Who drive the health policy agenda in India? Actors in National Health Committees since Independence

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ABSTRACT

Introduction: Health policies reflect the ideas and interests of the actors involved. The Indian Government constituted many health committees for policy recommendations on myriad issues concerning public health, ranging from tribal health to drug regulation. However, little is known about their composition and backgrounds. We reviewed these committees to map the actors and institutions.
Methods: We elicited information on all relevant health committees available in the public domain. All were constituted post-independence, except two, with recommendations that remain pertinent to date. Data for chairpersons and members - their professions, gender, institutions, and location were extracted and analysed. Reliable online sources were used to collate the information.
Results: We identified 23 national health committees from 1943 to 2020 with available reports. There were 25 chairpersons and 316 members. All except three chairpersons were men. Among members, only 11% were women. The majority (51%) had experience working in health systems; however, most were medical doctors, with negligible representation of other cadres. We noted the centralization of location, with 44% of members based in the national capital of Delhi. Government administrators were maximally represented (55%), followed by medical academia (19%). Post-2000, we have observed slightly improved diversity across some parameters like gender (15% women vs 9% earlier) and affiliation. However, the centralization of the location to the national capital had increased (55% post-2000 vs. 39% pre-2000).
Conclusion: Indian health committees lack diversity in representation from multiple perspectives. Henceforth, health policymakers should prioritize including diverse social, geographical, and health systems actors to ensure equitable policymaking.

1. Introduction

Health policy is defined as the 'decisions, plans, and actions that are undertaken to achieve specific healthcare goals' [1]. Healthcare is a complex issue, and health policy-making can be intricate in a large, culturally, and socio-economically diverse country like India [2]. The disparity in development is evident with the fact that three-fourths of the districts are off-track in achieving Sustainable Development Goal Targets by 2030, while one-fourth have shown improvement in the past years and still stand a chance to meet the targets by 2030 [3]. Therefore, there is a necessity for equitable health policies that address the needs of

India's diverse population, much of which is living in resource-limited settings [4].

India is a union of states with clear demarcation of roles of the union and state governments. While healthcare is primarily under the purview of individual states [5], the union government influences public health significantly by supporting health policies through guidelines and funding [6]. Since Independence, numerous national health committees (NHCs) have been appointed to make recommendations on public health issues in India [7]. The terms of reference for these committees are allotted by the union government and have historically been diverse, ranging from tribal health to integrative medicine. The reports and

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Table 1
Details of national health committees included

S. No	Official name	Popular Name (if any)	Year of formation	Year of reporting	Constituting body	Number of members
1.	Health Survey and Development Committee	Bhore Committee	October 1943	March 1946	Government of India	30
2.	Committee on Indigenous Systems of Medicine	-	December 1946	July 1948	Government of India	10
3.	Committee on the Reform of Education, Practice and Research in Indigenous Systems of Medicine	Udupa K. N. Committee	July 1958	April 1959	Ministry of Health	2
4.	The Health Survey and Planning Committee	Mudaliar Committee	August 1959	1962	Ministry of Health	18
5.	School Health Committee	-	February 1960	December 1961	Ministry of Health	8
6.	Special Committee on the Preparation for Entry of National Malaria Eradication Program (NMEP) into the Maintenance Phase	Chadha Committee Report	April 1963	November 1963	Government of India	26
7.	Mukerji Committee Report on Family Planning	Mukerji Committee	December 1965	1967	Central Family Planning Council	4
8.	Report of the Committee on Integration of Health Services	Jungalwalla Committee	February 1966	March 1967	Directorate General of Health Services	7
9.	Mukerji Committee Report on the Basic Health Services	-	July 1966	1968	Ministry of Health	6
10.	Committee on Multipurpose Workers under Health and Family Planning Programs	Kartar Singh Committee	October 1972	September 1973	Government of India	10
11.	The Committee on Drugs and Pharmaceutical Industry	Hathi Committee	February 1974	April 1975	Ministry of Petroleum and Chemicals	16
12.	Group on Medical Education and Support Manpower	Srivastava Committee	November 1974	August 1975	Ministry of Health and Family Planning	6
13.	Report of the Working Group on Population Policy	-	October 1978	May 1980	Planning Commission	17
14	Working Group on Health for All by 2000 A.D.	-	July 1980	March 1981	Planning Commission	31
15.	The Medical Education Review Committee	Mehta Committee	September 1981	December 1982	Ministry of Health and Family Planning	17
16	Expert Review Committee for Health Manpower Planning and Development	Bajaj Committee	May 1986	December 1986	Ministry of Health and Family Welfare	7
17.	High Power Committee on Nursing and Nursing Profession	-	July 1987	June 1989	Ministry of Health and Family Welfare	11
18.	Expert Committee on Public Health System	-	March 1995	June 1996	Ministry of Health and Family Welfare	5
19.	The Expert Committee on a Comprehensive Examination of Drug Regulatory Issues, Including the Problem of Spurious Drugs	Mashelkar Committee	January 2003	November 2003	Ministry of Health and Family Welfare	24
20.	National Commission on Macroeconomics and Health	-	March 2004	August 2005	Ministry of Health and Family Welfare	16
21.	High Level Expert Group Report on Universal Healthcare for India	-	October 2010	November 2011	Planning Commission	14
22.	Expert Committee on Tribal Health	-	October 2013	August 2018	Ministry of Health and Family Welfare Ministry of Tribal Affairs	12
23.	Committee on Formulation of Integrative Health System*	-	August 2020	-	NITI Aayog	19

