



## Building a fairer, healthier world

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A technical paper



# Background

How people are born, grow, live, work, and age significantly impact their health and access to quality health services. For example, many people worldwide who cannot make ends meet, live in impoverished housing condition, do not achieve good education levels, do not find employment, have no or little access to safe environmental conditions experience unnecessary suffering, avoidable illness and premature death. At the same time, it is possible to reduce this burden and variation.

The global leaders, time and again and, for example, as part of the Sustainable Development Goal (SDG) agenda, have agreed that all people must access quality health services when and where they need them, without financial difficulties. This arrangement is Universal Health Coverage or UHC, which is endorsed under target 3.8 in the SDGs. Besides, goal 10 in the SDG is to "Reduce inequality within and among countries". Equity is part of a few other SDGs as well (Box 1).

However, the COVID-19 pandemic has hit all the countries hard, and its impact has been harshest on the vulnerable communities, who are more exposed to the disease yet less likely to have access to quality health care services and, therefore, more likely to experience adverse consequences as a result of the pandemic. Further, the impact has been inequitable, both in terms of health and social parameters, as highlighted in the Oxfam published report in early 2021 which termed COVID-19 as 'The Inequality Virus'.

For the reasons mentioned above, the World Health Organization (WHO), very appropriately, has designated the theme of World Health Day 2021 (WHD 2021) as health equity. The slogan for this year WHD is "Building a fairer, healthier world."

## Structure of this paper

This technical paper on health equity in India aims to raise awareness of the concept and the current health equity situation in India. The paper has three sections. The first section provides a theoretical understanding of the health equity topic and underscore the relevance of the topic in the context of universal health coverage. The second section provides a data-based overview of health equity in India. The third section provides information on crucial ongoing initiatives and proposes solutions/approaches to achieve health equity in India. In the end, there is a listing of a few supplementary readings.

### Box 1: Equity and SDGs

In pledging to achieve the SDGs, countries have committed to leave no one behind.

SDG 10: Reduce inequality within and among countries

SDG 5: Achieve gender equality

SDG 3: Ensure healthy lives and promote well-being for all at all ages

SDG Target 3.8 Achieve universal health coverage

SDG Target 17.18: Enhance capacity-building support to developing countries to increase the availability of disaggregated data





# Understanding health equity and inequality

Health equity is when everyone has an opportunity to be as healthy as possible. Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, geographically, or demographically. Inequity in health is a normative concept and refers to those inequalities that are judged to be unjust or unfair because they result from socially derived processes.

While measurable health gains are happening over recent decades, there is evidence that achievements have been unequally distributed and have largely failed to reach the poor and the marginalised or socially excluded groups. Health inequity is unjust: differences in health between different social groups can be linked to forms of disadvantages such as poverty, discrimination, and lack of services or goods.

At least two concepts should be given attention as we deliberate and attempt to understand and achieve health equity: One is ensuring access, and the second is social determinants of health (SDH). Achieving health equity requires ensuring access to the resources that need to be healthy (Box 2) and addressing SDH. These enable reducing unfair, avoidable, and remediable differences in health outcomes between groups defined socially, economically, demographically, geographically and politically.

The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, age, and the broader set of forces and systems shaping daily life conditions. The SDH has an important influence on health inequities - the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health, and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

The studies have estimated that SDH account for between one third to half of health outcomes. Addressing SDH appropriately is fundamental for improving health and reducing longstanding inequities in health, which requires action by all sectors and civil society.

The concept of health inequity is widely known for long. Nearly five decades ago, in 1971, Julian Tudor Hart had given the concept of inverse care law, which argued that in most settings, poor and middle-income countries, good medical and social care is available

## Box 2: Ensuring access

It means addressing barriers faced by people in accessing health services

- Geographical barriers: target and prioritize underserved areas
- Gender barriers: gender norms, roles and relations that block access to services
- Information barriers: ensure information is sensitive to gender, ethnicity, age and disability
- Discrimination, stigma, fear of social isolation: reduce bias and address confidentiality.



inversely related to the needs of the people. Five decades later, a Lancet paper argued that while inverse care law is applicable in low and LMICs, the disproportionate care law in high-income countries, where socially disadvantaged people receive more care but of worse quality and insufficient quantity to meet their healthcare needs. (Cookson R, et al 2021)

Health Protection throughout the life cycle: People of all ages, whether they are infants, children, adolescents, adults (men/women/others) or older persons, need health care services throughout their lifetimes. Everyone is always vulnerable to adverse health events, which can strike anyone unexpectedly or result from their living conditions and lifestyles. Especially during ill-health periods, including catastrophic diseases, disabilities, and accidents, health protection, and access to equitable health services are essential.

## Not merely income differences

Historically, in health equity, the most significant emphasis has been placed on economic status and has included wealth-related inequities. It is not enough to say that health varies between rich and poor. However, other variables contribute to health inequity. There are also significant differences between male and female, highly educated or less educated, urban and rural residents. These are often described by the acronym PROGRESS (Box3).

In addition to PROGRESS, the other stratifies which can contribute to health inequities can be age, lack of civil registration, migrant and refugee status. These factors have been crucial during the COVID-19 pandemic.

The factors affecting and determining the equity have been presented in a conceptual framework by a few experts, shown in Figure 1 below (Ref: Balarajan Y, 2011).

