Abstract

The development in the country’s health status has not kept pace with its economic development. Although India along with most countries of the world was a signatory to the Alma Ata Declaration of 1978, its performance particularly on health equity and quality issues, so far, has been far from satisfactory. There are vast variations in health-care status by states, by ethnic groups, gender, and urban-rural difference. Till recently, government policies and people’s perceptions also seemed to be on the wrong track. Our priorities seemed to be all wrong – we seemed to prefer setting up of high-cost tertiary health institutions at the expense of the primary health centers. The recently launched Swachh Bharat and Ayushman Bharat schemes offer hope of addressing these asymmetries. This paper briefly dwells on these issues.

Keywords: Ayushman Bharat, equity, health care, India, quality, Swachh Bharat

Introduction

Key principles of primary health care are equitable distribution, community participation, intersectoral coordination, and appropriate technology. This was decided upon at the Alma Ata Conference on Primary Health Care in USSR in the year 1978, with a view to achieve health for all by 2000. India like most countries was a signatory to this declaration. From time to time, many measures were developed to ascertain how countries are faring toward this goal of health for all. The year 2000 came and went with some countries partly achieving health gains and others lagging behind.

In addition, the government of India has been launching various national programs since independence to improve people’s health. The results have been mixed. The National Rural Health Mission (NRHM) launched in 2005 aimed to improve rural health care which has been neglected for years. The NRHM laid the foundation for the more ambitious National Health Mission (NHM). NHM comprises two missions: the NRHM and the more recent National Urban Health Mission. The thrust of NHM is strengthening health infrastructure in both rural and urban areas.

Two important challenges in ensuring health for all are equity and quality of health care against the background of poor hygiene and sanitation. The present commentary deliberates how we fare in these two important aspects of health services and how the lack of access to safe water and sanitation contributes to disease burden. It also briefly discusses two recently launched government schemes, “Swachh Bharat” and “Ayushman Bharat,” and the likely impact these two are expected to have.

Where Do We Stand in Health Equity?

Equity in health-care delivery can be defined as equal access to preventive, promotive, and curative health services to the whole population, irrespective of residence, gender, caste, economic strata, and other factors. This concept termed “equitable distribution” has been envisaged as one of the principles of primary health care at Alma Ata in 1978. Few vital statistics mentioned in the following paragraphs reflect the lack of equity in health-care access in the country.
In the year 2016, the infant mortality rate (IMR), the most sensitive indicator of health, was 34/1000 live births for the whole country. There was a wide rural and urban difference – in rural India, it was 38/1000 live births, while the corresponding urban figure was 23.[4] There was also gender disparity in IMR, in female infants 39 as against 35 in male infants. Wide statewide variation in IMR was noted, with Madhya Pradesh having the highest infant mortality of 47/1000 live births and Kerala lowest at 10/1000 live births.[4]

Maternal mortality rates (MMRs) too show regional differences. While all India MMR in 2016 was 130/1 lakh live births in the country, it was highest at 237/lakh live births in Assam and lowest in Kerala (46/lakh live births). Northern states such as Uttar Pradesh (including Uttarakhand) also had high MMR (201/lakh live births).[5]

**Access to Sanitation and Safe Water**

Access to sanitation and safe water essential to check diarrheal and other excremental diseases and anemia was also unequal statewide. The National Family Health Survey 2015–2016 highlighted wide variations in households with improved sanitation such as toilets. While Kerala had the highest number of households with toilets (98.10%), the bottom five states were Jharkhand (24.40%), Bihar (25.20%), Odisha (29.40%), Chhattisgarh (32.70%), and Madhya Pradesh (33.70%).[6]

Lower rate of household sanitation was associated with diarrheal diseases and anemia. Kerala with the highest rate had the lowest rate of diarrheal disease (3.4%) and anemia in pregnant women (22.6%), while the corresponding figures in Bihar, one of the low sanitation states, were 10.2% and 58.3%.[6]

