# The Bhore Committee (1943-1946): health and colonialism

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## Abstract

The Bhore Committee was one more in a long series of commissions and committees, which sought to produce knowledge about a particular topic, but also to grant legitimacy to the State and guide processes of public policy making. This Committee was appointed in an agitated political context to conduct a study of the health of the Indian population and to make recommendations. I am particularly interested in the composition the Committee had and in the choice of methods to gather and produce knowledge. The members were specialists in public health, medicine and the administration of the health care system. The methods included the gathering of available information, the elaboration of studies and the request by the Committee for the participation of international advisors. By doing this, I hope to contribute to the studies on inquiry committees and commissions as well as to the social history of public health in India.

**Keywords**: inquiry committees and commissions, health care, colonialism, India

## Introduction

In early March 1946, the Report of the Health Survey and Planning Committee was finally published, after three years of the beginning of the inquiry. In its four volumes, the Report described the grim situation regarding vital statistics and health care in India, as well as outlined two programmes of action: one short-term to be achieved within two five-year periods and one long term to be achieved within 40 years (Bhore, 1946, p. II, p. 4).

The Committee had been led by Joseph K. Bhore, a member of the Indian Civil Service, with a long career in the colonial administration. Bhore led a Committee integrated by a group of 24 people, most of them experts in public health and its organisation, medicine and sanitation. They were also helped by a group of foreign advisors, experts like them who came from Australia, United Kingdom, the United States of America, and the USSR.

Committees and commissions like this one had been formed throughout the colonial period, and especially from the 1830s onwards to address several issues related with public policy. After 1857, the colonial government decided to have a better knowledge of the population and thus several commissions and committees were formed in relation to it, for example, commissions on public health and education. During the twentieth century, inquiry commissions and committees were used consistently to understand and make recommendations on a wide range of topics such as the study of finances and currency (Committee on Indian Exchange and Currency, 1919), the elaboration of a new legal framework for the colony (Indian Statutory Commission, 1928), the conditions of workers in

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industries, mines and plantations (the Royal Commission on Labour, 1929), and the definition of the boundary between India and Pakistan (Boundary Commission, 1947).

The literature regarding commissions and committees and other kind of social investigations carried out by the State that were formed in the nineteenth century and the first part of the twentieth century has provided important insights into their role in the making of public policy. There have been debates regarding the types of commissions and committees, the reasons behind their appointment, the process of gathering and generating information which speak about the State's contribution to the creation of knowledge, as well as their impact.

In a detailed article, H.F. Gosnell (1934) explores their relevance in the making of public policy, both in Great Britain and in the colonial world. In his text, he undertakes a thorough analysis of the types, composition and functioning of these mechanisms used by the State. He proposes seven types according to the subject, which included among others, public administration, social services, changes in private law and colonial administration (1934, p. 88-89). He also carefully examines the way commissions and committees were given terms of reference, which stated with precision the aims of their inquiry. The inability to go beyond those terms was frequently criticised by the press, which spoke about the interest generated by these bodies. But the interest and criticism also talked about the public demands which were at their origin (Gosnell, 1934, p. 90). Gosnell studies the possible types of commissioners: they could be representatives of interests or specialists in the topic to be investigated, but no matter what type, they were expected to be impartial (1934, p. 93-96). The different ways to gather information are also analysed by Gosnell who mentions public audiences, questionnaires, collecting documents, the hiring of special investigators, and visits by the members of the commission or committee (1934, p. 99-106).

For Adam Ashforth (1990), commissions and committees allow the State to show it solves problems in a rational and organised manner. He also elaborates about the type of members chosen by the State: representatives or experts. Sometimes, the State considers it needs to have certain interests represented, so it will appoint people who act like that. But other times, the State requires experts so that the Report has authority. But very often, Ashforth writes, it is difficult to differentiate between both types, since "…the greatest experts are precisely those with the greatest 'interest'" (1990, p. 14).

He proposes three phases to understand their work, which are important for understanding the Bhore Committee: the investigative, the persuasive and the archival. The investigative phase made possible the interaction of members appointed by the State with people with social interests in well-regulated contexts defined by the State -for example public audiences. The persuasive phase implies publishing a report and establishing a timeframe for actions to be taken (or not at all). And finally, the archival phase where they "become a source of historical 'facts'..." (Ashforth, 1990, p. 8).

Oz Frankel (1999, 2006) has written on the social investigations (including commissions and committees) carried out by the State, mostly in nineteenth century Great Britain and the USA. Particularly relevant to this text, are Frankel's analysis of the many unexpected consequences of these exercises. These inquiries were organised by the State, but unlike Ashforth (1990), Frankel contends that the actual process was not under its control, since they favoured contact between different sections of society (for example, commissioners, assistants, and local populations), and they could lead to criticism towards the State. Additionally, the reports produced contained not one voice (the State's), but many. For example, when Frankel analyses the Report written by the Children's Employment Commission (Mines) in Britain, he describes it as a "polyphonous document" since it included

the voices of the workers, of the subcommissioners and those of the senior commissioners (1999, p. 31-32). Interestingly, Frankel writes about the archival phase too: unlike other documents produced by the State that were meant to be read only by the State itself, the commissions and committees' reports were meant to circulate, opening spaces which were closed till then, for example the terrible conditions of workers in the case of Frankel (2006, p. 10-11) or the health situation in India in the case of the Bhore Committee.

