The history of health services development in India was influenced by a number of exogenous and endogenous factors at various points of time. Historically, apart from epidemiological, social and economic factors, one of the important engines which drove the Indian health services was the bureaucratic decisions undertaken through committees largely dominated by generalists. Considerations of equity, coverage, epidemiological scenario and the social and economic conditions of the people certainly played some roles in the initial blue printing of services. The various milestones and the shifts that have taken place in health services development in India were influenced by international policy changes, funding agencies and foundations such as Rockefeller and Ford as well as their reflections on the various committees that were constituted by the Indian government periodically. Despite discontinuities, it is possible to observe that the bureaucratic and top-down decision-making and the strategies suggested by the committees could have indirectly helped the half-hearted transition towards market-oriented health services, the only exception being the ICSSR-ICMR Committee Report. The report although necessitated by an exogenous event such as the Alma Ata conference gave an indication of the possibility of creating a space where state in
partnership with the civil society can take people-centred endogenous actions for achieving health for all. More importantly, the Report helped in re-asserting the social, political and cultural dimensions of health and health services and highlighted how the realization of health for all was a complex task with many nuances.

Among the various committees, the Bhore Committee appointed by the colonial government and its report considered as the blue-print of Indian health services had received the greatest attention and accolades. However, a critical reading of the Bhore Committee would reveal a number of negative and positive features. The decision to use allopathy as the system of medicine to be included in the health services for achieving a pan-Indian coverage was claimed to be the ‘modernizing approach’ of the professional and political elite at the time of independence. The recommendations of the Bhore Committee, however, were guided by ‘tendencies apparent in some of the more progressive countries of the world’. The health services prevalent in Great Britain, Australia, Soviet Union and New Zealand and the underlying principles had influenced the thinking of Bhore Committee\(^1\). These included - the right to health; the right to receive health care at the doorstep; the need to provide health care irrespective of the financial status. One could, therefore, consider this as the first exogenous influence on the shaping of health policy in the country.

However, the Committee had some truly progressive visions such as the need for universality, equity and comprehensiveness of health care. The ‘modern trend’ according to the vision of Bhore Committee at that time was not only with respect to a model of health services and the use of allopathy as the system of medicine but also the provision of as comprehensive a health services as possible to the community and the coverage of largest possible proportion of the community. This could be termed as a progressive public health vision as well. The important recommendation of the Bhore Committee which could be termed as the most progressive is, “No individual should fail to secure adequate medical care because of inability to pay for it”. The Bhore Committee proposed that in each village, a health committee consisting of 5 to 7 individuals should be constituted for procuring the active participation of the people in the health programmes. It is only since the implementation of the National Rural Health Mission in 2005 that something similar to this like the Village Health and Sanitation Committee was evolved. Subsequent committees appointed by the independent government of India for obvious reasons focused on specific programmes and manpower, managerial and technical approaches and some of the committee tinkered with these components to suit the programmatic requirements or to comply with international policy changes in health.

**ICSSR-ICMR Committee Report**

Three decades have passed since the two major funding agencies in medical science and social science joined together to produce a common report. This was truly remarkable given the considerable divide between the two areas and the obsession with ‘exactness’ by medical sciences. This was also evident from the general attitude of medical scientists towards social sciences. The attitude was “they are young, somewhat inexact, and often pretentious. Their findings are presented in a horrible jargon which obstructs clear thinking”\(^2\). The bridging of the divide was possible due to J.P Naik and Ramalingaswami, leadership in ICSSR and ICMR, respectively and their spirit and guidance. The foreword by Ramalingaswami mentions that J.P. Naik especially played an important role ‘in conceiving the idea and carrying it through’\(^3\).

The ICSSR-ICMR Committee stood apart from the linear-vertical character of many committee recommendations and the recommendations were unlike the instrumental nature of most other committees. Although not completely bureaucratically visualized and operationalized, it was set-up as a follow up of the Alma Ata conference on primary health care and, therefore, it was to a large extent influenced by the comprehensive visions and ideals of primary health care. It prepared a report on an alternative strategy on HEALTH FOR ALL which also served as a precursor to the National Health Policy of 1983\(^3\). The Committee had a progressive vision for addressing issues related to both the society and the health services. The Report adopted a comprehensive definition of health and placed it in the context of socio-economic transformation.

