REVIEW ARTICLE

A roadmap for achieving health equity in India: A proposed framework and assessment of the determinants of health equity

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Abstract

With the upcoming technical interventions in the health sector of India, India has been able to create a great scope for Medical Tourism in the country. People from different nations are coming to India to avail many critical treatments at an affordable price. Even after such great development, Health Equity has always been a great challenge for our country. Through Health Equity, we mean availing the standard health services by the under-privileged, marginalized group of people compared to the privileged segment of the community. The present study will help us to highlight on the prioritization of the allocation of the resources to the most eminent tier of the Health care structure. Also, this study will focus on the effectiveness of this component of the Health care structure of India and how this can help in throwing light on the disparity of the health care services through a proposed model.

Keywords

Equity, Medical Tourism, Healthcare, Health Disparities, Out of Pocket Expenditure

Introduction

It has been found that the health and the economy of a country are interdependent on each other. If the growing economy of a country can bring about growth in the health status of the country, then it may also be possible that the growth of health status can very well result in the high economic growth of the country.

As per Amartya Sen (2000), (1) the standard of living of the people of a nation should not be judged by their income but by their accessibility to all those things which are essential for leading quality life. This comprises education, health, and self-respect and community participation.

Economic disparities and their impact on the health of the people can be observed in instances played out in everyday life. For instance, people from affluent background can avail the best of medical services for an insignificant health issue whereas on the other hand people are deprived of a treatment even if plagued with fatal diseases, if they cannot afford it. This discrepancy is highly visible when a comparison is made between the rich nations and the emerging economies. This disparity exists not

only in the rich poor divide but also in the divide between Rich and Poor states.

Definition of health equity and its significance

The right to health as set forth within the WHO Constitution and international human rights treaties is that the right to "the highest possible customary of health."(1)

On the basis of practical implementation, the terms Health Equity and Health Disparity are two inseparable terms.

A Health Disparity basically relates to the social advantage and these associations should be frequent and persistent. It focuses on the different health outcomes among different groups of people.

The term Health Equity is generally referred not solely to the utilization of Health services, but conjointly to the allocation of health care resources, the funding of health care and even the quality of healthcare services. The notion of equal opportunities is to be healthy is key to the conception of equity in health and closely linked with the conception of equal rights to health. (2)

Health Equity in India – Present Scenario

India's health system faces the ongoing challenge of responding to the needs of the most disadvantaged members of Indian society. Despite progress in improving access to health care, inequalities by socioeconomic status, geography and gender continue to persist. This is compounded by high out-of-pocket expenditures, with the rising financial burden of health care falling overwhelming on private households, which account for more than three-quarter of health spending in India. In this paper, we have identified key challenges to equity in service delivery, and equity in financing and financial risk protection in India. These include imbalanced resource allocation, limited physical access to quality health services and inadequate human resources for health; high out-of-pocket health expenditures, health spending inflation, and behavioral factors that affect the demand for appropriate health care. (3,4)

Therefore, the vital question that lies at the heart of the medicinal services is in order to choose between the public and private suppliers for the wellbeing of the people. This aspect comprises two major dimensions. The primary dimension deals with the provision part of the Public health services which comprises of the quality of health services, human asset working in these offices and alternative appurtenant services (eg. medicines) that are provided in conjunction with the mainstream services of the healthcare structure. The alternative dimension focuses on the demand facet of the healthcare services that comprises the qualities of a person and the condition in which he resides. The Provision and Demand aspects are related problems that are linked together with elements like uncertainty in terms of time for availing the health services and also the advantages that are incurred from the availing services. In addition, it has been observed that most of the people's access is limited to the information related to the disease. Hence, we can very well observe that there are many factors that play a major role in influencing the choice of the healthcare provider. (3)

As per NSS 71st round survey, (2014), the following are few among the highlighted findings:

It has been identified that around 9% of rural population and 12% of urban population have been reporting ailment during a 15 days reference period. The findings that were observed related to percentage of treatment at public hospital were reported in rural areas of Assam (84%), followed by Odisha (76%), Rajasthan (44%) and Tamil Nadu (42%), and in the urban areas it was Odisha (54%), followed by Assam (44%) and Kerala (31%).