* Only the appointment letter detailing the date of appointment, chairperson and member details, and terms of reference was available.

recommendations of these committees have provided the foundation for subsequent policymaking and health program implementation in the country.

Characteristics like gender, experience, and location of decision-makers are known to impact their decisions. There is a paucity of literature on the impact of gender on health policymaking. However, evidence from smaller decision-making committees highlights that increased representation of women in leadership facilitates better representation of women in a committee, as noted in a study from the United States of America where it was observed that the proportion of women on the board of directors was higher when the chairperson was a woman [8]. Increased women representation is also important to ensure that a diverse range of issues is addressed by a committee [9]. Reduced diversity in terms of gender, race, and ethnicity is a problem that plagues committees formulating clinical guidelines as well. For example, women physicians were found to be significantly under-represented in author positions for formulating clinical guidelines [10].

Similarly, the location and experience of the decision-maker also play a significant role [11]. Although direct evidence of the impact of diversity of representation on policy formulation is limited, inference can be drawn from the similar impact of poor diversity seen in the world of academia [12]. Diverse representation has also been shown to improve the outcome of teams [13], better equipping them to handle inequities in health [14,15]. A lack of diversity could fail to address the perspectives of various vulnerable and oppressed communities [16]. Therefore, considering the impact of health policies and programs by the union government on the country's healthcare systems, it is important to understand the composition and characteristics of actors engaged in the national health committees.

To achieve equity in policies, the actors involved in policymaking committees should ideally be representative of the diversity of the country. However, despite the formation of numerous NHCs since Independence, little is known about the diversity and background of the individuals and institutions involved. In this policy review, we address this knowledge gap by analyzing the actors engaged in major NHCs in India since Independence. These committees have provided recommendations that have cumulatively shaped the public health systems infrastructure and policies of the country, and some of the recommendations continue to guide current health policies. Through this paper, we aim to study the composition of NHCs in terms of gender, affiliation, location and previous healthcare experience of committee members and chairpersons.

