberations collated huge amount of data on the under-mentioned topics, to make a diagnosis of what ailed India’s millions and draw the priorities for action. The areas that came under the committee’s scrutiny were (ibid., Vol. I):

- Data on health infrastructure available in the country, the number of health medical and paramedical health personnel available, the adequacy of their training, the types of organisations involved in providing medical relief, the nature of services provided by them and the conditions of service of the various health personnel.
- The status of availability of various therapeutic substances, instruments and appliances and the facilities for their production and the control of trade in these substances and equipment.
- Detailed data on the nutritional status of the people in different parts of the country, data on production of food grains and animal products and the institutional mechanisms for control of adulteration of food, supervision of the production and sale of food in public and an analysis of food storage and distribution.
- An in-depth analysis has been presented by the committee on health services for vulnerable groups like mother and children, schoolchildren.
- A very considered thought has been given to the poor standards of health of India’s workforce; a section which seems to have gone beyond the pale of health policy in independent India.
- A separate chapter has been devoted to in-depth analysis of morbidity and mortality due to diseases that posed the biggest public health problem in the country and has presented an account of the facilities available to deal with these problems.

One may say, ‘well isn’t this the obvious way to go about; so what is great about it?’ To absorb the full import of the committee’s methodology, one need only compare it with profound absence of this approach in health policy even after so many years of independence and acclaimed advancements in knowledge, institutional mechanisms and technological capabilities of the Indian state. Compared to the thoroughness of the epidemiological approach of the Bhore Committee, the ‘Mission Document’ of National Rural Health Mission (NRHM) is nothing more than a bullet point presentation that does not even attempt to analyse the reasons of the dismal state of health in rural India (Government of India, 2005). To take the words of Dr D Banerji, NRHM is nothing more than celebration of ‘public health quackery’ (Banerji, 2005).
A Systems Approach to Public Health

The terms of reference of the committee constrained the scope of its enquiry to ‘review primarily those activities which can reasonably be regarded as falling within the scope of health administration’ (Government of India, 1946, Vol. I, p. 4). However, this failed to obscure in any way the importance of health as a multidimensional phenomenon in the deliberations of the committee. Throughout the text of its report the committee has taken a ‘Health Systems View’ of health problems in India rather than keeping itself within the narrow confines of ‘health services system’.

The committee said:

While recognizing that it is not within the scope of our enquiry to suggest ways and means by which poverty and unemployment should be eliminated, we feel that 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.

In a reaffirmation of the principles regarding health policy in connection with discussions on the Beveridge report, the British Medical Association emphasized that ‘the health of the people depends primarily upon the social and environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities, and upon the facilities for exercise and leisure’.

(ibid., Vol. I, p. 17)

It is illuminating to compare this averment with the mention of ‘poverty’ in NRHM Mission Document—‘Over 25% of hospitalized Indians fall below poverty line because of hospital expenses’ and ‘improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the Below Poverty Line families’. There is no third mention of the word ‘poverty’ and mention of ‘unemployment’ simply does not occur in the document (Government of India, 2005); lest the mandarins of ‘Nirman Bhawan’ are to fret about something as silly as the relationship between ‘unemployment’ and health.

It is not just the mention of ‘poverty’ that testifies to the ‘systemic’ approach of the committee; their consternation goes deeper in stating unambiguously:

The modern public health movement is not concerned solely with the prevention of disease. It has the broader aim of creating an environment in which each individual can develop his potential fully and completely. (Government of India, 1946, Vol. II, p. 69)

The committee fully endorsed the statement of the ‘Nutrition Committee’ that

The general raising of the dietary standards throughout the country is an economic problem, the solution of which is dependent on the scientific development of agriculture, animal husbandry and fisheries, and the simultaneous development of industrial resources. … Agriculture and economic policy must be established which have as their
primary objective the betterment of diet. A food policy is necessary, and this must be firmly based on nutritional science. (ibid., Vol. II, pp. 70–71)

This is in sharp contrast to the rather pedantic debate on ‘Food Security Bill’ in the deliberations of the ‘National Advisory Council’; as though food security is just a matter of deciding whether to give 35 kg or 25 kg of food grains to the below poverty line families or to make the public distribution system universal or not (The Hindu, 2010).