Both in rural and urban areas maximum proportion (around 25%) for hospitalization (excluding childbirth) were basically for 'Infection' (inclusive of all types of fever, jaundice, tuberculosis, tetanus, diarrhoeas/dysentery and other infection).

Relatively as high as 86% of rural population and 82% of urban population are not covered under any scheme meant for health expenditure support.

Rural people for their health expenditure primarily depended on their 'household income/savings' (68%) and on 'borrowings' (25%). While, the urban masses depended much more on their 'income/saving' (75%) for financing expenditure on hospitalization, than on 'borrowings' (only 18%).

In the rural areas, percentage of childbirth that took place in public hospitals was reported to be 56% and 24% in private hospitals. While in urban areas, the findings are to some extent closer to each other with 42% and 48% respectively. The non-institutional childbirths were reported 20% in rural areas and 11% in urban areas.

The accessibility of pre-natal care taken by pregnant women in the rural and urban areas is about 89% and 93% respectively. While for Post-Natal care the availing percentage for rural and urban masses are 77% and 84% respectively.

It has been observed that most of the budget allocation is mostly confined to the tertiary sector making the primary and secondary underfunded. Due to this people started depending on the tertiary sector for even the basic healthcare treatments that can very well be provided by the other two tiers. Hence, we can very well state that the primary healthcare sector is mostly kept unutilized and whatever responsibilities they have, due to inadequate resources they are unable to fulfill their objectives. (5,6,7)

Infrastructural Bottlenecks

As per a report on Healthcare published in Outlook India (2015), it has been highlighted that as per the statistics, the infrastructure for healthcare in India is far below than many countries. It has been stated that in India where we have an allocation of one bed for every 1050 patients, US has one bed allocated for every 350 patients while in Japan, it is one bed for every 85 patients. This shortage would require an amount of $50 billion to be recovered which is a big challenge for India. (6,7)

As per WHO Standards, there need to be a ratio of one doctor to every 1000 patients while in India it has been observed that it is 0.7 to every 1000 patients. Along with this there is a great gap between the actual number and required number of paramedical and administrative professionals meant for delivering efficient healthcare services. (8,1)

It has been assumed that the main factors which have been the major cause for the lack of development in the **Rural Healthcare infrastructure are as follows:**

- Lack of funds and support from private bodies
- Lack of efficiency among Public segments
- Inadequate source of manpower support meant for the efficient delivery of the healthcare services
- Lack of the basic amenities like drainage, sanitation, electricity etc

Out of Pocket Expenditure

As indicated by WHO report (2012); this high number on the out of pocket expenditure is essentially attributable to the fact that shows government's share on the healthcare expenditure has been confined to a min of 3%.(8)

The Indian government's initiatives to improve the healthcare system comes as a response to the part that an average Indian spends around 70% of money from his pocket for his treatment whereas in other developed economies the citizens pay 15% (Denmark), 18% (UK), 52% (US) and 44% (China). The National Health Policy approved Union Cabinet has ensured that now the Government would play a major role in spreading the health services to different areas of the society with an affordable cost. To achieve this Government has planned to allocate 2.5% of GDP in the Healthcare sector of the country. Though, we are sure that this may not suffice to fulfil the demands of such a huge population but still may help the sector to improve to a bit. (9)

Government's role in achieving health Equity

Government of India has introduced many schemes for the efficient supply of healthcare facilities to the beneficiaries, comprising of the rural people and the urban slum dwellers. But, they haven't been sufficient enough to eradicate the disparity in the healthcare system of India. It has been observed that only a small percentage of 10 from the gigantic population of 133 crores have medical insurance, financial protection against therapeutic consumptions is a long way from reality.