2. Methods

A descriptive analysis of 23 key NHCs in India, appointed from 1943 to 2020, was undertaken to understand the diversity in representation of the chairpersons and committee members.
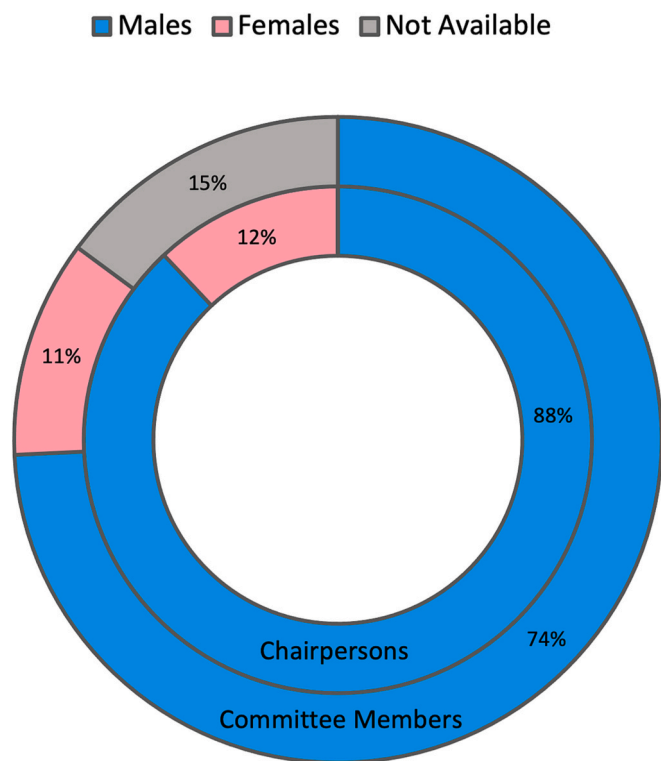
Fig. 1. Gender distribution of National Health Committees.

Table 2

Gender, affiliation, and healthcare experience of chairpersons and committee members of National Health Committees

	Number (%)	
	Chairpersons (N = 25)	Committee Members (N = 316)
Gender		
- Male	22 (88%)	236 (75%)
- Female	3 (12%)	34 (11%)
- Not Available	0	46 (15%)
Affiliation		
- Medical Academic Institution	4 (16%)	59 (19%)
- Non-medical Academic Institution	2 (8%)	20 (6%)
- Government Health service Admin	11 (44%)	138 (44%)
- Bureaucrat from other (non-health) departments/General administration	2 (8%)	36 (11%)
- Minister/Legislator	4 (16%)	10 (3%)
- Private doctor/Hospital	1 (4%)	2 (1%)
- Professional association	0	17 (5%)
- NGO	1 (4%)	15 (5%)
- Others	0	7 (2%)
- Not Available	0	12 (4%)
Previous healthcare experience		
- Yes	13 (52%)	161 (51%)
A. Medical Doctors	13 (100%)	154 (96%)
B. Others	0	7 (4%)
- No	11 (44%)	104 (33%)
- Not Available	1 (4%)	51 (16%)

We used the READ approach to conduct the policy document analysis [17]. Following the sequential approach used by Dalglish et al [17], we created a list of relevant public health committees. The Ministry of Health and Family Welfare, Government of India website [18], Indian Association of Preventive and Social Medicine health committee report database [19], 'Health Sector, State and Decentralised Institutions in India' (a book by S. Hooda [20].) and Google search were used to collate a list of all relevant national health committees in India in the study period defined above. The final list consisted of 36 health committees.

As per our inclusion criteria, we included committees that provided recommendations on the structure and functioning of the public health systems with implications for larger health policies. Committees with reports not available in the public domain were excluded from the analysis.

Based on the abovementioned criteria, out of the 36 committees, 28 committees were included. Eight NHCs were excluded as they were either review committees (Review of State of India's Health, 1992, Health Sector Reforms Report, 2004 and 2007), commissioned before Independence (National Planning Committee series sub-committee on National Health - Sokhey Committee, 1947), dealt with a very specific issue pertaining to a single health program (National Malaria Eradication Program Committee to Determine the Alternative Strategies, 1974), or did not have wide implications on public health systems (Jain Committee on the Rural-Urban Relationship, 1966, Task Force on Conservation and Sustainable Use of Medical Plants, 2000 and Directorate-General of Health Services Committee Report on Spurious Drugs, 2001). The terms of reference and reports of 5 committees were not accessible and they were excluded from the final analysis.

The Health Survey and Development Committee (Bhore Committee, 1943) and the Committee on Indigenous Systems of Medicine (Chopra Committee, 1946) were included despite being commissioned before Independence, as their recommendations provided the foundation for public health systems design of post-independence India and subsequently formed the basis of several review committees.

The reports of the NHCs were obtained from the government and other websites in the public domain. The list of the committees included is mentioned in *Table 1* and their reports can be accessed using the links in *Supplementary Table 1*. Information on the year of appointment of the committee and submission of the report, constituting body, and the information about chairpersons and committee members, with their affiliations, location of the affiliated institution, gender, and previous experience in healthcare was extracted from the report. If any information was not available, other online sources like official websites of the affiliated organizations, newspaper archives, and members' profiles from third party websites were used. All members who had been a part of the main committee at any point in time were included, irrespective of resignation/replacement during the tenure of the committee.