**Where Do We Stand in Health Access Quality?**

Very recently in addition to equity, a measure of quality of health services, the Health Access Quality Index (HAQ Index), has been added.[7] A recent paper published in Lancet for the first time reported performance using HAQ Index.[7]

The HAQ Index was computed using the data from the Global Burden of Disease 2016. The collaborators used the Nolte and McKee list[8] of causes, which enumerates 32 conditions from which death should not occur provided there is access to quality health care. Death from any of the 32 diseases reflects poor access and quality of health care. Each cause was transformed to a scale of 0–100, 0 being the first percentile (worst) and 100 as the 99th percentile (best) possible access and quality. These thresholds were applied at the country level and then to subnational regions. Data for the 195 countries were compiled for over a quarter of a century, 1990–2016, to see the trends of health-care access and quality. The investigators studied the correlation of HAQ Index with Socio-Demographic Index (SDI) and total spending on health.

Of the 195 countries for which data were available to compile the HAQ Index, India stands dismally at the 145th position, ahead of only Pakistan and Afghanistan among Asian countries. Even Bangladesh at the 133rd position and Sri Lanka, with all its political strife in recent decades, at the 71st position are way ahead.[7]

China and India showed the largest gaps between the have and have-nots regarding quality health care. In China, HAQ Index ranged from 91.5 in Beijing to a low of 48.0 in Tibet. In India, there was a 30.8 point disparity with Goa recording the highest HAQ Index of 64.8 and Assam lowest at 34.0. In fact, over the past 25 years, this gap has widened from 23.4 difference in 1990 to 30.8 point difference in 2016. The performance on the HAQ Index was positively correlated with SDI, total health spending by government, and health systems inputs. The authors of this exhaustive report conclude that there is a need to reorient both primary and secondary health-care services to overcome the stagnation and wide disparities in health gains over the past 25 years.[7]

**What are the Social Determinants of Inequity and Poor Quality of Health Services?**

Just calculating the difference between the top and bottom of the pack in the HAQ Index is oversimplification of the underlying issues. There is a social gradient in health running through the spectrum of socioeconomic status from the top to the bottom, emphasizing that inequities in health-care access is a whole population issue.[9]

For every patient who seeks health care, there are many others who fail to make it to the health facility. What causes this disparity? The social factors behind this are many. They may be control over one’s life (compromised in regions promoting gender or other types of discrimination), awareness, literacy, beliefs, trust, participation in the decision-making process, etc., Availability of health-care resources is influenced by the social determinants of health and health inequities. These are power, income, goods, services, globally, nationally and subnationally, and predicaments, for instance, their access to health facility and educational facilities. Facilities for recreation, town planning, conditions at work and home environment are additional determinants of health.[10]

Another important factor in the Indian context is the meager public expenditure on health India which has hovered around 1% of the country’s gross domestic product (GDP) for decades. Only nine countries in the world have a lower ratio of public expenditure on health to GDP.[11] As a result, public expenditure on health accounts for less than one-third of the total health expenditure. Only a few countries such as Afghanistan, Haiti, and Sierra Leone have a lower ratio of government expenditure to total health expenditure. The rest is out-of-pocket expenditure which drives many people below the poverty line. This sets up a vicious cycle as poverty and health are interrelated.
The State of Government Health Facilities in India

Adequately run primary health-care systems can meet most of the patients’ needs. In our country, the first contact with the health system is at the subcenter (SC) and primary health center (PHC) levels. For remote villagers and people in tribal areas, these may be the only health care easily accessible to them. Regrettably, the states of these peripheral health facilities are far from satisfactory. This drives the patients to private health care, leading to corporatization of medical care with a profit motive. India has one of the most commercialized health-care systems in the world.[11]

Survey of government health facilities by the International Institute for Population Sciences, Mumbai, brought out glaring deficiencies. Only 69% of PHCs had at least one bed, only 20% had adequate communication, and only 12% were properly maintained.[11] These are national averages and the corresponding figures for poorer states are worse. In Bihar, a large majority of PHCs had no electricity, weighing machine, or even a toilet. Even when present, the utilization of government health facilities was low. Absenteeism of health workers ranged between 35% and 58% in different Indian States in 2002–2003.[12] This leads to serious loss of opportunity to educate the population and improve their health status.

