RESURRECTING BHORE
Re-emphasizing a universal health care system

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Universal Health Care (UHC) is a human right. The Health Survey and Development Committee, popularly known as the Bhore Committee (after is Chairperson Joseph Bhore), underlined this fact while constructing the national health plan:

"..We feel we can safely assert that a nation's wealth prosperity and achievement and advancement, whether in the economic or the intellectual sphere, are conditioned by the state of its physical well being".

"..Expenditure of money and effort on improving the nations health is a giltedged investment which will yield not deferred dividends to be collected years late, but immediate and steady returns in substantially increased productive capacity. 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 got the building up of a healthy, virile and dynamic people". (II. 1-2).

The Bhore Committee made a global review of recent trends and developments in health care services. It looked at the developments in Britian, Australia, New Zealand, Canada, USSR and the USA and found an increased role of the state in providing health are. It concluded that the ferment of ideas arising out of the World War has resulted in an increasing awareness, on the part of the governments and people, of the need for measures which will ensure 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)

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 services should be a salaried one and whether some measure of choice can be given to the patient as regards his doctor.

1. Whether the medical service should be free or whether it should be paid for?

"Whether fell 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 scheme 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 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 enquiries… 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' (II.14)

2. 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 is 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 subsidised 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, individuals and 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)

3. 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 the 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).

Thus we see that the concept of UHC was well entrenched on the eve of India's Independence. The National Health Plan keeping the view the socio-economic and health conditions in India the Bhore Committee set itself the following objectives to 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 field 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 varied character, which together constitute 'group' practice should be made available.

6. Special provision will be required for certain sections of the population, e.g. 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.

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 (II. 17).

The Bhore Committee further recognized that vast rural-urban disparities in the existing health services and hence based its plan with specifically the rural population in mind. Its plan was for the district as a unit. "Two requirements of the district health scheme are that the peripheral of the (health) organisation 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, was to be organised 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 organisation which will include, within its scope, all the facilities that are necessary for modern medical practice as well as supervisory staff who will be responsible for the health administration of the district in its various specialized types of service'. (II. 22)

This health organisation would provide integrated health services, curative, preventive and promotive - to the entire population. 'The health organisation is expected to produce a reasonably satisfactory service for rural and urban communities alike. It is based mainly on 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 tem programme which was to be realised within a period of 30 to 40 years (II.35). That is, by the early eighties all the facts of the Bhore Committee should have been realised. We are now in the year 1992-93 and very well know (and it is very humiliating to know) that we are nowhere close to what the Bhore Committee has 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 fare lower than the level most developed countries has reached on the eve of World War II!

RECOMMENDATION OF BHORE COMMITTEE

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

1. Minimum Required Ratios:

567 hospitals beds, 62 doctors, 151 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.

2. Organisation of Health Care Services:

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

Primary Unit
Every 10,000 to 20,000 population (depending on density from on 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 organise 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 (now a part of Madhya Pradesh) 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 specialties; 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 first level referral hospital would supervise both the preventive and curative work of 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.

District Hospital
Every district centre would have 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 pediatric beds, 300 leprosy beds, 40 infectious diseases beds, 20 malaria beds and 400 beds for mental diseases. A large number 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 programmes, keeping in mid the special problems that India faced due to its economic and political conditions, that would provide support and strength to this health organisation.

These included special attention to diseases like malaria tuberculosis, small pox, leprosy, plague, cholera, venereal disease, hookworm, filariasis, guineaworm, cancer, mental illness, diseases of the eye and blindness. Also, special programmes for health of mothers and children and environmental hygiene and an occupational health service for industrial workers were indicated. We must point out here that this special consideration were not to be independent programmes but a part of the general health service.

BHORE COMMITTEE NEGLECTED: A MISSED OPPORTUNITY FOR A COMPREHENSIVE HEALTH CARE SYSTEM

The above review of the Bhore Committee Plan has been done with the purpose of showing as we missed the opportunity of establishing a comprehensive health care system. At that point of time the capital cost for Bhore's plan was only one percent of GDP and the recurring cost (including amortisation of capital expenditure) a mere 1.33% of gdp. This level of spending was about three times less (as % of GDP) than what many developed countries were spending during those years.

Instead, the private sector, then very small in the hospital sector, was allowed to grow rapidly - rapid expansion of drug industry, private medical practice and private hospitals supported by an ever-increasing supply of trained doctors and pharmacists mainly from public institutions. Though private practitioners were a fairly large number then, they were a vulnerable profession and could have been institutionalized into a state controlled health care system.

Today, with increased commodification of health care, the private health sector has developed strong vested interests which, especially in the present climate of privatisation and liberalisation, has now become a major barrier to developing UHC system.

MODIFYING THE BHORE PLAN

The recommendations of the Bhore Committee make sense even today, 46 years later. If, implemented over the present decade they could transform radically health and health care in the country. However, the last four decades have seen the kind of changes which now make the Bhore recommendations, as they stand, very difficult to implement.