A sequential approach was followed to identify the biological gender (male or female) of an individual. At first, prefixes like Ms., Mrs., Dr. (Mrs.), and Smt. were screened to identify females, and Mr. and Shri were considered for males. In case of ambiguous prefixes like Dr. and Prof., available profiles or images on the individual's institutional websites were referred to. If this information was unavailable, a classification based on the individual's name was followed, if not culturally gender-neutral [21].

The affiliation of a person was extracted from the report, and in the case of multiple affiliations, the first-mentioned affiliation was included in the analysis. If affiliation was not available in the report, we elicited this information by referring to other online sources and correlating it with data provided by the committee report.

The location of the individuals was determined based on the location of their affiliated institution mentioned in the committee report. For ministers, central government health departments, and other central government departments, the location was assumed to be the national capital, i.e., Delhi. For representatives of the state administration, it was assumed to be their respective state capital. The location of the legislators was determined to be the area they represented in the legislative bodies, for which information was obtained from the Lok Sabha website (the official website of the Indian Parliament) [22].

For professional background information, we considered all healthcare workers and public health specialists as having previous health experience. These included nurses, medical doctors, i.e., practitioners of modern and alternative medicine, and people with public health qualifications. They were subsequently classified as medical doctors and others. A medical doctor with an additional public health degree was
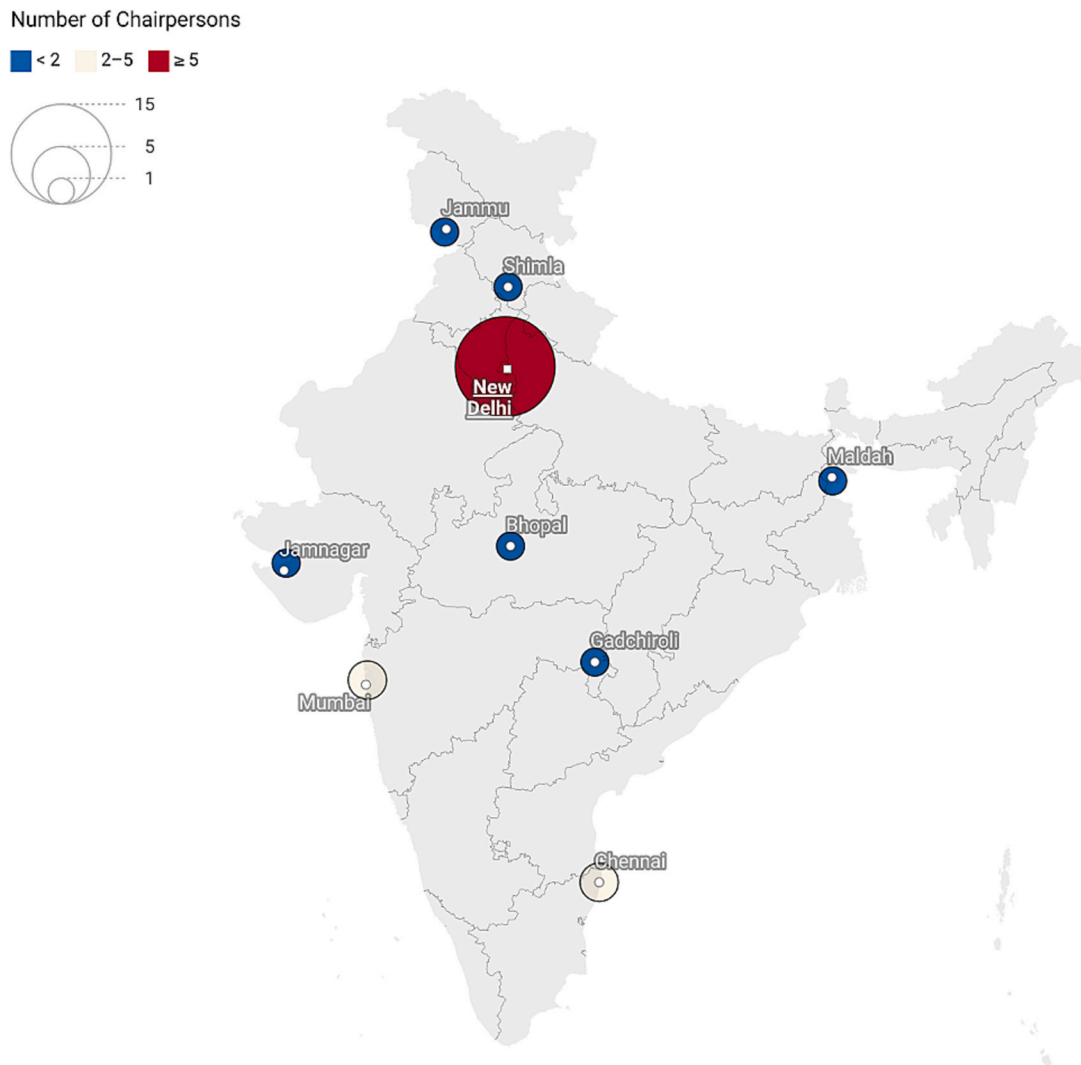
Fig. 2. a: Diversity in location of committee members.
b: Diversity in location of chairpersons.