The committee included in separate chapters its recommendations on important issues from public health point of view on ‘Environmental Hygiene’, ‘Rural and Urban Housing’, ‘Town and Village Planning’, ‘Public Health Engineering’, ‘Professional Education’, ‘Medical Research’, etc. (Government of India, 1946, Vol. II, pp. 70–71). It is indeed remarkable that such an important programme as the NRHM does not have any mention whatsoever of creating institutional mechanisms to meet the demand of training huge numbers of public health professionals with social, political and epidemiological competence that such a programme essentially requires. The only mention is that of the training of Accredited Social Health Activists (ASHAs) (Government of India, 2005) and that too has now been outsourced to NGOs.

**Concept of Integrated and Universal Health Care**

Universal access to integrated (preventive, promotive and rehabilitative) health care remains the cherished public health goals even today. The committee had firmly rooted its proposals for the long- and the short-term plans in complete concordance with these lofty public health ideals. It said:

> We consider that a combination of curative and preventive health work is in the best interests of the community and of the professional efficiency of the medical staff employed. In fact the two functions cannot be separated without detriment to the health of the community. (Government of India, 1946, Vol. II, p. 40)

We need only compare this notion of integrated health care with the superb dichotomy between the preventive care for the rural India and concentration of curative care in the urban India that we have achieved in the development of health services in ‘independent’ India. Perhaps some of the greatest ideas are also the simplest of the ideas; however, that does not always ensure that they are put into practice as simply.

There is a flawed impression in the minds of some scholars that in its proposed short-term programme the committee proposed coverage of only a fifth of the population in the initial 5 years and barely half the population by the end of 10 years. This situation in the opinion of these scholars was further compounded due to the committee’s recommendations against the indigenous systems
of medicine and for the abolition of the system of licentiate medical practitioners (Gautam and Shyamprasad, 2010).

The actual position, however, is that the committee stood for universal coverage from the very beginning, limited though their proposals were due to the constraints of resources. Talking of its short-term plan the committee said:

We wish to make it clear that the proposals that will be discussed in the succeeding paragraphs embody recommendations which are intended to supplement and not supplant the existing health facilities in the areas where our scheme will be introduced. We consider moreover, that our recommendations constitute an irreducible minimum, and, were it not for the limitation imposed by the inadequacy of staff and funds, we should unhesitatingly have proposed a more comprehensive scheme than the one indicated below. (Government of India, 1946, Vol. II, p. 37)

As a matter of fact the committee to its credit never lost sight of the need of universalisation of health care. It put it on record in as unambiguous terms as the following:

We have come to the conclusion that the new health services, in howsoever attenuated a form they may be started, should be initiated on as wide a territorial basis as possible. We feel that, for the purpose of demonstrating the resulting improvement in the public health of a province as a whole, the application of our proposals in every district, though it may be over a limited area in each to begin with, will be more effective than concentration of effort in one or two small areas in the province. (ibid., Vol. II, p. 38)

Where Did the Committee Fail?

As is the wont of all great things, they need to be measured against equally great standards. The committee is as monumental in its failure as it is in its achievements. Just as the positive recommendations of the committee were rooted in the objective social and political conditions of the time, its failings are also no abstractions and are firmly rooted in the political character of the governance paradigm that existed in India around the time of the committee’s deliberations. The failures of the committee could be many, perhaps even more than its achievements listed earlier; however, we shall dwell here on the ones which had the most far-reaching impact on the development of health services in the country. A committee of such cardinal importance as the ‘Bhore Committee’ cannot but be held responsible for the consequences of its recommendations.

It must be borne in mind that the Sirs, Colonels, Khan Bahadurs and Dewan Bahadurs on the committee were no radicals. They were persons in positions of power and well ensconced in the colonial set-up. Apart from the political compulsion of having to deal with the rising aspirations of the people, their vision went only as far as the ruling set-up of the day permitted and was marred by the colonial attitudes towards the people at large.