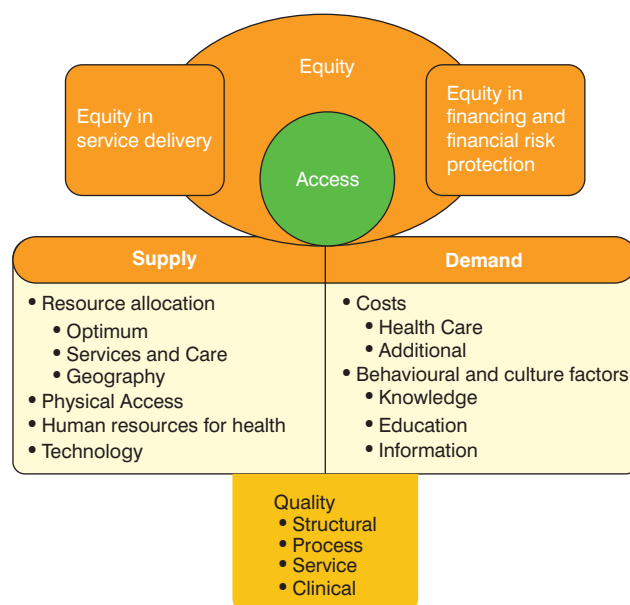
### Box 2: Ensuring access

PROGRESS: the stratifiers, commonly linked to health inequities.

- **Place** of residence (rural, urban and others)
- **Race** or ethnicity
- **Occupation** (workers, employed and unemployed)
- **Gender** (sex)
- **Religion**
- **Education**
- **Socioeconomic status**
- **Social capital** and resources

## Health inequality monitoring

One of the first steps in taking corrective measures is identifying the challenges. Therefore, identifying health inequalities and their drivers-across and within countries—is essential for achieving health equity. Conducting health inequality monitoring provides information that can allow policies, programs, and practices to reduce health inequity. Health is a normative concept and cannot be precisely measured or monitored. However, inequality (which are the observable differences between sub-groups within a population) can be measured and



monitored. Identifying health inequalities and their drivers is essential for achieving health equity.

Health inequality monitoring identifies the measurable differences and changes in health indicators in sub-group of populations. While health monitoring only considers data related to health indicators, health inequality monitoring requires additional intersecting data streams related to a dimension of inequality such as wealth, education, etc.

Health inequality is multi-dimensional; therefore, monitoring requires two sets of data. One on health status of population and second set of data on the dimensions of inequality (the stratifies) as in Box 2. Creating an effective monitoring mechanism would also require creating data sources, which provide timely, reliable, and quality information. There could be three different type of data sources:

- **Population-based:** census, vital statistics system, and household surveys
- **Institution-based:** Administrative reports such as the number of health facilities; number of vaccination session done; Individual records
- **Surveillance system:** for specific purpose.

Health inequality can be measured in different ways. Two commonly used approaches are absolute inequality and relative inequality (in health). Absolute inequalities depict the rate difference between the two groups, usually depicted by subtracting the worst-performing subgroup from the best performing sub-group. For example, if institutional deliveries in the wealthiest quintile are 80% and the poorest quintile is 40%, the absolute inequality is 40%. Relative inequality is reflected as a ratio. Therefore, for the same example as above, the relative inequities would be poorest quintiles /richest quintiles, which would mean 0.5.

In addition to these approaches, there is a need to assess the trend over population subgroups.

## Tools and data sources to measure health equity

### The Health Equity Assessment Toolkit (HEAT)

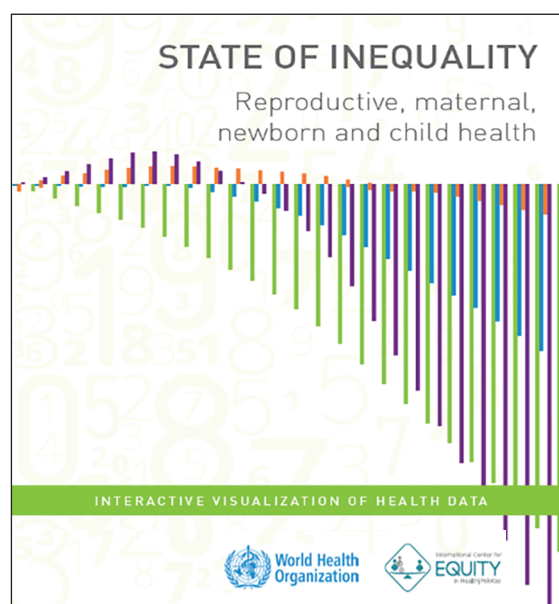
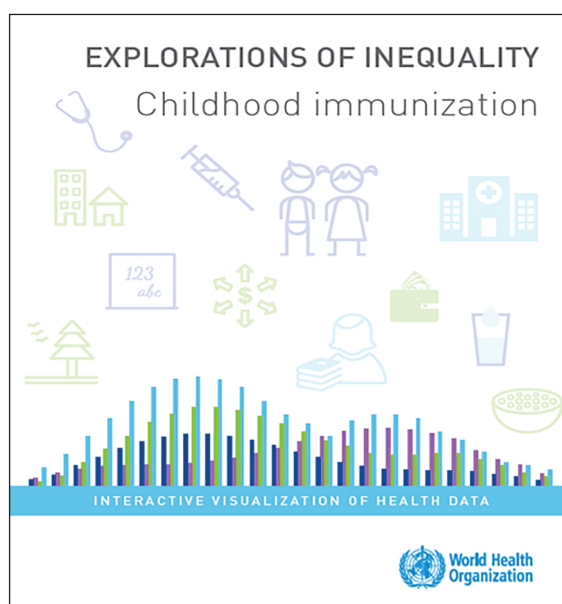
HEAT is a software application that facilitates the assessment of within-country health inequalities. HEAT, Built-In Database Edition, which comes pre-installed with the Health Equity Monitor database. HEAT: Plus, Upload Database Edition, which allows users to upload and work with their database. Both HEAT and HEAT Plus are organised around two main components: Explore inequality, which enables users to explore the situation in one set of interest (e.g. a country, province or district) to determine the latest inequality situation the change in inequalities over time. Compare inequality, which enables users to benchmark, i.e. compare the situation in one set of interest situations in other settings.