considered a medical doctor for the purpose of the study. All other professionals were classified as not having health experience if the relevant data was available.

The extracted data was compiled into a Microsoft Excel spreadsheet (Microsoft 365) and a descriptive analysis was conducted to portray the composition and background of chairpersons and committee members across all 23 NHCs after classifying the extracted data into discrete variables *(Supplementary Table 2)*. We also conducted segregated analysis for committees constituted before and after 2000, to look at any evolving trends vis-a-vis gender, background, affiliation, and location diversity. Initially, we analysed the decadal trend in the composition of NHCs, however, a notable change in composition was observed only after the year 2000, hence we included pre- and post-2000 analysis in our final results.

3. Results

There were 25 chairpersons and 316 members among the 23 committees. Two committees, the National Commission on Macroeconomics and Health and the High-Power Committee on Nursing and Nursing Profession had two chairpersons. While the former committee had two co-chairs appointed for the entire tenure, the latter committee underwent a replacement of the chairperson midway through the meetings.

3.1. Gender distribution in the committees

All but 3 chairpersons were male (88%), with 2 of the females heading the High-Power Committee on Nursing and Nursing Profession (1987), and the third female heading the School Health Committee (1960). Of 316 committee members, data on gender could be ascertained for 270 (85%) individuals. There were 236 (75%) males and 34 (11%) females. (Fig. 1) Gender composition of all committee members could be ascertained for 14 committees out of which 11 (79%) had less than 33% females and there was not even a single female in 5 (36%) of the committees.