The Choice of the Health Care Model

Before arriving at its scheme for the development of health services in the country the committee thoroughly studied the ‘Modern Trends in the Organization of Health Services’ across the world in order to choose the model for India (Government of India, 1946, Vol. II, pp. 6–16). Broadly, it narrowed down to two models to choose from—the ‘Welfare State’ model as came into existence in Britain and the model of ‘Health as a Right’ that existed in the ‘Soviet Union’. We need only elaborate at some length on what the committee itself said about the difference between the two. Regarding the attitude of the Soviet government towards the health of the people, quoting Prof. Sigerist, it said:

Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health accessible to all, free of charge; medicine like education is then no longer a trade, it becomes a public function of the State. (ibid., Vol. II, p. 10)

Further elaborating on the implications of ‘Health as a Right’ model the committee observed:

This conception of health as a public function has resulted in the development of a co-ordinated scheme of preventive and curative health services, which exists in no other country, and in the recognition of the need for providing an environment which will enable the body to remain healthy and to resist disease. For this reason the control of housing, of industrial conditions, and other aspects of life, comes under the care of the People’s comissariat of Public Health. (Government of India, 1946, Vol. II, p. 10)

The pro-people character of the latter model of health care is further brought out thus:

The structure of the Soviet medical system follows the general administrative structure of the country. In order that planning may be complete for the whole State it is controlled on the one hand by the People’s Commissariat of Health, on the other hand by health committees and health nuclei organized in every factory, on every one of the large collective farms, and in every district. The one form of control is the natural outcome of the recognition that health protection is a function of the State, the other is the logical outcome of the principle that the workers themselves must take an active part in the protection of their own health. The system as it now stands is therefore not one forced on either the people of Russia or the medical profession by a particular group or class, but has had the active support and criticism of those interested in the service either as the purveyors of medical treatment or as the consumers of medical care. (ibid., Vol. II, p. 11)

The ‘Welfare State’ model, on the other hand, is heavily dependent on the initiative of the state to ensure the physical and economic access of universal health care. People are reduced to being mere recipients of health care with little practical day-to-day control over it.
Given these options, the committee consciously chose the ‘Welfare State’ model. Proposing anything less than what was being implemented in Britain almost at the same time would have been outrightly rejected by the people. The people thus were segregated from the process of implementation of their own welfare and the nature of the Indian state, constrained as it was by the colonial institutions of governance and the colonial mindset even after 1947, led to the state straying away from its declared objectives.

Failure to adopt ‘Health as a Right’ approach was the first major flaw of the Bhore Committee.

**Lack of Ideological Conviction in Proposing Universally Free Health Care**

We felt 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 at least its economic condition is materially improved. ... We 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. (Government of India, 1946, Vol. II. p 14) (emphasis by the authors)

It is very evident from the statement made earlier that the committee’s position against imposition of ‘user fees’ in health services was more due to the expediency of the poverty of the people at that time rather than any ideological commitment towards provision of free health care. In this sense the committee left a toehold for the later attempts to introduce user charges to get a foothold in health policy.

**Imposition of the Western Model of Health Care**

It is hardly a secret that the Indian systems of medicine were allowed to languish during the colonial period, which had resulted in their becoming scientifically stagnant. Nevertheless, the practitioners of the Indian systems of medicine, whatever their drawbacks, continued to command a huge clientele in vast areas of the country both among illiterates and the intelligentsia. This, however, did not impress upon the committee to consider any role for the indigenous systems in the future organisation of health services in the country; rooted as their convictions were in the positivist notions of bio-medicine. They said:

It was not until the middle of the 19th century that medical science became firmly established on a secure foundation. The invention of the compound microscope, the rapid development of Organic Chemistry and latterly of Bio-Chemistry and Bio-Physics have led to such an advance that we can say with truth that 95% of the total
corpus of knowledge with regard to the working of the human body has been obtained within the life time of men who are still with us. (ibid., Vol. II, p. 456)

Their firm belief was that:

Public health or preventive medicine, which must play an essential part in the future of medical organization, is not within the purview of the indigenous systems of medical treatment as they obtain at present. (ibid., Vol. II, p. 455)

Further:

No system of medical treatment, which is static in conception and practice and does not keep pace with the discoveries and researches of scientific workers the world over, can hope to give the best available ministration to those who seek its aid. (Government of India, 1946, Vol. II, p. 455)

The degeneration brought about due to particular social, economic and political conditions led the committee to virtually declare the indigenous systems of medicine as ‘unscientific’, rather than propose ways and means of isolating and developing the scientific content of these systems in order that they may serve better the millions who continued to have faith in these systems. Such a contemptuous view was in no way different from the attitude of the colonial masters towards these systems and was compounded by the fact that not even one representative of these systems was on the committee.