The Problems with Private Health Facilities

While the problem is more for the poor Indian, preference toward private health facility is common even among the well to do because of overcrowding and neglect in government hospitals. Private clinics and hospitals are no better. They are unregulated leaving patients at the mercy of sometimes unscrupulous practitioners. A battery of investigations, overmedication, high pricing, and unnecessary surgery are common in the private health sector. A study found that in the private sector, 47% of deliveries performed were by cesarean which is higher than the WHO norm of 15%. The corresponding proportion of cesarean in the public hospitals was 20%.[13] Another study from Delhi and Madhya Pradesh revealed that both public and private health sector offered poor quality services, with simple diseases being inaccurately diagnosed and inappropriately treated in majority of patients.[14]

Strengthening Primary Health Care is the Key to Population Health

In a study of primary health-care services across 13 developed countries, it was revealed that the stronger the country’s primary health services, the lower were the rates of all-cause mortality, premature mortality, mortality from asthma and bronchitis, emphysema and pneumonia, and cardiovascular diseases.[15] In the USA, there were fewer differences in self-rated health between high- and low-income groups where good primary care services were provided. Similar evidence for reducing health inequities is also available from countries in Africa and Latin America and Kerala in India.[15]

Health lies in spreading medical care wide not high.[16] Majority of patients suffer from common and preventable ailments which can be treated at the primary care level. If the PHCs function efficiently, the cost of travel and treatment involved in accessing these tertiary care hospitals will be reduced. If we have good primary and secondary level health facilities, it would also reduce treatment by quacks and unqualified practitioners in remote areas.

Recent Government Initiatives to Address the Problems of Sanitation, Inequity, and Poor Quality of Health Services

Swachh Bharat Mission 2014

The government of India launched the Swachh Bharat Mission in 2014, the biggest sanitation campaign in the world. This will address the burden of excremental diseases. More than 95 million toilets have been built since the launch of this mission. The initial impact assessment shows some evidence of decline in diarrheal diseases since the launch of this campaign.[17]

National Health Policy 2017, Ayushman Bharat, and Health and Wellness Centres

The latest health policy by the government, the National Health Policy 2017 (NHP 2017),[18] reiterates the goal of universal health coverage. Following this, the political commitment for implementing the NHP 2017 in letter and spirit is evidenced by launching the bold and ambitious Ayushman Bharat Program (ABP) in the Union Budget 2018–2019.[19] The ABP consists of two strategies: first, the delivery of comprehensive primary level health care by upgrading 150,000 health SCs and PHCs to Health and Wellness Centres (HWCs) by the year 2022, and second, catering for secondary and tertiary level medical care under the National Health Protection Scheme (NHPS).[19]

Upgrading of 150,000 SCs/PHCs to HWCs will be accompanied by expanding the scope of health services provided, going beyond mother and child health services to implement the National Health Programs extending to services to address noncommunicable- and lifestyle-associated conditions. If implemented, people will have access to primary health services within a walking distance of 30 min.

The NHPS under Ayushman Bharat is the world’s largest public-funded insurance scheme,[19] assuring coverage of rupees 5 lakhs per family annually for secondary and tertiary level of health care. The financial burden for implementing the Ayushman Bharat would be around rupees 70–100 thousand crores.[20] This is in harmony with the NHP 2017 target of government spending of 2.5% of GDP on health by year 2025.[18]

The Way Forward

The political will has been established by the launch of Swatch
Bharat and Ayushman Bharat schemes by the government of India. From the public health point of view, this is a good beginning and the battle half won. To win the other half, the momentum has to be maintained by ensuring proper implementation of these schemes. Widespread media and public attention on these schemes should sustain the tempo and ensure that there is no deviation from the roadmap drawn by these two programs.

**Conclusion**

India, aspiring to be a superpower, so far, has had a poor report card in health-care equity and quality. Compared to its neighbors, India’s performance is an embarrassment given how improvement in health in the country trails behind its economic development. Recently launched schemes such as Swachh Bharat and Ayushman Bharat offer the opportunity to the nation to achieve universal health care and realize its full human resource potential.