In her book on the colonial archive, Ann Laura Stoler (2009) studies inquiry commissions, particularly those related to social reform in the nineteenth century Netherlands Indies. Two sets of ideas are particularly relevant for this discussion. One is related to the colonial archive and the multiple voices found inside. Stoler reminds us that many people contributed towards its making: those directly linked to the colonial State (such as governor-generals and their subordinates), but also those who had tenuous links to it (such as doctors and clergymen) (2009, p. 20-21). Besides, Stoler points to the fact that the colonial archive is the site not only of command, but also of countercommand: neither the colonial archive nor the colonial power were monolithic (Stoler, 2009, p. 50-51).

Regarding inquiry commissions, Stoler writes about two of these bodies appointed to study European pauperism in the colony (1872 and 1901). For her it is important to notice the way commissions validated certain forms of knowing, while displacing others. She acknowledges the role these investigations may play in distracting public attention, but also in mobilising interest (2009, p. 29-30). In her account of the way those two commissions functioned, she emphasises how they worked under certain assumptions, regarding the native and the poor Europeans living in the colony. Interestingly, the 1872 commission departed from the norm: it did not publish its results and it did not carry a survey, because it did not want to attract attention to the kind of life these Europeans were leading, since it did not befit the colonisers (Stoler, 2009, p. 146-149).

Studies regarding the Bhore Committee have explored the context of formation, the composition, and the role of the advisors, as well as its legacy (Amrith, 2006; Bajpai & Saraya, 2011; Murthy *et al.*, 2013, Carballido-Coria, 2020).

In his important book on international health, Sunil Amrith (2006) situates the Bhore Committee as an effort by the colonial regime to gather support. The nationalist agitation, especially the Quit movement, posed a challenge to the colonial government which tried to show its concern towards the Indian population by outlining a blueprint for public health after the war. Amrith depicts the international advisors to the Bhore Committee as a group of progressive doctors, one of whom had socialist leanings, in contrast to the commissioners who were "conservative Indian civil servants" (2006, p. 58). Amrith highlights two points of the Bhore Report: it stated that public health was the responsibility of the state, and it emphasised the economic impact of life loss and illness. The latter was particularly relevant for the Indian National Congress, which cited the Bhore Report in its own Report: the Sokhey Report (2006, p. 61-63).

Vikas Bajpai and Anoop Saraya (2011) assess the elements present in the Report. Regarding its valuable contribution, Bajpai and Saraya mention the responsibility of the State concerning public health, the primacy that public health should have, and the detailed study elaborated by the Committee which carefully identified the causes of the difficult situation India faced. The last element is particularly relevant because to date no similar in-depth study has been produced by the independent government.[1] But the Report had shortcomings too:

[1] Bajpai and Soraya mention as an example the National Rural Health Mission (2005) and its superficial study (2011, 219).

it proposed a public health system where the people relied on the State as a provider (instead of a system built around the idea of health as right), it did not introduce the idea of a universal free health system, and it did not envisage the updating of indigenous systems of medicine to meet scientific standards, among other elements. For the authors, the Bhore Report is key to understand India's present state of health (Bajpai & Saraya, 2011).

Prathima Murthy *et al.* (2013) focus on the composition of the Committee. In a way similar to Amrith, they compare the international advisors with the commissioners. Whereas the former had political positions and progressive views regarding health as a people's right and the central role to be played by the State, the latter were civil servants with no specific political orientation (Murthy *et al.*, 2013, p. 76). Interestingly, towards the end of the article they also reflect on the failure of the independent State to implement the recommendations of the Bhore Report. In light of the pressing problems of the new country, health became secondary, an idea which they emphasise by naming their article's last section "Aftermath: A Vision Betrayed." Years later, this neglect was confirmed by the privatisation of the health sector (2013, p. 76-77).

Laura Carballido-Coria (2020) has written about the first years of independent life, where many of the Bhore Report's recommendations became the founding stone for the health care system, a decision which makes us reflect on the relationship between the colonial and postcolonial periods. The main point of her article is the Mudaliar Committee, appointed in 1959 to study the First and Second National Plans, as well as, to make recommendations keeping in mind the changes in the country since the Bhore Committee had elaborated its study (Carballido-Coria, 2020).

My work seeks to learn from and engage with the questions and debates posed by all these authors. The Bhore Committee was appointed to grant legitimacy to the State in an agitated political context, and guide processes of public policy making as in many of the cases studied by Gosnell (1934), Ashforth (1990), Frankel (1999, 2006), and Stoler (2009). The studies about the Bhore Committee (Amrith, 2006; Bajpai & Soraya, 2011; Murthy *et al.*, 2013; Carballido-Coria, 2020) have not paid enough attention to the type of commissioners the Committee had and to the choice of methods to gather and produce knowledge. The methods included the elaboration of studies by local authorities and civil servants and the request by the Committee for the participation of foreign advisors. By doing this, I hope to contribute to the studies on inquiry committees and commissions as well as to the social history of public health in India.