Further insult to injury was added by the recommendation to have only one and highly trained type of doctor as a basic doctor and the recommendation to abolish the licentiate system of medical practice. They said:

Having regard to the limited resources available for the training of doctors, it would be to the greater ultimate benefit of the country if those resources were concentrated on the production of only one and that the most highly trained type of doctor, which we have termed the ‘basic’ doctor. (ibid., Vol. II, p. 340)

The authorship of the Bhore Committee conveys enough intellectual depth and grasp of socio-economic realities of India on part of the committee to suggest that the class background of the medical graduates passing out from the then existing medical colleges would not have been lost on the minds of the members and that the committee could have lost sight of the fact that that these urban and at that time purely upper class graduates would be highly resistant to man the health services in the much impoverished countryside. It is pertinent to remember here that all policies regarding affirmative action notwithstanding, the elitist class character of medical profession in India remains unchanged till this day.

The Bhore Committee further ended up fortifying these elitist credentials by recommending that:

There should hereafter be a single portal of entry into the medical professions and that portal should be the Universities…. We are confirmed in this view by the reasons advanced by the Inter Departmental Committee (the Goodenough Committee) on Medical Education in Great Britain in support of University Medical Education. (Government of India, 1946, Vol. II, p. 342)

The honourable members of the committee could not have been so naive as to not realise that at that point in time it were largely the elite who could afford university education for their children. The only leeway for the committee could have been in the misplaced hope that the social orientation of medical education would somehow do the trick, which obviously did not materialise. Such ahistorical, colonial and elitist policy orientation is at the root of the development of entrepreneurial model of Western oriented technological health care that privileges curative over preventive care and cities over towns, besides making the provision of health care costly and perennially dependent on the West. This model was more suited to the Western rather than the indigenous health care needs. It is little wonder then that the Indian medical graduates have migrated in their droves to keep the health care systems of the US and UK afloat (Gautam and Shyamprasad, 2010). It is the oppressed poor masses who have had to pay the price of such a policy.

It is not as though the alternatives did not exist or were not proposed; to the contrary, the sub-committee on ‘National Health’ of the ‘National Planning Committee’ of the Indian National Congress, which was chaired by Col. S.S. Sokhey, proposed a more self-reliant path of health development suited to the specific conditions of development in India. The Sokhey Committee emphasised:

From the standpoint of reorganizing the medical education of the health personnel in the country, Indian Universities have almost all been devoted to medical science and research as taught in the West in all its branches. … If medical advice and treatment to the mass of the people is to be provided on the necessary scale free of charge, the National Plan will have to bring the indigenous Vaidya, Kakim, or Dai into line with more elaborately or pretentiously trained physician or surgeon, gynecologist or obstetrician. It is more a matter of the technique particularly in the case of the last named, and certain precautions by way of cleanliness, than a matter of the actual drugs or appliances used. (Sokhey Committee, 1948: 35)

While not discounting the importance of the modern technique and latest appliances, the Sokhey Committee said:

These, however, must be made or found in the country in an ever increasing degree. An important sector of the Plan will, no doubt, have to be the provision, from the country’s own resources, of all the drugs, medicines, appliances and instruments in safeguarding the health of the nation. (Sokhey Committee, 1948: 35)

It is important to note that the policy framework of Bhore Committee was approved by eleven of the sixteen Indians on the committee and among them were
such ‘nationalist’ leaders as Dr B.C. Roy. This in itself bears testimony to the fact that the governance paradigm post 1947 was in essence the continuation of the colonial paradigm with the ‘brown sahib’ replacing the ‘white sahib’; a truth that we shall see being borne out more fully in the recommendations on population policy.

**Giving Fillip to Vertical Health Programmes**

Even though the Bhore Committee adopted an epidemiological and systemic approach to public health, many of its recommendations for disease control ended up laying the ground for implementation of a series of what are now called vertical disease control programmes beginning immediately after independence. With the benefit of hindsight we now know that these vertical programmes proved to be a big hindrance in the composite development of the general health services in the country. Of the different health programmes we mention here the recommendations made for the control of malaria and tuberculosis.