The prime objective of Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) was to remove the health in-equalities that one observes at regional basis through working on the availability and affordability of Quality based Tertiary **Healthcare services.**

As per National Rural Health Mission (NRHM), the pattern for funding for healthcare is a ratio of 75:25 between Centre and State. This pattern is similar for all the states with the exception of North-Eastern States including Sikkim and other uncommon classification States of Jammu and Kashmir, Himachal Pradesh and Uttrakhand, for whom the ratio of Centre-State financing design is 90:10. A cost of Rs. 748.00 crores has been made in the twelfth Plan. These schemes include programmes like National Mental Health Programme (NMHP), National Programme for Control of Blindness (NPCB), National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Strokes (NPCDCS) and National Programme for Health Care of the Elderly (NPHCE). (5,6)

As per Govt. of India, one ASHA worker has been allocated for every 1000-2500 population covering roughly 200 – 500 households and aims to function as an efficient, demand generating link between the sickbay and the urban slum population.

Framework and its implications in India

Institute for Healthcare Improvement (IHI) has enlisted a number of determinants based on the figure 2 for health care organizations to judge their

present status on health equity as well as initiatives taken for improvement taking into consideration the five factors of health equity framework.(10)

Figure 2: A Framework for Health Care Organizations to Achieve Health Equity1

This framework has been studied by us and we have proposed a framework for curbing health inequities in India which is a combination of IHI parameters and India specific parameters.

Conclusion

Proposed Framework: Based on the above criteria, we have been able to develop a framework meant for the Healthcare organizations working at the grassroot level in order to achieve Equity in Healthcare services. (Figure 3)

A description of Five Point Parameters customized for the Indian Sub-Continent has been stated:

Making Health Equity a Strategic Priority – The government has segregated the health structure of India in three basic Tiers – Primary, Secondary and Tertiary. It has been observed that most of the budget allocation is mostly confined to the tertiary sector making the primary and secondary underfunded. We should focus on all the three levels while as the demand of Primary care services is far more than the other two levels of services so special focus needs to be provided to this level.

Develop Structure and Processes – There should be a proper framework of the governance and monitoring at different levels and periodic assessment need to be done in order to identify the issues and flaws that is leading to health inequities. There should be an Assessment in which the results are evaluated through a comparison between Measured Performance and the Expected Performance. If the expectations are found to be more than the Measured Performance, then an improvement is necessary, which is done after analyzing the causes for the gap. This procedure is called as the Quality Management Cycle.(11)

Strategies meant for different determinants that play a major role in influencing the Healthcare demand in India – There are many determinants that play a major role in influencing the Healthcare demand in India; they are Quality Healthcare facilities, Socio-economic status, physical environment and health related behaviours. Strategies need to be made and there should be proper monitoring systems to check this Quality issues.

Decrease in Institutional Racism – In India the stratification is basically on the basis of caste and it need to made sure that the distribution of the health facilities should be beyond in the discrimination parameters

Develop Partnership with community organization – This is not a small task, people from different areas have to come together in order to fulfil the objectives of the health care sector and creating an environment which would be far away from health inequity. Corporate, voluntary organizations, communities need to come together, work as a team in order to ensure Quality life for each and every individual.

Recommendation

The suggested model would be helpful for the efficient implementation of the Health services at the grassroot level. The impact factor of the primary health care can be magnified if the suggested guidelines are complied with.

Limitation of the study

One of the shortcomings of our study is that it is entirely based on secondary data analysis; however, inclusion of Primary data would have enriched the content. Time constraint was the reason behind using Secondary Data only.

Relevance of the study

The study reflects the existence of inequality in the healthcare services at the Primary level which has been resulting the downfall of the holistic development of the country. Due to ineffective control and monitoring mechanism, the discrepancies in the system still persists resulting in the failure of the government interventions. Hence, the model developed will to some extent prove significant in ensuring efficient delivery of the health services at the grassroots level and creating equality of treatment. Further the adoption of the measures proposed by WHO, UNDP, IHI will help in achieving better results.