First, I will point out to important historical developments in the context of formation of the Bhore Committee. Then, I will analyse the way the Committee was appointed: its membership and terms of reference. I will also look into the type of investigation carried out and the various materials it produced. To do this, I will use official correspondence, newspapers, and various types of printed reports.

## Context of formation

The construction of a health care system in colonial India was fraught with difficulties and tensions. Even though initially the main concern of the colonial administration had been the health of the army and the European population, gradually its scope expanded due to many factors: the relevance of health to economic activities, the international pressure because of the spread of disease through pilgrimage, the expansion of Western medicine as part of its civilising mission and the criticism by the nationalist movement, which pointed to the health problems as part of the consequences of colonialism (Arnold, 1993; Harrison, 1994; Amrith,

2006; Sehrawat, 2013). According to Samiksha Sehrawat the ideal health care system for the British was a combination of State's and voluntary associations' initiatives. However, in India British colonialism departed from this model and did fund voluntary projects to show responsibility towards its colonisers, but also to set an example to Indian elites. By doing this, they hoped the elites would also give funds and engage in voluntary projects (2013, p. 2-3).

Another factor that explains the many problems affecting the health care system was the legislation. Since 1914 the colonial government had shown interest in keeping control only of medical research and in transferring all other subjects to the provinces. The India Act of 1919 materialised it by introducing diarchy and giving more autonomy for provinces. Thus, medical administration and education, public health, sanitation, and the gathering of statistics were left in the hands of provincial governments (Bhore, 1946, p. I, p. 25). The result was a health care system without a central authority, with financial constraints and a very limited outreach (Amrith, 2006). This system had an important participation of voluntary associations and quasi-governmental projects (funded partially by the government and backed by authorities or notable people such as the vicereines) which carried out tasks that should have been in the hands of the State (Sehrawat, 2013, p. 103, p. 118-119).

During the decade of 1920 and in the beginning of the decade of 1930, the Health Commissioners had written about the need to spend more on public health, to strengthen the number of personnel, to have reliable statistics and to create a Ministry of Health which could coordinate activities in the whole of British India. Despite the deficiencies in information, the Health Commissioners had consigned alarming mortality rates, the paucity of hospital beds and the lack of health personnel in rural areas (Graham, J.D., 1933, p. 2-3).

The decade of 1930 had seen a great political agitation around the three Table Conferences (in 1930 and 1932). The project for a new Act for India had generated expectations in many areas, but in the eve of important 'constitutional' changes, wrote the Health Commissioner, health was relegated (Graham, J.D., 1933, p. 2-3). Finally, in 1935 the new India Act was approved, which meant a federal system at the centre and more power to the viceroy. Besides, it allowed a greater proportion of the population the right to vote, among other relevant changes. Under the new organisation, diarchy had disappeared, and all government departments passed under the provincial governments (Bose & Jalal, 1998, p. 150-151; Banerjee-Dube, 2019, p. II, p. 297-299). This decision confirmed health as a provincial topic, both in terms of organisation and budget, which meant that efforts in this direction were left again to the energies and resources of the provinces and local governments.

India had suffered the consequences of the Depression, limiting the expenditure regarding health. At the beginning of the Second World War, economic problems deepened, prices went up and a there was a further reduction of public expenditure, which had an impact on health and sanitation by extension. There was also scarcity of goods such as clothes, food, and kerosene oil due to the fact that they were being sent to the war front and that imports from Great Britain had diminished (Bose & Jalal, 1998, p. 157).

In the decade of 1940 two more developments were added on. There was a political agitation against colonial rule, the 1942 Quit India Movement. The mobilisation had been so widespread that the colonial government lost control over some districts. It also meant a high number of the leaders of the nationalist movement were in prison.

And the Bengal Famine developed in late 1942 and the first part of 1943, causing around 2-3 million deaths. The Famine had its own commission appointed (the Woodhead Commission) to investigate the causes and to make recommendations so that such an event

would never take place again. Interestingly, its works coincided part of the time with those of the Bhore Committee.

Keeping in mind the weaknesses of the health care system and the way it had been affected by developments in the decades of 1930 and 1940, it comes as a surprise that the colonial administration decided to appoint a Health Survey and Development Committee. Undeniably, an assessment of the situation in terms of vital statistics, personnel and infrastructure was needed to draft a plan to use after the war and it was a task to be expected from the colonial State. But the evidence to be gathered would not show the colonial administration in a favourable light.