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**References**

1. WHO and United Nations Children Fund. Primary Health Care. Report of the International Conference on Primary Health Care Alma Ata USSR 6-12 September, 1978. Geneva: World Health Organization; 1978.
2. National Rural Health Mission 2005-2012. Mission Document. Available from: http://www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf. [Last accessed on 2019 Aug 30].
3. Ministry of Health and Family Welfare, Government of India. National Health Mission. Available from: https://nhm.gov.in. [Last accessed on 2019 Aug 29].
4. Central Bureau of Health Intelligence. National Health Profile 2018, 13th issue. Directorate General of Health Services. New Delhi: Ministry of Health and Family Welfare, Government of India. Available from: http://www.cbhidghs.nic.in/WriteReadData/892s/Chapter%201.pdf. [Last accessed on 2018 Jun 28].
5. Government of India, Niti Ayog. Available from: https://www.niti.gov.in/content/maternal-mortality-ratio-MMR-100000-live-births. [Last accessed on 2019 Aug 29].
6. Salve P. At 732 million, India Tops List on Number of People without Access to Toilets: Report. The Wire 16 Nov 2017. Available from: https://thewire.in/health/732-million-india-tops-list-number-people-without-access-toilets-report. [Last accessed on 2018 Jun 28].
7. GBD 2016 Healthcare Access and Quality Collaborators. Measuring performance on the healthcare access and quality index for 195 countries and territories and selected subnational locations: a systematic analysis from the global burden of disease study 2016. Lancet 2018;391:2236-71.
8. Nolte E, McKee M. Measuring the health of nations: Analysis of mortality amenable to health care. BMJ 2003;327:1129.
9. Friel S. Improving equity. In: Guest C, Ricciardi W, Kawachi I, Lang I, editors. Oxford Handbook of Public Health Practice. 3rd ed. Oxford: Oxford University Press; 2013. p. 406-16.
10. Commission on Social Determinants of Health. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health, Final Report on the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008.
11. Dreze J, Sen A. India’s health crisis. In: An Uncertain Glory. India and its Contradictions. New York: Alllen Lane and Imprint of Penguin Books; 2013. p. 143-81.
12. Chaudhury N, Hammer J, Kremer M, Muralidharan K, Rogers FH. Missing in action: Teachers and health workers absent in developing countries. J Econ Perspect 2006;20;91-116.
13. Sreevidya S, Sathiyasekaran BW. High caesarean rates in madras (India): A population-based cross sectional study. BJOG 2003;110:106-11.
14. Das J, Holla A, Das V, Mohanan M, Tabak D, Chan B, et al. In urban and rural india, a standardized patient study showed low levels of provider training and huge quality gaps. Health Aff (Millwood) 2012;31:2774-84.
15. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005;83:457-502.
16. Jindal RP. Health Lies in Casting the Medical Net Wide, not High. The Tribune; 2017. Available from: http://www.tribuneindia.com/news/comment/health-lies-in-casting-the-medical-care-net-wide-not-high/399991.html. [Last accessed on 2018 Jul 01].
17. Dandabathula G, Bhardwaj P, Burra M, Rao PV, Rao SS. Impact assessment of India’s swachh bharat mission clean India campaign on acute diarrheal disease outbreaks: Yes, there is a positive change. J Family Med Prim Care 2019;8:1202-8.
18. Government of India. National Health Policy 2017. New Delhi: Ministry of Health and Family Welfare, Nirman Bhawan; 2017. p. 1-32.
19. Lahariya C. ‘Ayushman bharat’ program and universal health coverage in India. Indian Pediatr 2018;55:495-506.
20. Lahariya C. Strengthening Primary Healthcare: From Promises to Reality. Ideas for India; 2018. Available from: http://www.ideasforindia.in/topics/human-development/strengthening-primary-healthcare-from-promises-to-reality.html. [Last accessed on 2019 Aug 29].