The committee fully endorsed the views of the Director, Malaria Institute of India calling for a verticalised approach towards malaria control; he said—‘an essential preliminary to the successful control of malaria in India is the formation of an adequately staffed permanent malaria organization in each province, the activities of which should be linked up with those of the central organization of the government of India’ (Government of India, 1946, Vol. IV, p. 34).

The committee said,

> Our recommendations, therefore include the establishment of anti-malaria organizations in the provinces as well as the strengthening of the staff of the Malaria Institute of India in order to enable it to fulfill its important tasks of advising provincial administrations in the development of anti-malaria measures, of coordinating such work in the provinces and of training the higher types of malaria personnel for the country as a whole.

This was accompanied with the recommendations for setting up of vertical management of supply of drugs, appliances and other equipment. The emphasis given to the use of insecticides over the public health measures like the draining of the swamps, public health engineering and general sanitary measures gives away the techno-centric bias of the committee (Government of India, 1946, Vol. IV, pp. 35–36).

Likewise for the comprehensive and integrated service for tuberculosis, formation of a ‘tuberculosis organization’ comprising the following components was proposed:

> ‘(1) A domiciliary service, (2) clinics, (3) hospitals, (4) after-care colonies, (5) homes for the incurable and, in addition (6) certain ancillary services.’ Five Year Plan-wise expansion in the clinical services for tuberculosis was also proposed (ibid., Vol. IV, pp. 36–37).
India did launch soon after the transfer of power a massive military-like campaign in the name of the ‘National Malaria Control Program’ which was followed by the equally grandiose ‘National Malaria Eradication Program’. Though not successful in achieving its objectives, the programmes did reduce the public health problem of malaria considerably, but left the general health services emasculated and the country is still having to live with malaria in the absence of the more fundamental public health measures.

The other vertical programme that played truant with the health services was the massive family planning programme.

**Views on Population Policy**

One of the most central questions in development policy is how do we view the people—whether they are the motive force for change or they are part of the problem. Deciding on this decides the orientation we adopt in instituting development policies, that is, the poor, impoverished, illiterate and diseased people are the muck that needs to be cleared and hence the programmes for education, health care, housing, nutrition, etc., or the poor are seen as long suffering victims of social, political and economic injustice and hence the need to ameliorate their suffering in right earnest. While the former may result in some improvement, it is the latter that results in palpable improvement in the lives of the people.

That in the case of the Bhore Committee former is the case is given away by its views in the chapter titled ‘The Population Problem’ (ibid., Vol. II, pp. 477–89), that is, to say that people are the part of the problem. The committee has adopted a belligerently Malthusian position at a time when Malthus had since long been discredited in his own country. We feel obliged here to let the views of the committee be expressed in its own words at considerable length. It said:

> The history of the growth of population in India, therefore, seems to illustrate the contention of Malthus that disease and famine impose checks on an unlimited growth of population. (Government of India, 1946, Vol. II, pp. 477–78)

So the fact of the matter ultimately is that disease and famine are not to be looked as causes of human suffering but as instruments that apply ‘check’ on population. We can understand that the committee did not have the gumption to indict the colonial loot of India in any way; but here it has been found fit to in a way mock at the suffering of the people. Most shockingly the committee stated:

> A reduction in the rate of growth of population may be brought about by permitting the death rate in the community to rise. Our social instincts militate against this. … One of the objectives universally accepted in all civilized countries is reduction of morbidity and mortality in the community. We have, therefore, to turn to other means for decreasing the rate of growth of the population. (ibid., Vol. II, pp. 483–84)
It almost appears that but for the ‘social instincts’ brought to bear by the civilised countries, the committee might as well have recommended population reduction by ‘permitting the death rate in the community to rise’. How else do we understand the emergence of such a thought on part of a committee charged with the task of improving the people’s health.

**Intentional Limitation of Families**

Here the committee’s sheer contempt for the people and basal thinking with respect to ‘population question’ seems to have known no limits. It writes:

If we believe that limitation of families is advisable, we should first ask ourselves the question whether it is possible that this could be secured through self-control. Our answer must be, we fear, not to any material extent. A limited number of individuals may be under-sexed or may, by nature, be so constituted that they can sublimate most of their sexual urge into intellectual, artistic or other creative channels. But the large majority of mankind, while they may be able to convert a part of their sexual impulse into activities useful to the community, will still have to find satisfaction in the sexual act itself.