Finally, it is relevant not to miss the relation between the Bhore Committee and similar exercises (Pati & Harrison, 2009, p. 2-3). On the one hand, back in 1938 the Indian National Congress had set up the National Planning Committee, which would start its activities in early 1939. The aim was to study "all parts and aspects of the national life and work in accordance with a predetermined Plan" (Sokhey, 1948, p. 6). Twenty-nine subcomittees were formed and organised in eight groups: health was part of the Group VI Health and Housing. However, the imprisonment of Jawaharlal Nehru in 1940 interrupted the work of the parent Committee and even though he was freed a year later, the extension of the war made it impossible to continue its work till 1945. On the other hand, in Great Britain there was pressure too to organise the reconstruction work after the war, as well as the idea to centralise the health system. Thus, two committees were formed. One was the Social Insurance and Allied Services, appointed in 1941 and headed by William Beveridge. The Report outlined recommendations for the post-war welfare state (Whiteside, 2014). The other was the Goodenough Committee, whose first meeting took place in April 1942 (Stoney, 1944). The Goodenough Committee was closer to the Bhore Committee, since it focused on medical schools. Both, the Beveridge and the Goodenough Committees, contributed to ongoing debates which would lead to the formation of the National Health Service in 1948.[2]

## Setting up

Under these difficult circumstances, on 18th October 1943, the colonial government decided to appoint the Health Survey and Development Committee, also known as Bhore Committee, because of its chairman, Joseph Bhore. As in every other commission or committee, the terms of reference outlined the goals of the inquiry from which it could not depart. In this case, they were comprehensive: "to make a broad survey of the present position in regard to health conditions and health organization in British India and to make recommendations for future development" (Bhore, 1946, p. III, p. 299).

The terms of reference stated that the Government of India had to be prepared to make informed decision as soon as the war was over, thus detailed information regarding public health was a requisite to organise reconstruction work after the war (Bhore, 1946, p. I, p. 1-2). Sunil Amrith has written that the Committee was formed to gather allies, and to show concern for 'national welfare' (2006, p. 57). From the official correspondence, it can be inferred that the government wanted to present itself in a favourable light, but interestingly, there is also a need to differentiate the authorities in India from those in the metropolis, particularly, in terms

[2] Noël Whiteside has noted that the creation of the National Health Service (NHS) is generally attributed to Beveridge. However, the three main ideas contained in the Beveridge Report (family allowances, a free National Health Service and "state maintenance of full employment") had being debated for some years. As a matter of fact, Whiteside writes, the Beveridge Report supported the creation of the NHS, but it only gave some financial advice, without making specific suggestions about its structure (2014, 5).

of responsibility. Thus, in a letter from the Secretary of State for India, Leo Amery to W.U. Willink, the Minister of Health, he emphasises the relevance of the work of the Bhore Committee in view of the consequences of the Bengal Famine. He adds that they should collaborate with the arrangements (in this case was the arrangements dealing with the advisors requested by the Committee), since part of the animosity extended to them. While reading this, it feels almost as if the metropolis was not involved or benefited from its colony:

> *The disease which followed in the wake of the recent famine has shown how important and how urgent is the task undertaken by the Committee. Some of the odium of the Bengal catastrophe has fallen upon the Home Government, by virtue of our residuary responsibility in respect of India, -and perhaps that is a further reason why we should bestir ourselves to help in the present matter if we can (Amery, 1944, August 5).*

Except for the Chairman whose main contribution was a deep knowledge of the colonial system, the majority of the members of the Bhore Committee were experts in the field: some were directors of Public Health, some belonged to the Indian Medical Service or the Women Medical Service, others worked at universities and hospitals, others represented medical associations, and most of them were doctors.[3] For example, the Committee included the Director General of India Medical Service, J.B. Hance; as well as Directors of Public Health from Punjab and United Provinces, and several members of the Medical Council of India (a regulatory body for doctors). There was present the Director of the All-India Institute of Hygiene and Public Health, Dr. J. B. Grant, who was also part of the International Health Division of the Rockefeller Foundation.

As it has been mentioned, existent literature has paid more attention to the international advisors, than to the members themselves. Sunil Amrith has written that "On the surface, the Bhore Committee – as it was known – exhibited a somewhat predictable membership, similar to countless colonial commissions of inquiry in preceding years" (2006, p. 57). And while it is true that the advisors who helped the Bhore Committee had very interesting careers and major accomplishments, this Committee was integrated by specialists. Besides, previous commissions and committees in India had memberships that combined interested parties, remarkable (and loyal) bureaucrats and politicians, and sometimes people with expertise. As Gosnell (1934) and Ashforth (1990) have shown, it is difficult to differentiate between representatives and experts. Take for example, the Simon Commission (as the Statutory Commission was commonly known) which was appointed to study the functioning of the government system and to make recommendations regarding its reform: its members came from the Parliament and the chairman was John Simon, a politician who occupied key positions like Home Secretary. Interestingly, since the progress of education was one of the themes to be studied, the Commission appointed a Committee to carry out an in-depth study. This auxiliary Committee was composed by civil servants who knew about education, *i.e.*, specialists such as the vice chancellor of Patna University or the Director of Public Instruction in Punjab; and by a couple of members of Legislative Council: one of them

[3] Apart from the Chairman, there were four members who were not doctors. Out of them, Frederick James, Pandit L. K. Maitra, and P.N. Sapru participated in the Central Advisory Board of Health. The fourth was Shiva Rao, who was part of the international labour movement. His presence is explained because one of the topics included in the investigation was the health of the industrial worker.

was a woman, Muthulakshmi Reddi, not a very common event (Government of India, 1929, p. 1-2).