3.2. Background of chairpersons and committee members

Data on affiliation was available for all chairpersons and 304 (96%) members. The chairpersons of the health committees were most commonly from the government health service administration (11 [44%]), followed by medical academic institutions (4 [16%]) and legislative bodies (4 [16%]). *(Table 2)* As for background, 13 (52%) of the chairpersons were medical doctors. Among members, maximum representation was of the government health services (138 [44%]) followed by medical academia (59 [19%]) and other government administrations (36 [11%]), respectively. Out of the 161 (51%) members with a
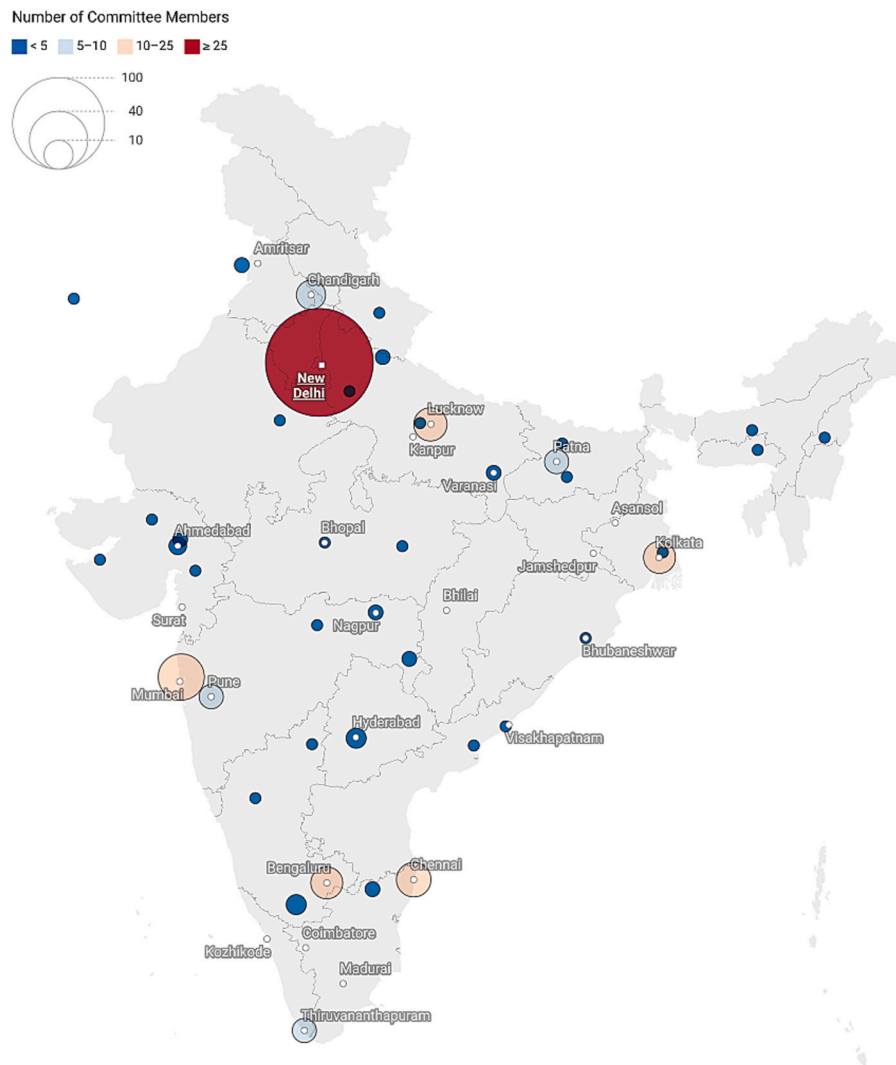
Fig. 2. (*continued*).

healthcare background, 154 were doctors. Among 7 members classified as 'other health workers', 6 were nurses in a single committee, the High-Power Committee on Nursing and Nursing Profession.

3.3. Geographic distribution of chairpersons and committee members

The majority of the chairpersons (15 [60%]) were affiliated with organizations situated in Delhi - National Capital Region. (Fig. 2) Data on location was available for 284 (90%) members. Delhi NCR was the most represented area with 138 (44%) members. Mumbai contributed 24 (8%) members, followed by Chennai (13 [4%]), Lucknow (12 [4%]), Kolkata (11 [3%]), Bengaluru (11 [3%]), and Chandigarh (9 [3%]), Pune (6 [2%]), Thiruvananthapuram (6 [2%]) and Patna (6 [2%]). Other locations contributed less than 2% each. (Fig. 2b)

3.4. Pre-2000 versus post-2000 changes in the composition of committees

We also analyzed the composition of the committees appointed before and after the year 2000. Before 2000 there were 18 committees with a total of 19 chairpersons and 231 members and post-2000 there were 5 committees, with 6 chairpersons and 85 members. The majority of chairpersons pre-2000 were affiliated with the government health service administration (10 [53%]) though there was no discernible trend post-2000. Among committee members, the maximum representation continued to be of the government health service administration, though
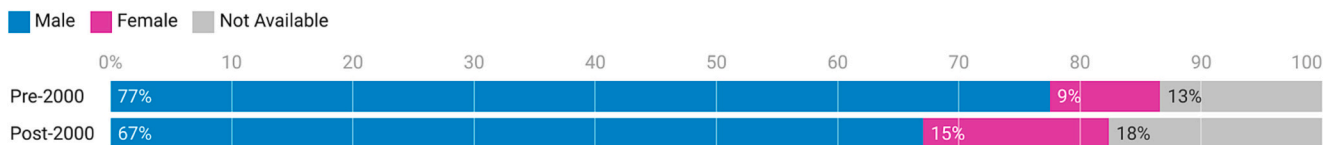
there was a relative decrease post-2000 (114 [49%] vs 24 [28%]). There was an increased representation of non-medical academic institutions, other government (non-health) departments, professional associations, and Non-Government Organization (NGOs) post-2000, with a decrease in the representation of legislators. Gender distribution among committee members was marginally better post-2000 (13 [15%] females) as compared to pre-2000 (21 [9%] females). (Fig. 3)