In committee’s opinion birth control through ‘positive means’ was the only option (Government of India, 1946, Vol. II, pp. 483–84). Thankfully it did not suggest what these ‘positive means’ could be.

It is more than a queer co-incidence that our present health minister, Mr Gulam Nabi Azad, had this to suggest for controlling the population of the country:

If there is electricity in every village, then people will watch TV till late at night and then fall asleep. They won’t get a chance to produce children. … When there is no electricity there is nothing else to do but produce babies. (Blakely, 2009)

There is a more fundamental bond between the two statements—the bond of the colonial arrogance of the ‘brown sahibs’.

All science, all caution, all niceties and restraint were thrown to wind in commenting thus on the character of the impoverished:

A birth control campaign has certain inherent dangers. … Contraceptive practices are, therefore, more likely to be used by the more successful and intelligent sections of the community than by those who are improvident and mentally weak. It may also be mentioned that a certain number of defects, and diseases are known to be heritable. These include…. The classes which possess many of these undesirable characteristics are known to be generally improvident and prolific. A continued high birth-rate among these classes, if accompanied by marked fall in the rate of growth of the more energetic, intelligent and ambitious sections of the population, which make much the largest contribution to the prosperity of the country, may be fraught with serious consequences to national welfare. (Government of India, 1946, Vol. II, p. 487)

The members of Bhore Committee recommended legalisation of ‘voluntary sterilisation’ and advocated a full-fledged ‘eugenic programme’ to improve the
‘future composition of the community’ as had been so successfully done by man in case of different species of plants and animals (ibid., Vol. II, pp. 488–89).

If the post 1947 experience is anything to go by then, it seems that the views of the Bhore Committee on the population question seem to have had an overbearing influence vis-à-vis its other recommendations. India was the first country in the world to launch a family planning programme.

**Conclusion**

The struggle for the improvement of health services in the country is an ongoing struggle of the people. The recommendations made by the Bhore Committee have an enduring value in this context. Both the positive as well as the negative features of the committee have basis in the objective historical and political conditions of the time of its deliberations. Unfortunately, the failure of the health policy paradigm in the country after 1947, especially the developments after the introduction of the World Bank-guided health reforms resulting in unfulfilment of promises made at the time of independence, makes the positive recommendations of the committee look even greater.

The analysis presented here has important implications for policy-making in the field of health. The fact that the country has not even succeeded in achieving the targets laid out in the short-term plan of the committee, which was to have been achieved by the beginning of the 1980s, calls for renewed vigour in the planned expansion of integrated, that is, preventive, promotive, curative and rehabilitative, health services in the country, especially in the rural areas. It is a matter of great worry that some of the most fundamental principles of public health planning, that is, epidemiological approach, a systems approach to health care and provision for training of public health personnel, as were espoused in the recommendations of the committee, are missing in the planning of the country’s most ambitious health plan of recent times, that is, the NRHM.

Apart from this the pitfalls of techno-centric approach in health planning geared towards expansion of costly curative health care, on one hand, and technology-driven vertical disease control programmes, on the other, are clearly brought out in our analysis. These remain potent threats to the wholesome development of health care services in the country even now. There is a need to sublimate technology to the requirements of the people rather than sublimating people to the requirement of preconceived technological solutions on the offer by the policy planners.

The biggest threat, however, emerges from the continuance of the colonial governance paradigm in the country post 1947. That it comes packaged in the form of seemingly liberal bourgeoisie democracy makes it more surreptitious, but no less dangerous. This fact highlights that the struggle for development of pro-people health services in the country is a political struggle in the main. Academics, health planners and health activists need to be aware of the class
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arrangement of forces in this struggle. While pushing for pragmatic health reforms in view of the present arrangement of class forces, they should seek to impress upon the need for a political struggle to change this arrangement.

Acknowledgements

The authors wish to acknowledge the encouragement received from Dr K.R. Nair, Prof. Centre for Social Medicine and Community Health, Jawaharlal Nehru University, in the preparation of this article.

References