### Global Health Observatory (GHO) data and Health Equity Monitor

GHO is a database of disaggregated data. It has around 30 reproductive, maternal, newborn and child health indicators, which are disaggregated by 6 inequality dimensions (economic status, education, urban/rural, subnational region, age, and sex). The database is from >450 international household surveys (DHS, MICS, RHS), collected between 1991 and 2019 in around 118 countries. The database provides an opportunity for interactive data visualisations and country profiles. There are global reports, along with a few state reports.







## Policy and programmatic interventions (to reduce Reducing inequalities)

Developing an understanding of health inequities is intended to initiate the policy interventions and corrective measures.

Addressing inequalities in health care requires active engagement in the planning, implementation, and regulation of health systems. The strategies should prioritise that the need of subgroups falling behind is addressed. The approach to tackle health inequities will also be dependent upon the local situation. An indicative approach is suggested in Box 3.

### Box 3: Ensuring access

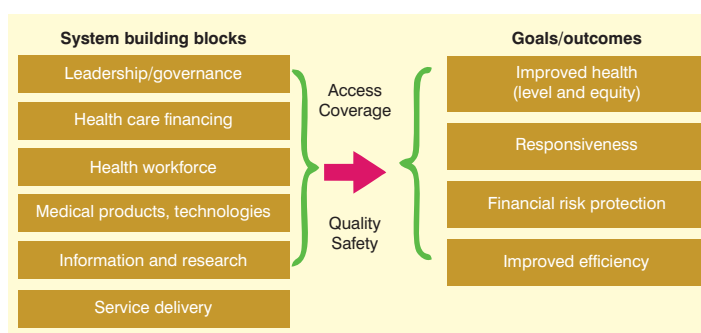
Appropriate actions for addressing health inequalities

- **Complete Coverage:** need continued monitoring
- **Marginal exclusion (most disadvantaged population has the lowest coverage):** actions targeted at the underserved
- **Incremental linear pattern (approximately equal increase in all subgroup of population):** combined universal and targeted approach
- **Mass deprivation (a large proportion of population has limited access to health services):** universal action at entire population.

## How health equity fits into the context of UHC and health systems?

The global community and countries across the world have committed to UHC. The UHC aims at access to health services by all populations. It intends to achieve universal coverage, which would reduce inequities.

While UHC is a goal, the health systems strengthening (HSS) is a tool to achieve the goal of UHC. Amongst the final goals of health systems (above), improved health equity is one of the goals, nearly always listed first goal of health systems.



While this has always been considered, what is of contemporary relevance is that the causes of health inequity, once thought to be beyond the realms of intervention, are now routinely being considered for inclusion within progressive health programming parameters.

**Health Equity through Primary Health Care Systems:** The WHO identifies primary care as the linchpin of health equity and achieving health outcomes for all, supported by robust theoretical and empirical evidence, with strong national primary care systems associated with improved equity and health indicators. Generally, primary health care is perceived as more equitable than other forms of health care because it requires fewer resources. Numerous studies have identified the link between strong primary health care and improved health outcomes related to mortality, morbidity, patient experiences and self-reported health status.<sup>iii</sup> These outcomes are commonly associated with lower expenditure on individual and system costs.

### Vaccine equity in COVID-19 pandemic

Only a select few countries can produce and manufacture the vaccines. This is true for COVID-19 vaccines as well. Vaccines are a proven tool to prevent diseases and has also been recognised as an important tool to fight the ongoing COVID-19 pandemic. Yet, access to COVID-19 vaccines is disproportionate. Even till the end of March 2021, many of the low and low-middle-income countries did not have access to any COVID-19 vaccines even for their healthcare workers.

Recognising and anticipating this challenge, In January 2021, WHO had issued a call to all countries to work together in solidarity—and in each of their best interests—to ensure that within the first 100 days of the year, vaccination of health workers and older people was underway in all countries. This call to action is at the heart of WHO's campaign for #VaccineEquity.

To ensure that by World Health Day 2021, COVID-19 vaccines are being administered in every country as a symbol of hope for overcoming both the pandemic and the inequalities that lie at the root of so many global health challenges.