The representation of the Delhi and National Capital Region (Delhi-NCR), which includes Delhi, and other adjoining cities, increased post-2000, among both chairpersons [53% (pre-2000) vs 83% (post-2000)] and committee members [39% (pre-2000) vs 55% (post-2000)] respectively. The proportion of chairpersons having healthcare experience increased post-2000 (47% vs 67%), with a marked decrease among committee members (57% vs 34%).
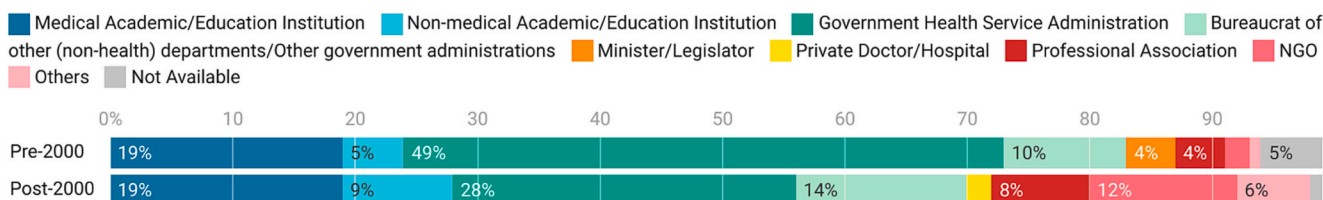
4. Discussion

In this study, we analyzed the composition of key NHCs of India, appointed between 1943 and 2020, to understand the diversity and representation of leadership and members. To the best of our knowledge, this is the first attempt to decipher the composition of actors driving the health policy agenda in India. Our findings reveal significant gender disparity among NHC leadership and members. In addition, we observed a centralization of location among actors, with a majority of the NHC leadership and a significant proportion of members based in
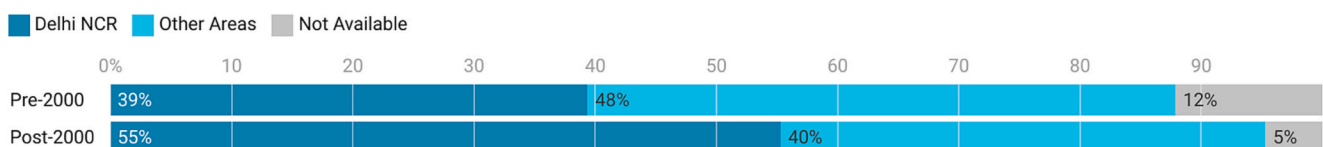
Gender

Male   Female   Not Available

Pre-2000	77%	9%	13%
Post-2000	67%	15%	18%

Affiliation

Medical Academic/Education Institution   Non-medical Academic/Education Institution   Government Health Service Administration   Bureaucrat of other (non-health) departments/Other government administrations   Minister/Legislator   Private Doctor/Hospital   Professional Association   NGO   Others   Not Available

Pre-2000	19% 5% 49% 10% 4% 4% 5%
Post-2000	19% 9% 28% 14% 8% 12% 6%

Location

Delhi NCR   Other Areas   Not Available

Pre-2000	39% 48% 12%
Post-2000	55% 40% 5%

Healthcare Experience

Medical/Public Health   Non-medical   Not Available

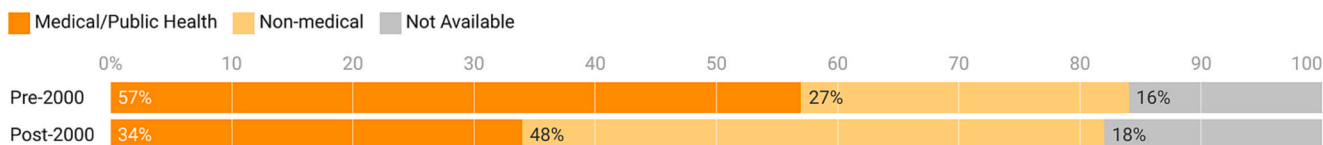|	
Pre-2000	57% 27% 16%
Post-2000	34% 48% 18%

Fig. 3. A comparison of member diversity of committees appointed before and after year 2000.