A second example is the Royal Commission on Labour (1929), whose membership included representatives of interested parties: labourers, employers, and government. The chairman, John Henry Whitley, was a politician with experience in the topic, since he had led a committee on employer-employee relations, after First World War (Carballido-Coria, 2019, p. 94-95). This may seem like a minor element, but otherwise the argument made by Amrith himself about the Bhore Committee being an instrument for the colonial government to gain legitimacy and support loses strength (2006, p. 57).

Prathima Murthy *et al.* (2013) describe the membership in these terms: "a civil servant at the heart of the process (Joseph Bhore), a number of doctors in practice and with 'influence', and hardly any from the academic or teaching faculty" (2013, p. 76). They are right at pointing out the lack of more doctors who were part of teaching or research institutions. But as in the case of Amrith (2006), they fail to acknowledge the expertise that most of them had and some important elements such as the participation of three women. Two of them were female doctors: one was Dosibhai J. R. Dadabhoy, the first Indian woman in doing an MD in tropical medicine in London. After she returned to India, she opened a maternity clinic, apart from working at the Cama Hospital and at King Edward Memorial Hospital. She was also the first Indian woman to be President of the Association of Medical Women of India (Ramanna, 2008, p. 72, p. 74-76). The other was Dr. H. M. Lazarus, who studied in Madras Medical College and in London and Dublin. She was the first Indian woman to join the Women's Medical Service, under whose service worked in various positions (Forbes, 2004, p. 163-164; Chattopadhyay, 2018, p. 223-225). The third woman was Mrs. Shuffi Tyabji, from Bombay, who was one of the vice presidents of the National Council of Women in India, which fought for women's rights (1936-1937, p. 5).

It is relevant to note that in previous enquiries, women were rarely included, and if they were, they were British or were consulted as advisors. For example, when the Royal Commission on Labour was appointed in 1929, it included only a British woman, as a reply towards demands for women's greater participation in the metropolis. Indian women were consulted during the tour of the Commission (Carballido-Coria, 2019, p. 95). In the case of the Bhore Committee, the fact that female doctors had been appointed talks about their hard-worn presence in the field of health (Forbes, 2004) and their involvement in various organisations.

The members of the Committee would conduct a detailed study, facing the restrictions imposed by war and using a methodology which would undermine the very aim of the colonial State: the search for legitimacy and allies.

## The Bhore Committee's methodology

The task set before the Committee was very ambitious, since producing a study of the health of the population, and the various institutions involved (without even considering the fact of making recommendations and writing the Report) in 26 months seemed almost impossible. Particularly, if we compare it with similar exercises. For example, the Goodenough Committee focused only on the medical schools in Great Britain, which had a smaller territory and population and had the same time to produce a Report (Bhore, 1946, p. I, p. 3).

It is remarkable to note that while reading the Bhore Report the references to the historical processes going on, and which have been mentioned; include only the war and the

challenges and difficulties that arose to carry out the study. The extraordinary of the circumstances, the Report stated, made the works of the Committee difficult, for it would be very unlikely that provincial governments would be able to prepare all the data required by the Committee. Thus, they would have to rely on existent material (Bhore, 1946, p. I, p. 2). The lack of lodging in the provinces and the restrictions for travelling by train would make almost impossible for the Committee to travel to secure first-hand data, therefore they should have to form four groups that would tour all provinces, except Assam and Baluchistan. These visits had to be brief and very selective for the time available was very little. As it has been mentioned, the work had to be completed in 26 months.

Finally, the last impact of the war on the functioning of the Committee was the decision to establish 1941 as the final year for collecting information. The reason was that the entry of Japan to the war had had a great impact on India. Given that the study aimed at assessing the health and sanitation under "normal conditions" to make accurate recommendations, 1941 was the year chosen, as the section with recommendations on contagious diseases explains (Bhore, 1946, p. II, p. 143).

As it has been mentioned, Frankel has written that even if States sought to empower themselves by organising enquiries and publishing information and reports, they could not control all the process and unexpected outcomes occurred, either because different sections of society came into contact, either because sectors who had been unrepresented were brought into light (Frankel, 2006, p. 2-4, p. 14-15). Also, there was no such a thing as a unified voice of the State, since the various participants (State officials and legislators) who wrote the reports enjoyed a sense of authorship. Frankel draws attention to the fact that, very often, the reports are called after the names of individuals, rather than after the State that created the commission or committee, something that happened with the Bhore Report (Frankel, 2006, p. 2-4).

In the case of the Bhore Committee the unexpected consequences were many. First, the knowledge gathered produced by local authorities and experts in India at the request of the Committee exposed the many failures of the colonial state in expanding Western medicine and in its civilising mission in general. Second, the contact established with foreign specialists to ask for opinions and the request to invite international advisors deepened the interest and criticism, which was reflected in the Indian press. Third, the material written by these advisors became a source of concern in the metropolis.

The Committee decided to divide its work in five consulting committees: public health, medical assistance, professional education, medical research, and industrial health. Each one of these areas would have a group of specialists who would oversee gathering the data (Bhore, 1946, p. I, p. 3). Data included both the material already existent and the material created *ex professo* for the Committee. In the first case, there was a wide range of printed texts, such as the annual reports of the Health Commissioner for British India and of the Indian Red Cross Society or the quinquennial reports of the Lady Hardinge Medical College and Hospital for Women and Children, Delhi.