Therefore, WHO has called upon, specifically for:

- **World leaders** increase contributions to the COVAX facility and share doses with COVAX in parallel with national vaccine rollout.
- **Vaccine manufacturers** to share know-how with C-TAP to scale up vaccine manufacturing and dramatically increase the global supply of vaccines for the coming years. Furthermore, we ask for leaders to prioritise supplying to COVAX over new bilateral deals.
- **Regulatory bodies** accelerate approval processes safely and deliberately.
- **Ministries of Health** to work with WHO and others to invest in and prepare their primary health care systems for distribution of COVID-19 vaccines to their health workers and to develop data systems on vaccine supply, distribution and uptake, including sex- and age-disaggregated sub-national data, to drive delivery, equality and impact.
- **All governments** ensure that COVID-19 vaccines are distributed free at the point of care and without risk of financial hardship. The free distribution to follow vaccination starting with health workers and those at the most significant risk of COVID-19; prioritising affected communities and the voices of essential workers in decision-making, and ensuring gender equality is central to all actions.





# Who is being left behind?

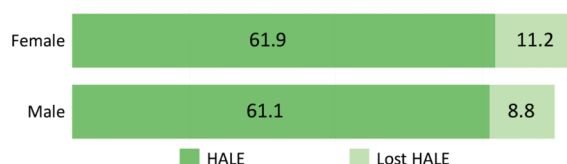
## Inequities in health in the South-East Asia Region

Equity is at the heart of World Health Day 2021 “Building a fairer, healthier world” and the 2030 sustainable development goals. The 2030 agenda emphasizes the need to reduce avoidable inequity. The most common ways to look at health-related inequities are by income group, sex, education, and place of residence. Equity stratified data are quite limited. This fact sheet highlights several examples of inequities where data is available.

### Overall health-related inequities in SEA Region Member States

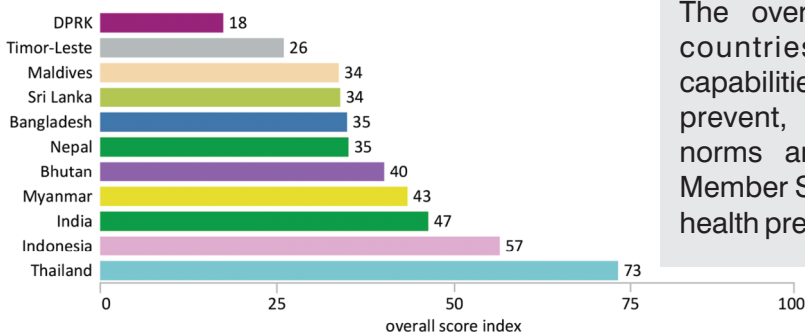
#### Healthy life expectancy (HALE), 2019

HALE represents the average equivalent number of years from birth of living in good health without disease or injury. Females have 2.8 years more lost HALE than males in the WHO SEA Region



Source: WHO Global Health Observatory

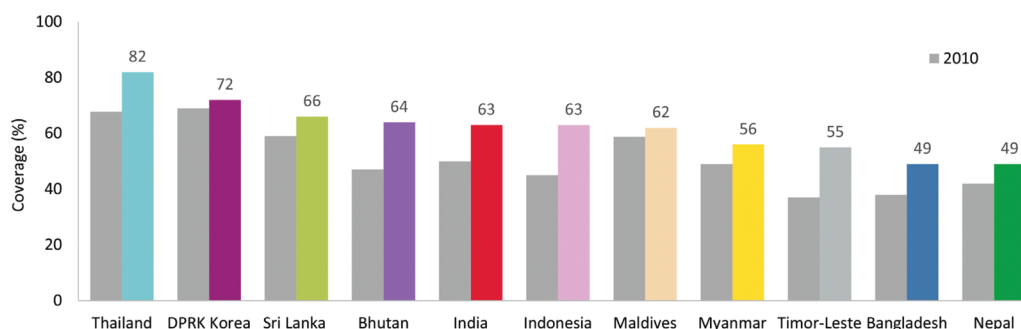
#### Variation in global health security index



The overall GHS Index assesses countries' health security and capabilities across six categories: prevent, detect, respond, health, norms and risk. In SEA Region, Member States differ widely in overall health preparedness and readiness.

Source: Global Health Security Index 2019. <https://www.ghsindex.org/>

#### Universal Health Coverage (UHC) essential health services coverage index (%) (SDG 3.8.1), 2010–2020



Source: Monitoring progress on universal health coverage and the health-related sustainable development goals in the South-East Asia Region: 2020 update

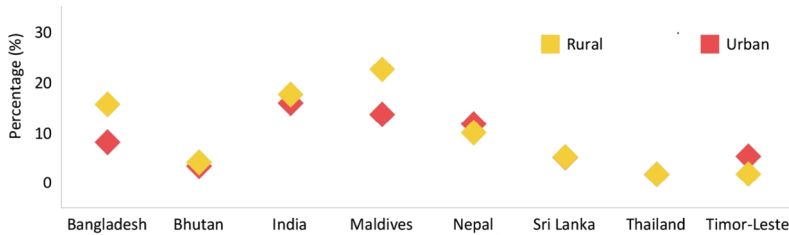




Levels of essential service coverage estimated for 2020 vary across Member States from 49% to 82%. Although all Member States have improved essential health services coverage since 2010, the levels of this coverage estimated for 2020 vary significantly across Member States.