Delhi-NCR. We also noted a lack of diversity in professional affiliation and background among actors engaged in NHCs, with medical doctors dominating these committees. Furthermore, our analysis showed that post-2000, there was a marginal improvement in gender diversity and representation from NGOs and non-medical academic institutions. However, representation from Delhi-NCR increased sharply post-2000. Scholarly literature abounds on the influence of actors, their backgrounds, and positionality on the health policy-making process. In India, the influence of NHCs is widely documented, and our findings shed critical light on the taxonomy of actors engaged in influencing health policies in India.

We observed a negligible representation of women in NHCs in India, a trend that has been highlighted in healthcare systems identified globally [23]. Women constitute approximately 40% of the health workforce in India, yet their representation in leadership is minimal [24]. There is a need for affirmative action to ensure equal representation of women in future health policy-making committees in India.

In addition, the committees were also heavily represented by government health services and medical doctors, with a marked centralization of location to Delhi-NCR, the national capital of India. The location of the chairpersons and committee members indicates that large segments of the population and geographic locations are underrepresented. The hilly areas of the North-Eastern states have very low representation in the committees, while the metropolitan cities are disproportionately represented.

On a positive note, the committees formed post-2000 have shown increasing diversity, with greater representation of women, NGOs and non-medical academia. Notably, these committees were constituted to discuss broader perspectives on healthcare, such as macroeconomics

and health, integrative health services, and tribal health, thus reflecting more diversity. However, the increasing representation of the national capital is rather contrary to the diversifying trend and indicates even greater centralization of actors in NHCs.

5. Study limitations

The study findings contribute to filling a critical knowledge gap map regarding the composition of actors engaged in health policy in India. However, there are a few limitations worth mentioning. Firstly, our analysis was limited to only those committees with publicly available online reports largely appointed by the Ministry of Health and Family Welfare. However, we selected all committees that gave critical health policy and public health recommendations. Secondly, data for some of the committee members and chairpersons, primarily for older committees, was unavailable. We, however, scoured multiple online sources to elicit the necessary data. We were also unable to examine the diversity of committee members and their impact on recommendations. Lastly, although the social construct of caste has been a barrier in achieving equitable healthcare in India, we were unable to reliably determine the caste of members and chairpersons purely on the basis of their names and the data available to us.

The role of decentralized planning and policy in a federal government structure is proven to be critical for policy success [25]. Our findings highlight the need for substantial efforts in India to ensure more inclusive health policymaking and the importance of a rational appointment process for experts in health committees, as they play a critical role in guiding the diverse healthcare system across the country. Future research should aim at a more comprehensive analysis of policy

actors, emphasizing other characteristics like age and caste and their association with the characteristics of recommendations from health committees.

6. Conclusion

This study provides critical insights into the actors driving the health policy agenda in India as leaders or members of national health committees. Our findings suggest an over-representation of men, government health service representatives, medical doctors, and individuals located in Delhi-NCR. The emerging results indicate a 'centralization' of the health policy process in India, a union of 28 diverse states with diverse socio-economic backgrounds and health systems. Future health policy processes and committee formation must ensure diversity of representation in terms of gender, geographical location, affiliation and healthcare background for more inclusive health policy and planning.

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Patient and public involvement

Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication

Not applicable.

Ethics approval

Not applicable.

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Nil.

Authors' contribution

VRK conceptualised the study. PS did literature search. PS and DA did data extraction and analysis with inputs from VRK. DA drafted the manuscript, PS and VRK provided critical inputs for revision of the manuscript. All authors reviewed and approved the final manuscript.

CRediT authorship contribution statement

Disha Agrawal: Writing – original draft, Methodology, Formal analysis, Data curation. **Parth Sharma:** Writing – review & editing, Supervision, Methodology, Formal analysis, Data curation. **Vikash R. Keshri:** Writing – review & editing, Supervision, Methodology, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare no conflict of interest.

Data availability

All data relevant to the study are included in the article and supplementary material. All data are publicly available.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.dialog.2024.100167.

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