In the second case, there were 206 texts prepared especially for the Committee. They included letters addressed to members of the Committee, notes and memoranda on different topics such as medical research in India or the training of hospital social workers, proposals to deal with different problems in short and long-term and replies to questionnaires sent to people outside India, for example, to Dr. J. J. Heagerty, Director of Public Health Services, Canada; Dr. Winslow, who had taught Public Health in Yale University and to Charles Seeley, of the Birmingham Regional Officer of the Ministry of Health (Bhore, 1946, p. III, p. 303-311).

A couple of concrete examples of the investigations set in motion by the Committee are illustrative. The first example is the extensive report prepared by Col. Moore Taylor, Medical Superintendent Ranchi European Mental Hospital. At the request of the Committee, he made a tour of mental hospitals in Calcutta, Madras, Bangalore, Poona, Bombay, Nagpur, Agra, Lahore and Ranchi itself. At the end of it, he wrote a report detailing the characteristics of several hospitals, ranging from the type of equipment available and the infrastructure, to the number of nurses, and the quality of the diet. The methods were diverse: he visited the hospitals, gave questionnaires to the superintendents, received notes from them and interviewed personnel from teaching institutions (Bhore, 1946, p. III, p. 42-68).

After summarising the information collected at all the places he visited, Taylor wrote an analysis on mental hospitals in India, as well as a series of recommendations to improve them. His last few lines convey the alarming situation: "Finally, I would stress that the conditions in some of the Mental Hospitals in India today are disgraceful, and have the makings of a major public scandal" (Bhore, 1946, p. III, p. 68).

The second example is the report on urban and rural planning in India elaborated by B.R. Kagal, who worked for the Department of Education, Health and Lands (Bhore, 1946, p. III, p. 73-90). Kagal elaborated a questionnaire that was sent across to people in key institutions, received memoranda from interested parties and conducted interviews. He conducted the interviews during a tour from October to December 1944, when he visited: Delhi, Shimla, Lahore, Karachi, Hyderabad (Sind), Ahmedabad, Baroda, Bombay, Poona, Kirkee, Bangalore, Madras, Hyderabad (Deccan), Nagpur, Jamshedpur, Calcutta, Patna and Kanpur (Bhore, 1946, p. III, p. 73).

At the end, Kagal sent a report to the Committee which contained an analysis on urban and rural planning, along with as a series of recommendations. In his report, he depicted the lack of interest in town planning (but for a few exceptions), problems with finance, and absence of projects to deal with housing for the poor, among many other concerns. All these was accompanied with documents supporting the report. This was the type of documents that would be studied carefully by the Committee.

However, another important source was consulted. After several months of being appointed, in July 1944 the Committee requested "…that certain experts of standing from other countries should be invited to India to assist Committee" (Government of India, 1944 July 28). In the same telegram, the Government of India stated that the Committee had asked for: 1) John A. Ryle from social medicine in Oxford, 2) for Wilson Jameson Chief Medical Officer Ministry of Health or for Weldon Dalrymple-Champneys, who was the Deputy Medical Officer and 3) for a member of the Goodenough Committee on medical schools. All costs would be covered by the Government of India.

After this initial telegram, further correspondence was exchanged amongst several members of the government. There, they pondered not only the relevance of helping to satisfy the request, but also the difficulties to do so. For example, in a Draft telegram to reply to the initial one, it was explained that the Ministry of Health could not spare Jameson, but it could spare Dalrymple-Champneys, and that the only member available of the Goodenough Committee was Janet Vaughan: "…of whom they speak in highest terms and I should think a woman member might be particularly useful unless you see strong objection" (Draft Telegram, 1944).

On August, the Bhore Committee requested another expert, but this time from the USSR:

> *Committee wishes to discuss with foreign experts and has asked that one from Russia should also be invited, suggesting Director V.I.E.M., Moscow, or other English speaking expert able to give information on general health administration in Russia (Government of India, August 11, 1944).*

The official correspondence expressed concern about ensuring the quality of the advisors. In a letter from the Secretary of State to the Government of India, it was mentioned the advise given by Hance: to invite a representative of Royal Medical Colleges and, if possible, someone from the Netherland East Indies Government. The reason being that the former would contribute his knowledge on the topic, whereas the latter "would add authoritative international opinion..." (Amery, 1944, September 27). The interesting element is that Hance mentioned the original idea came from Linlithgow, when he was a Viceroy. However, when the idea was presented to the Government of India, it was considered unnecessary (Amery, 1944, October 18).

Correspondence was also sent to the governments of Australia and United States to invite experts and to the experts themselves.