## Inequity in financial protection

Incidence of catastrophic health expenditure (SDG 3.8.2): population with household expenditure on health > 10% of total household expenditure/income (%) by geography in eight SEA Region Member States

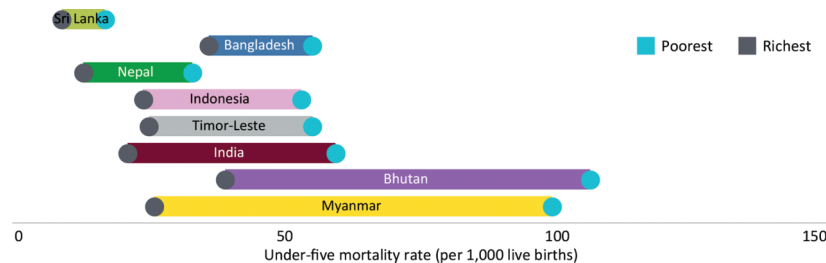


Source: Wang et. al Financial protection analysis in eight countries in the WHO South-East Asia Region.2018.

Approximately 16% of the population in the Region (307.4 million people) experienced catastrophic health spending in 2015, with rural households often worse off than urban households.

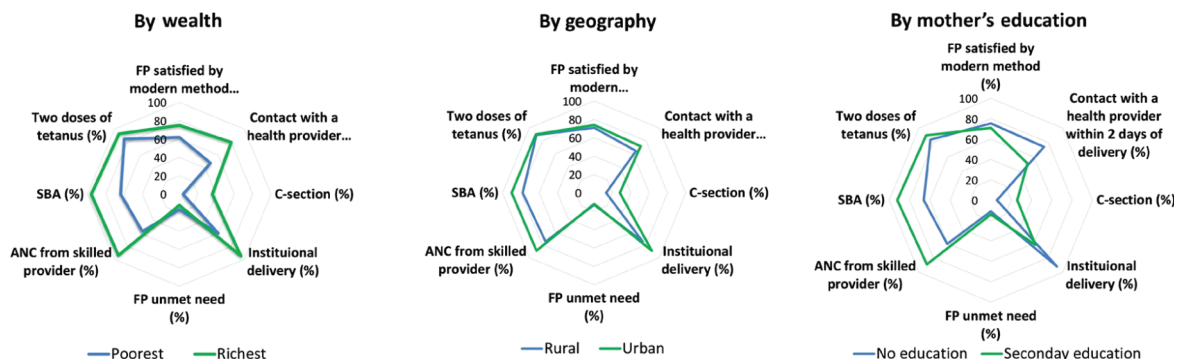
## Health inequity in sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH)

Disparity in under-five mortality rate (SDG 3.2) by income across eight SEA Region Member States



Children under five from the poorest households are 2 to 4 times more likely to die than those from the richest households.

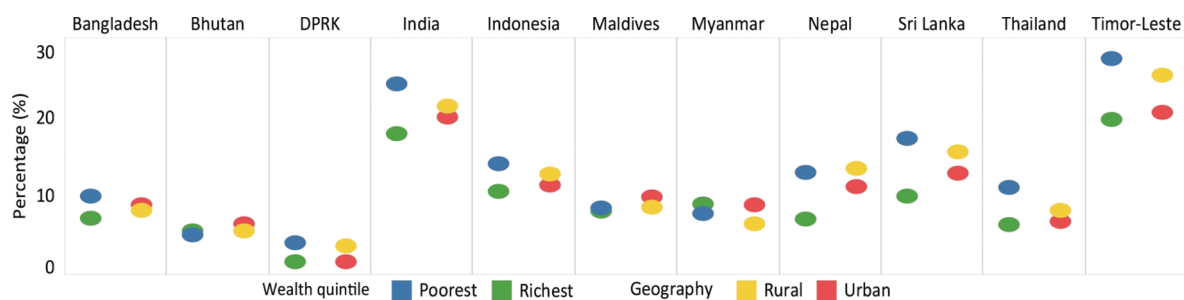
Variations in SRMNCAH services coverage in SEA Region, by income, place of residence and mother's education



Source: : DHS/MICS 2010-2019

Disparities across eight indicators of services coverage are apparent by multiple dimensions of inequity.

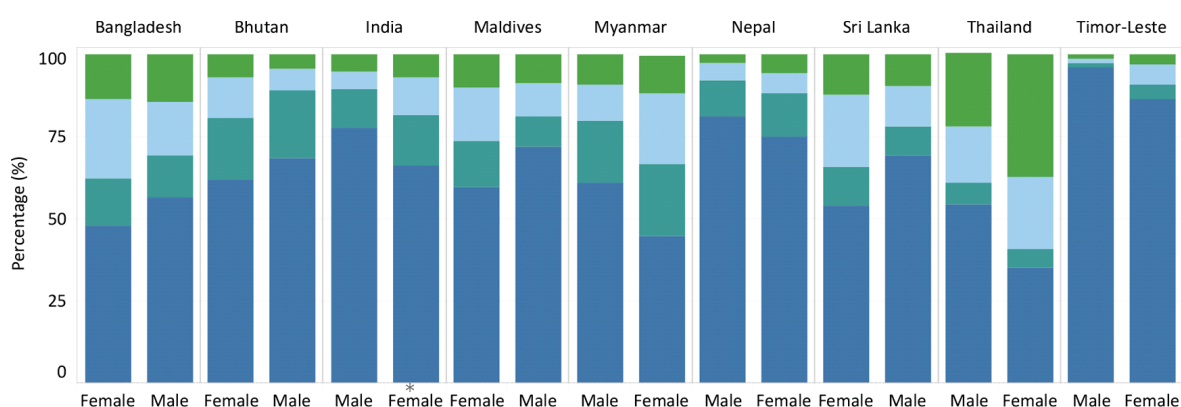
## Difference in prevalence of wasting among children under-five by wealth and geography