Authors Contribution

RO: Substantial contributions to conception and design, Drafting the article or revising it critically for important intellectual content; SA: Final approval of the version to be published; PS: Acquisition of data, or analysis and interpretation of data.

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Tables

TABLE 1 AS PER OUR PLANNING COMMISSION, THESE ARE THE FOLLOWING NORMS MEANT FOR THE EFFICIENT DELIVERY OF THE HEALTH SERVICES

Centre	Population Norms	
	Plain Area	Hilly/Tribal Areas
Sub - Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Centre	1,20,000	80,000
Centre	Infrastructural Requirements	Manpower Requirements
Sub - Centre	Waiting Room One Labour Room with one labour table and Newborn corner One room with two to four beds (in case the no. of deliveries at the Sub-centre is 20 or more, four beds will be provided) One room for store One room for clinic/office One Toilet facility each in labour room ward room and in waiting area (Essential)	Two Auxiliary Nurse Mid-wife (ANMs) A male health worker.
Primary Health Centre	Sign-age Entrance with Barrier free access Waiting Area Outpatient Department with separate areas for consultation and examination Separate wards meant for males and females 4-6 beds Operation Theatre (Optional) Labour Room Minor OT/Dressing Room/Injection Room/ Emergency Laboratory	One Medical Officer- MBBS One Accountant cum Data Entry Operator One Pharmacist Three Nurse-midwife (Staff-Nurse) One Health worker (Female) One Health Assistant. (Male) & One Health Assistant. (Female)/Lady Health Visitor One Laboratory Technician Two Multi-skilled Group D worker One Sanitary worker cum watchman

	General store Residential Accommodation for Medical Officer, nursing staff, pharmacist, laboratory technician and other staff	
Community Centre	Thirty indoor beds; wards Separate for Males & females One Operation theatre, One labour room, X-ray, ECG and laboratory facility Signage at Entrance Zone Out Patient Departments with their rooms Waiting Room Pharmacy Emergency Room /Casualty Minor OT Injection Room and Dressing Room Observation room New Born Care Stabilization Unit Residential facilities for the Staff	One Block Medical Officer/ Medical Superintendent One Public Health Specialist One Public Health Nurse Five Specialists One Dental Surgeon Two General Duty Medical Officer One Medical Officer – AYUSH Ten Staff Nurse & Eleven Paramedical Staff Six Administrative Staff Six Group D Staff