The advisors brought with them their expertise in different aspects of public health administration, research, and an interest in social medicine. Weldon Dalrymple-Champneys, was deputy medical officer in Britain and John Ryle was a professor from Oxford and a leading figure in public health. John Henry Cumpston, Director General of Health, Australia, who was interested in infant healthcare: he insisted in the importance of health visitors and maternal education. Janet Vaughan was a physiologist and principal of Somerville College, Oxford. She was also known for having established the first blood transfusion service and was interested in studying the link between poverty and disease. Joseph Mountin of the US Public Health Service, who advocated universal health care (Murthy et al., 2013, p. 72-75). Henry Sigerist, a historian of medicine from Johns Hopkins University, who saw health as a right, and who had open socialist views (Amrith, 2006, p. 58-59). The last one to arrive in India was Professor Boris Vladimirovich Ognev, Chairman of the Central Institute of Higher Medical Training who was sent by the USSR at the invitation extended by the British Government (From Moscow to Foreign Office, 1944, December 8).

It is interesting to ponder why the Bhore Committee would have chosen to have advisors? And why did they think of some names and characteristics in particular? Did their presence work as a sort of confirmation or support towards the findings and recommendations they wanted to advance? Amrith has written about the progressive views of several of the advisors: they saw the State (not volunteers or reformers) as the main responsible for public health. He has also pointed to the criticism towards the colonial administration implicit in the Report (2006, p. 61). By asking the colonial state to invite these people in particular, the Committee was clearly curious and open to hearing about other possible schemes regarding health care systems.

The interest in the presence of the advisors extended to the press and to other spheres showing criticism for the failure of the colonial State regarding public health. The *Hindustan Times* reported the arrival of the experts and the tour of India they were to do in these sarcastic terms:

> *The visitors […] wonder what Cuttack must be looking like since it has been described to them as the museum of diseases. The capital of Orissa is said to be a breeding place for all sorts of human ailments […] and Shahdara, known as the museum of insanitary conditions (Six Foreign Health Experts in India, 1944, November 7).*

In these few lines, the newspaper was anticipating the results of the investigation. If the Bhore Committee had been appointed to express both the concern by the colonial administration for its population and the conviction to draw a blueprint, only the former came out according to plan.

**The Report and other materials**

The Bhore Committee produced directly and indirectly several materials among which it is important to distinguish. On the one hand, there was all the print and oral evidence, which comprised not only official correspondence, but also the studies elaborated specifically for the Committee (which have been described), private memoranda, speeches, and declarations. On the other hand, as in previous enquiries, a report would be published. The report would be part of the archive, but unlike the first type of documents, it was meant to circulate (Ashforth, 1990; Frankel, 1999, 2006; Stoler, 2009).

In the case of the Bhore Committee, there is the official correspondence, from which the intentions, the aims, and the contradictions of the colonial state have been reconstructed. But there are also the correspondence and the memorandum written by the international advisors.

After they left India, the three British advisors, Dalrymple-Champneys, Ryle and Vaughan, decided to write a memorandum with their impressions of the health situation in the colony and their recommendations. Ryle sent the text to Amery, in the India Office, specifying that even though only the three of them had written it, they had no doubt the other three advisors shared their views (Ryle, 1945, January 10). Apart from an introduction, the memorandum is divided in two parts: the first one presents the current situation and the second one contains the recommendations (Dalrymple-Champneys et al., 1945).

They criticised the lack of cooperation inside the areas of Health Services, Education and Agriculture despite the fact of being part of the same Ministry, the lack of clarity regarding the relation between the Centre and the provinces on these matters, the apathy of the civil servants, the lack of funding and the emphasis on treating diseases instead of on introducing preventive medicine. Their suggestions aimed at solving these problems (Dalrymple-Champneys et al., 1945).

Two things are relevant to understand their role in the study conducted by the Bhore Committee. One is the relationship between them and the commissioners. They viewed themselves as sharing similar opinions regarding the problems and the kind of health care system needed. This is mentioned explicitly and implicitly in the letters and in the memorandum (Ryle, 1945, January 10; Dalrymple-Champneys et al., 1945).

The other is that they thought of themselves as witnesses. The advisors made a tour of India and went back to Delhi. There, they held a meeting to share and clarify their ideas (which would evolve into the memorandum), before meeting the commissioners. During the

conversations with them, they touched not only the impressions gathered during the visits to industries, hospitals, and slums, but they also explained the way health care systems worked in their countries (Ryle, 1945, January 10).

However, their opinions and memorandum became a source of concern for the colonial State. After they returned from India, people approached them to find out about their observations. Dr. John Ryle wrote once to the Secretary of State looking for guidance in this respect and the reply he got was: "I am afraid I could not possibly agree to your showing a copy of your memorandum to Dr Katial. The memorandum is, as you will realise, very frankly critical of the whole organisation of the Government of India" (Amery, 1945, March 24).

It is important to consider this because even if this type of enquiries helped to constitute the archive, Frankel has remarked that they also raised relevant questions about consignment: "what should be published and what should remain secret, private, or merely unpublished, and, by implication, whether the state or its officers have a protected sphere of private writing" (2006, p. 10).

And there is also the Report, which was published in four volumes in 1946. The first volume depicted the state public health and the way it was organised. The second volume had the recommendations made by the Committee. The third volume contained a great amount of data used: from the number of hospital beds per inhabitant, and the specific reports elaborated by functionaries to morbidity and mortality statistics. And finally, the fourth volume contained a summary of the Report in 90 pages.