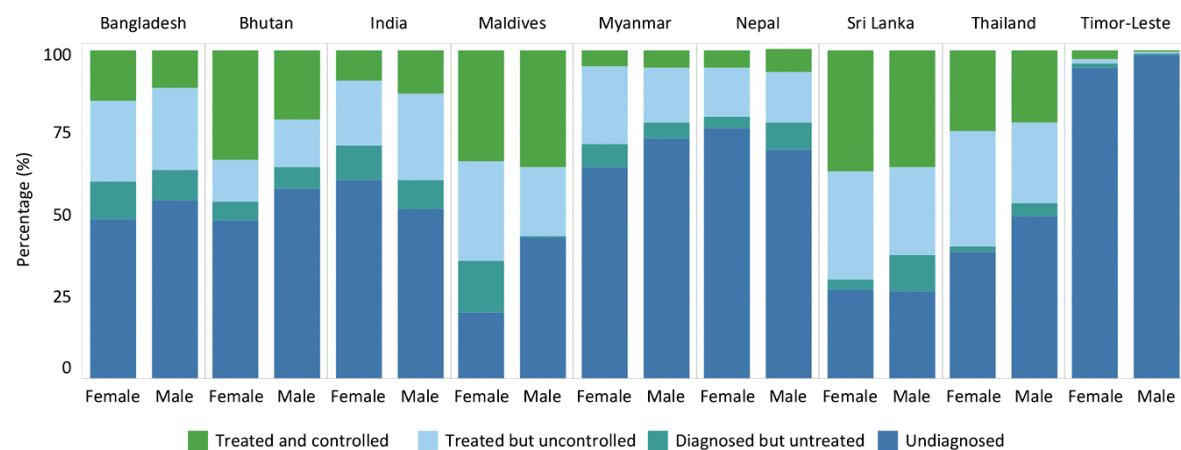
Source: DHS/MICS 2010-2019

## Assessing health inequities by sex in some key disease conditions

### Diagnosis and treatment gap for hypertension, by sex



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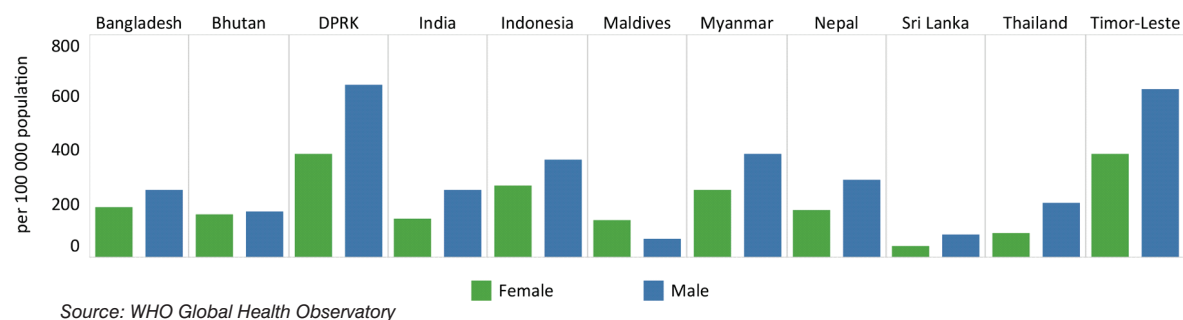
A larger proportion of women tend to be diagnosed, put on treatment and controlled for hypertension and diabetes mellitus than men.

\*among people who were measured to be hypertensive or diabetic at the time of the survey.

Sources: Calculated from different WHO STEPS surveys or equivalent population-based surveys. Geneva and New Delhi: World Health Organization; 2014–2018 (respective years in parentheses by country) and for India (for selected 15 states only), Thailand (NHES, 2014)