Hence, given the basic idea, a modified system now needs to be evolved for achieving the objective of UHC. A state run salaried health care service, as recommended by Bhore, is no longer possible or feasible because of the manner in which health care services have grown in

India, as well as due to the prevailing global economic scenario. There are also lessons to learn from the experience of the welfare approach of western capitalism and 'right to health care' approach of socialism.

In India's case of British experience is most relevant.

When the British NHS was started the situation of private health care was similar to what it is in India today.

However, the difference lies in the ability of the estate to state to undertake the task of organising the myraid health care services under a universalised umbrella. It is not that the Indian State cannot do what its British counterpart did over four decades ago. The problem lies in the unenviable position of the Indian state the total lack of any professional or statutory regulations and controls over medical proactive, the multiplicity of system of practice (along with rabid cross practice), the current structural adjustment requirements which reduce resource availability for social sectors, and, of course, the past health policies and programmes which have created a dual system of health care services (rural and urban differences).

Given this scenario what are the possibilities of setting up an UHC system, given a basic political will and the pressure exerted by widespread poverty.?

Where the basic model of health care delivery is concerned the one delineated by the Bhore Committee is the basic requirement. There should be no dispute about this because this minimum decent standard is absolutely necessary for any worthwhile, effective and egalitarian system. The are of modification that is necessitated by the historical experience is the mechanism of financing and the provision of routine curative care.

MODIFICATIONS AT THE PRIMARY LEVEL

The structure recommended by the Bhore Committee at the primary level is also institution based and it is here that the major modification is required.

Given the vast number of individual practitioners of all varieties (over 7 lakhs in numbers) existing today, routine care cannot be institutionalized as envisaged by the Bhore committee.

We are here not discounting the primary unit hospital, which is recommended at the 20,00 population level. That is a must, along with its preventive and promotive infrastructure. However, the primary unit must be a referral unit for first level hospitalization, including maternity cases. Routine medical care must be decentralized by involving the existing general practitioners into some contract or insurance based system. Efforts must be made to assure that undeserved areas get general practitioners to serve the population. We have enough doctors to spread across the population on the basis of one GP per 150 to 200 families. The GP, or more appropriately the family physicians, will be the first level for any medical attention, except an emergency, which needs a higher level care.

Here, we will not go into the details of the structure to be evolved. It will suffice to say that each family physician should have a fixed number of families to look after and s/he will be reimbursed a contracted amount for providing such care. This also implies universal enrollment; redistribution of medical practitioners to cover the absolute minimum requirement; regulation, standardisation and audit of medical care; and price fixing. In other words, the State has to play an even more significant role in organising and monitoring health services.

Whether such a reorganisation is feasible both organisationally and financially. Our answer is Yes. The State regulates myriad activities in the public and private spheres and hence creation of a regulation mechanism for medical care and practice should not be difficult. Whenever a new area is regulated vested interests, usually a dominant group opposes it. However, historical experience shows that if the State exerts its political will, the dominant forces can be overcome because the State can generate easily a mass support for its actions. One needn't given examples of such actions by the Indian State in various spheres. They are well known.

We are fortunate today in having lessons from various countries, which have implemented systems of UHC. One can use these experiences to organise a system of UHC most suitable and appropriate to own socio-economic setting.

Financially too a UHC is feasible, India is today spending about 6% of its GDP on the health sector, i.e. about Rs.36,000 crores (about one-third by the State). Because of the disorganised and marker oriented system there is a lot of wastage of resources. A properly organised, regulated and a monopoly buyer system of health care delivery can cut this wastage and reduce the burden on many household, especially the poor ones.

The essence of such a system should be that no direct payment is involved. Tax revenue will remain one important source of financing. Segments of population which can afford to pay must be charged on their income/production. Thus employers, organised sector employees, middle and upper levels of self employed (including farmers) and professionals etc. can make contributions either as insurance or as a health protection tax. Those who fall into the 'cannot-afford' category (about three-fourth of the population) will have the same rights as those who contribute. If health becomes a right and adequate and quality services are easily available then those who can afford to pay will most willingly contribute to any prepayment scheme.

The intention of this paper has been to only present an idea and hence we will not go into any detailed plans and modeling of organizational and fiscal structures.

CONCLUSION

To conclude we would like to indicate important issues which need to be thrashed out in designing an UHC system.
Integration of multiple systems of medicine and creation of a single family physician cadre.
Restructuring medical education in the above context.
Policies regarding redistribution of medical human power to meet the population's and the new system's requirements.
Creation of mecahnisms for regulation, monitoring and audit of health care provision and providers.
In the context of the above evolving various standards of medical practice.
Stronger regulation of drug production and pricing
7. Setting up a fiscal mechanism for raising resources as suggested in the above discussion social insurance, health protection tax etc…
Organising a system of compensation for providers of services.

Note: All references refer to Bhore Committee Report Volumes and page no. (e.g. II.6 means Vol.II page 6)

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