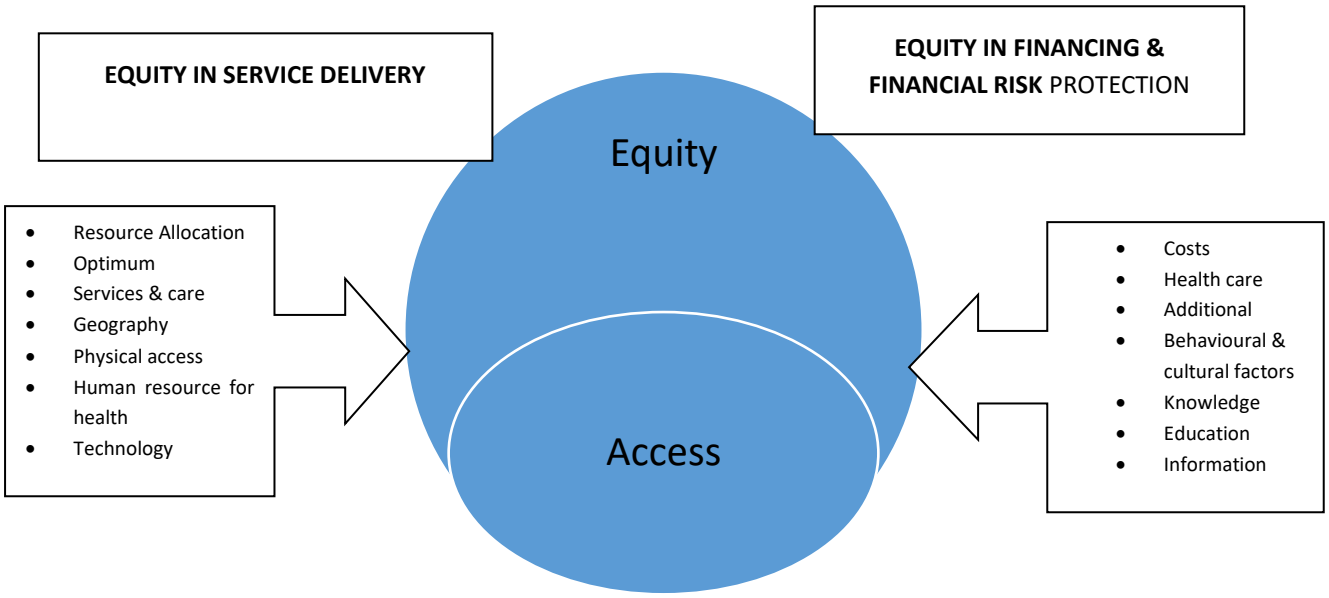
TABLE 2 COMPARISON BETWEEN THE NUMBER OF REGISTERED NURSES AND HEALTH VISITORS

Year	No. of General Nursing Midwifes	No. of Auxiliary Nurse Midwifes	No. of Health Visitors & Health Supervisors
2010	1238874	603131	15880
2014	1780006	786061	52963

Source: Ministry of Statistics & Program Implementation/ Statistical Yearbook 2016/Indian Nursing Council

Figures

FIGURE 1: CHALLENGES OF CREATING HEALTH EQUITY



Source: Health care and equity in India, 2011

FIGURE 2: A FRAMEWORK FOR HEALTH CARE ORGANIZATIONS TO ACHIEVE HEALTH EQUITY1

Make Health Equity a strategic Priority	•Demonstrate leadership commitment to improving equity at all levels of the organization •Secure sustainable funding through new payment models
Develop Structure and Processes to support health equity work	•Establish a governance committee to oversee and manage equity work across the organization •Dedicate resources in the budget to support equity work
Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact	•Health care services •Socioeconomic status •Physical Environment •Healthy Behaviours
Decrease institutional racism within the organization	•Physical Space: Buildings and Design •Health Insurance Plans accepted by the organization •Reduce implicit bias within organizational policies, structures, and norms, and in patient care
Develop partnerships with community organizations	•Leverage community assets to work together on community issues related to improving health and equity

Source: WHITE PAPER of Institute for Healthcare Improvement: Achieving Health Equity: A Guide for Health Care Organizations

FIGURE 3 PROPOSED FRAMEWORK FOR HEALTH CARE ORGANIZATIONS

Making Health Equity a Strategic Priority	•Planning to incorporate health equity strategies at all levels of the Healthcare Structure in India •Identifying proper funding sources in order to enhance the fund allocation meant for Healthcare services
Develop Structure and Processes	•Formulating a framework in order to eradicate health inequities by ensuring proper governance at all levels of Healthcare structure •Ensuring more funds from the Govt.'s end and reducing the Out of Pocket Expenditure in order to ensure Equity in the Healthcare Service Utilization
Strategies meant for different determinants that play a major role in influencing the Healthcare demand in India	•Quality Healthcare Facilities •Socioeconomic Status •Physical Environment •Health related Behaviours
Decrease in Institutional Racisim	•Need to ensure that the basic ammenities meant for hygiene and sanitation need to be without any stratification
Develop Partnership with community organisation	•Partnering with corporates,NGOs inorder to enhance community participation in eradicating different health issues and ensuring health equity.