## Variation in tuberculosis (TB) incidence (SDG 3.3.2) by sex

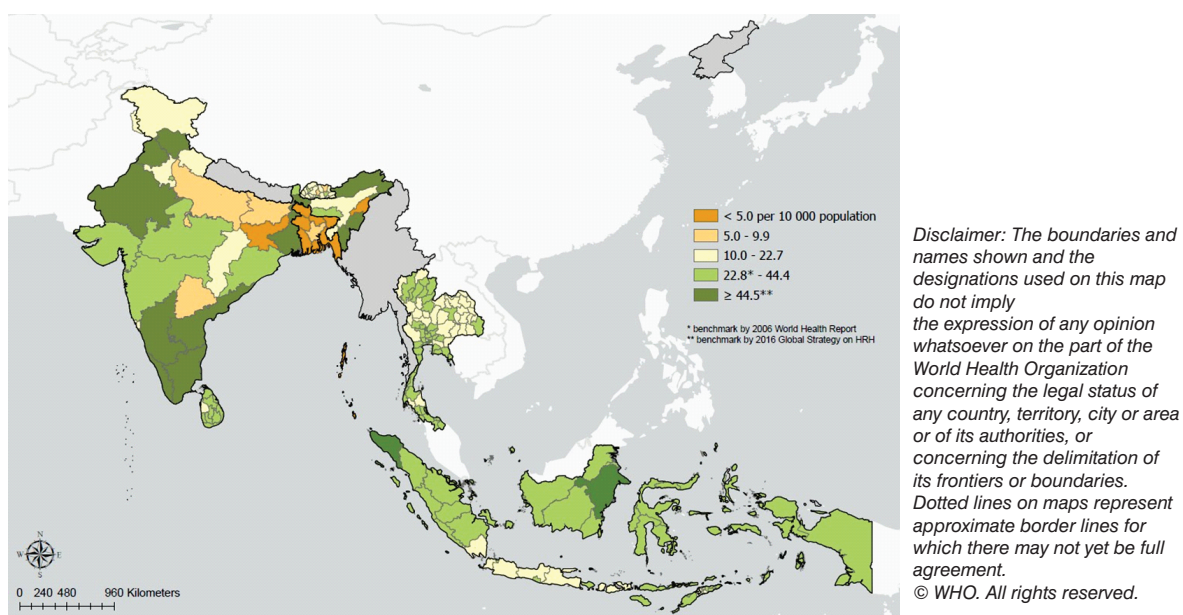


Estimated TB incidence is higher in men than women in 10 out of 11 SEA Region Member States

## Health inequity in health system capacities

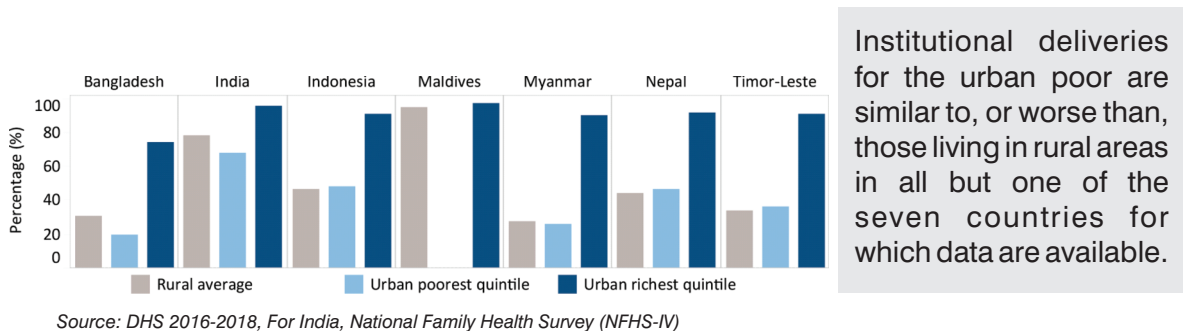
There are wide intercountry and intracountry variations in availability of critical health workforce.

## Distribution of doctors, midwives and nurses across Member States, 2018



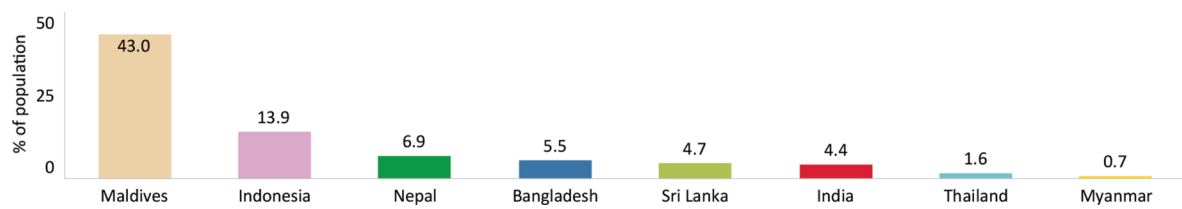
Source: Decade for health workforce strengthening in SEAR 2015-2024, mid-term review: 2020

## Institutional deliveries by wealth and geography in seven SEA Region Member States



## COVID-19 vaccine delivery status

Covid-19 vaccine delivery, as percentage of population



## Monitor and address health inequities for a fairer, healthier world

The data shows some people are able to live healthier lives and have better access to health services than others – entirely due to the conditions in which they are born, grow, live, work and age. This leads to unnecessary suffering, avoidable illness, and premature death. And it harms our societies and economies.

Member States should collect and analyse health information that is disaggregated by various relevant equity- related stratifiers and use the findings to inform health policies and actions for a fairer, healthier world.





# India and health equity

India has launched the flagship National Rural Health Mission (NRHM) in the year 2005, intending to strengthen primary healthcare services in rural areas. The National Urban Health Mission (NUHM) was launched in May 2013. More specifically, the NUHM focused on improving the poor and marginalised health outcomes, especially in the urban slums. Two missions together are now called National Health Mission or NHM.

India has worked to strengthen the primary healthcare system in the country. The task force report on primary healthcare, released in 2015-16, was followed by National health Policy 2017. The NHM has a core principle of health equity. The central goal of NHP 2017 is fully aligned with the concept of UHC in India.