From the social determinants point of view, the Committee had a clear vision of health as an integrated development which can eliminate poverty and inequality, spread education and can enable the poor and underprivileged to assert themselves. This involved full-scale employment; improvement in the status of women; adult and universal elementary education;
welfare of the scheduled castes and tribes; creation of a democratic participatory form of government; organization of the poor and under-privileged groups, etc.

The Committee recognized that the existing health sector is exotic, top-down, elite-oriented, urban-based, centralized and bureaucratic with over-emphasis on curative care. It suggested an alternative model rooted in the community which could provide adequate, efficient, cost-effective and equitable referral services; integrate promotive, preventive and curative aspects; and combine valuable elements in our culture and tradition with the best elements of the Western system. From the programme point of view, the report suggested: (i) integrated plans for health and development including family planning; (ii) reorientation of existing priorities so that bulk of the funds can be spent on programmes on nutrition, improvement of environment, immunization and education rather than on curative services, and on basic community services at the bottom than superspecialities at the top; and (iii) replacement of the existing model of health care with an alternative model which integrated promotive, preventive and curative services and is community-based, participatory, decentralized, and democratic.

Despite a strong pressure to change the direction of the health services in the country, all the negative trends that the ICSSR-ICMR Committee noted (exotic, top-down, elite-oriented, urban-based, centralized and bureaucratic) continued to plague delivery of health care in this country.

The eighties and more prominently the nineties saw further erosion in the primary health care ideals and the broader vision for health services which explains why the recommendations of the Report could not be taken forward. It started with a national health policy of 1983, which only selectively picked up points from the ICSSR-ICMR Committee such as integrated preventive, promotive, and rehabilitative services, health education and some specific programmes while advancing the agenda of population stabilization, privatization, etc. The policy gave indication to the impending privatization plans of the government and to the reduction of government expenditure in the health field when it stated that private medical professionals and non-governmental agencies be allowed to establish curative centres and offered to provide logistical, financial and technical support to voluntary agencies culminating in the celebration of Public-Private Partnership in the new millennium.

It is against this background that we need to analyse the resurgence and reassertion of the social determinants framework largely spearheaded by Professor Michael Marmot and supported by the World Health Organization (WHO). The framework of this initiative is also influenced by the studies undertaken by Marmot and co-workers such as the Whitehall study and his own writings and the variables that they adopted as social determinants. Social determinants according to this group are the factors and circumstances in the society which impact on health, also named as “causes of causes”. These pathways include proximal-downstream variables such as stress to more distal upstream variables such as social gradient. The framework adopted by the WHO commission on social determinants of health (SDH) also includes variables such as social exclusion largely due to the influence of Amartya Sen who was also a member of the commission and civil society organizations such as SEWA in India. The commission submitted its report in 2008 and ever since, efforts are on to mobilize member States to declare commitments for achieving ‘health equity through action on social determinants’. The WHO also held a series of regional consultations and commissioned a series of country-level case studies to highlight action on these fronts. The latest in this heightened action is the recently concluded World Conference on Social Determinants of Health at Rio de Janeiro in which health ministers, academic experts and the civil society participated to endorse a political Rio declaration on SDH. The other salient turning point is the Report of the High Level Expert Group on universal health coverage. The Report has a section on social determinants although this was not in the original terms of reference for the Committee. Despite great clarity regarding universal health care and a broader and appropriate conceptualization, universal health is normally operationalized in terms of provision of care and services and the critical areas for achieving it such as financing, norms, human resources, community participation, access to medicines, vaccines and technology, managerial reforms, etc. are also service-oriented and largely proximal.

It is quite evident that the importance of social determinants and universal coverage has been raised at various points of time by many public health scholars in India which also got reflected in the ICSSR-ICMR Committee Report. In fact, the framework and the approach now being centre-staged by the WHO is
also clearly and cogently articulated in this Report, and this framework is more contextualized with a broader vision regarding social determinants than the universal approach of the WHO Commission on Social Determinants. It is this spirit of the ICSSR-ICMR Committee Report that the country needs to adopt as a framework for action on social determinants and universal health coverage.

K.R. Nayar
Centre of Social Medicine & Community Health
Jawaharlal Nehru University
New Delhi 110 067, India
knayar@gmail.com

References
5. PHFI. High level expert group report on universal health coverage for India. Instituted by Planning Commission, New Delhi: Public Health Foundation of India; 2011.