The first volume set as a goal the improvement of the health of the Indian population. The subject of the text is the "people": the people suffering from poor sanitation, as well as the people who would eventually enjoy better circumstances. Even if in the past the volunteer had been important figure in the provision of health (or the Church in the European context), one of the key ideas present in the Report was that the State had to create an adequate health administration: it was its responsibility (Bhore, 1946, p. I).

Another important conclusion was that in the history of health decisions made by the colonial administration, there had been a tendence towards giving power back to the provinces. However, it had also implied passing on to the provinces the responsibility to get funds for these and other subjects. Even though there had been an effort to centralise information in the decade of 1940 with the creation of the Central Health Legislation, it was not clear where funds would come from (Bhore, 1946, p. I).

Summing up, the first volume presented a bleak picture on health in India in terms of mortality (particularly serious for mothers and children), life expectancy, and inadequate nutrition. The deficiencies in existent infrastructure, the lack of coordination as well as the limited availability of health personnel were also described.

The volume two outlined a short-term programme to be developed in 10 years, as well as a long-term one. For the Committee, it was important to make a realistic assessment considering the timeframe to develop adequate staff and the financial resources: "we have tried to bear in mind the necessity for tempering enthusiasm with a sense of reality" (Bhore, 1946, p. II, p. 4). Some key ideas included the need to prioritise the rural population, since it was the one that sustained the country; the attention paid to the building of health infrastructure for women and children, and the organisation of the health system without implying a great cost for the individual.

The third volume contained the data behind the survey, detailing the terrible conditions India was in (Bhore, 1946, p. III).

The analysis and recommendations made by the Committee circulated not only due to its Report and its summary, but also due to the press, which was very critical. For example, the *Statesman* called it "A Bold Scheme," while at the same time reinforcing what the main problems were: "They have put problems in their proper order: maternity and child welfare, malaria, tuberculosis, the epidemic diseases." (March 6, 1946). The *Hindustan Times* summarised the findings of the Report and the legacy of the colonial period: "This is the verdict on our rulers' criminal neglect of the people's health" (Post-war Reconstruction. Public Health Committee, March 4, 1946). Whereas the *Eastern Economist* complained about the Report forgetting to plan for the "immediate present," and drawing instead plans whose results would be seen in ten years or more: "This shows the immediate necessity of a short-term plan to be put to right now. In this respect, the Bhore Committee must be regarded as a signal failure." (A National Health Plan, 1946, March 15).

## Final considerations

I would like to conclude by offering two sets of interrelated ideas. One idea is linked to the aims of the colonial administration by appointing the Bhore Committee: a draft for reconstruction work, which would show its commitment to the Indian people. Of course, this element was not new, but part of its mission in India. Back in 1926, the *Annual Report of the Public Health Commissioner* presented the state of public health in India. Apart from dealing with the causes of mortality and the main projects undertaken by the government, there were also ideas about the need to promote health education amongst the Indian people to make them aware of how best to fight disease, but also to make them participate actively in voluntary associations, proving their real patriotism. At the end of the *Annual Report*, there was a clear sense of trust and commitment about what they would leave behind at the end of the colonial period:

> *It is our duty when the time comes to hand over the Government*
>
> *of the country to its own sons to see that we leave it with*
>
> *a strong, well organized and efficient public health service;*
>
> *and that is, I believe, the greatest boon which western medical*
>
> *science can confer upon India (Graham, 1928, p. 219-220).*

But when the Bhore Committee concluded its Report a year before independence, ironically it was not a summary of the benefits of the colonial era, but of its terrible inheritance as David Arnold has written (2006, p. 350-351). And it was because the policies of health deployed by the British colonial state (as colonial states did) touched only the fringes of society, so rather than focusing on the extraordinary moments of action, attention should be given to the lack of it, affirms Amrith (2006, p. 11).

This inquiry which was meant to grant support and legitimacy to the colonial State involved a series of doctors and public health administrators from India and other countries, who ended up producing a critical appraisal of health in India, but, unknowingly, also a blueprint for the independent State. Its scope was so comprehensive, that the closest inquiry has been the Mudaliar Committee (1959) (Carballido-Coria, 2020). The challenges outlined in 1946 remain to this day a goal to be achieved (Bajpai & Saraya, 2011).

The other idea is regarding the need to study this type of inquiries by themselves, and not as simple sources of information. Commissions and committees are generally seen as unproductive and expensive exercises by the State, but as I have shown, they need to be interrogated to understand the multiple voices of the State: the distinction established between the Government of India and the metropolis, while at the same time the awareness that they shared a responsibility and a reputation. It is also important to scrutinise carefully the various methods and categories used in this kind of social investigations, as well as their unintended consequences. In the case of the Bhore Committee, the tours, and the request for information from doctors and civil servants, many of them Indian, could not but create or confirm a sense of dissatisfaction with the British civilising mission. Additionally, the invitation extended to international advisors with progressive views put the colonial administration in a difficult position both in the colony and in the metropolis.

Together these two ideas shed light on a mechanism frequently used by the colonial and the postcolonial states and the permanence and uses of this mechanism.

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