## India: Health of the Nation's States

The India State-Level Disease Burden Initiative

INDIAN COUNCIL OF MEDICAL RESEARCH  
PUBLIC HEALTH FOUNDATION OF INDIA  
INSTITUTE FOR HEALTH METRICS AND EVALUATION



ICMR



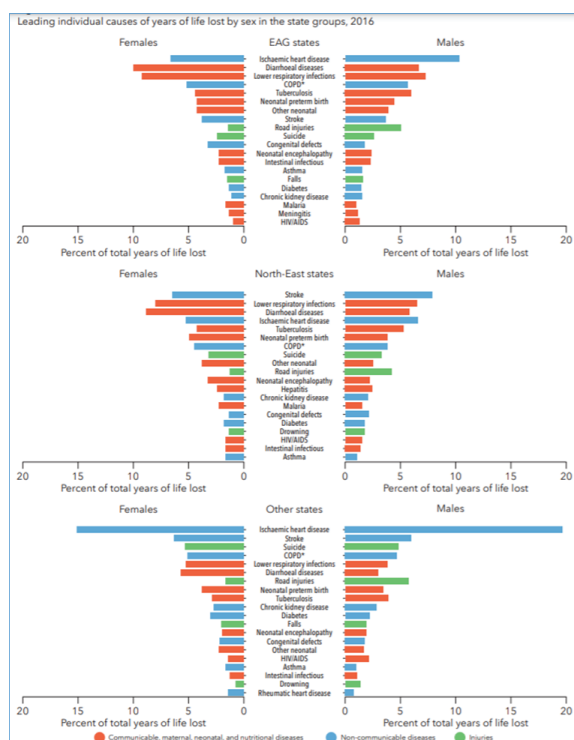
Department of Health Research  
Ministry of Health and Family Welfare  
Government of India



PUBLIC  
HEALTH  
FOUNDATION  
OF INDIA



IHME



In November 2017, a national report titled "India: Health of the Nation's states" was launched. It provided information on state-level disease burden and provides an essential data set for various types of health inequities.

In early 2018, India's government launched the Ayushman Bharat program, which has two components - Health and Wellness Centers (HWCs) for Primary Health Care and Pradhan Mantri Jan Arogya Yojana (PMJAY) for secondary and tertiary care. These components are linked to address the significant challenges of ensuring a continuum of care, two-way referral system and gatekeeping. The government is committed to strengthening 1,50,000 facilities as Health & Wellness Centers, which will



deliver Comprehensive Primary Health Care closer to people living in rural and urban areas. Pradhan Mantri Jan Arogya Yojana (PMJAY) is an insurance system that would cover Rs. 5 lakh per family per year and is cashless. Approximately 10.74 crore poor & vulnerable families are entitled to receive benefits of PMJAY, without any cap on family size or age, and portable across the country.

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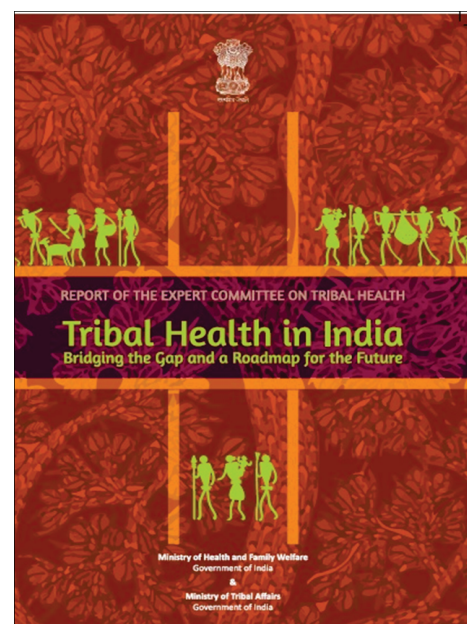
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## Proposed policy interventions

All health systems aim to achieve health equity in outcomes; however, it requires direct attention and interventions. Strengthening the public health infrastructure, supporting the effective delivery of public health services, and increasing collaboration within the health care system and other sectors to achieve common health goals, including health equity. The foundation of achieving health equity is laid with strengthening the systems for data collection, analyses and report and use the results for policy and programmatic interventions. This technical brief provides a few actionable suggestions, as an indicative list and not comprehensive, for as India aims to address health inequities:



### **Develop a system for monitoring equity and collection of data through the routine system**

There is a need for strengthening the health data recording and reporting system in India. This will provide timely and helpful information for the action. The existing mechanisms, such as academic institutes, should be involved in the process and guide the approaches to tackle health inequities. The medical and nursing graduate and postgraduate students should be trained about health inequities.

### **Focus and implement health initiatives targeted at underserved populations.**

As an example, the expert committee's report on tribal health in India had identified the inequities in health outcomes of the tribal population in India. The recommendations and suggestions for such and similar expert groups should be used for policy formulation and programmatic interventions. To make these workable health initiatives should be linked to other broader ongoing initiatives such as the aspirational district's program and Poshan Abhiyan. While these settings have health facilities, there is a need for matching the facilities with providers and services by fulfilling Human resources gaps. The IEC efforts should also be conducted. The budget provision of 2021-22, where additional resources have been allocated for such settings, may be helpful and should optimally be used. Local-level community-based systems should be used.

### **Village level health services in rural areas and attention on urban poor and migrants**

Establishing effective community linkage and strengthening primary health services at the village level should help health equity. These initiatives include attention to health-seeking behaviour, community-based screening (under HWCs). Furthermore, the number of community-level health workers and volunteers need to increase in under-served areas. Focusing on urban primary health care

### **As part of the World Health day 2021 campaign, the WHO has called upon global leaders to**

- **Work together:** Work hand in hand with affected communities and individuals to address the root causes of inequities and to implement solutions—within and beyond the health sector—to address them. The impact will be most significant when governments and communities work together in a coordinated approach.
- **Collect reliable data:** Ensure collection and use of timely and reliable health data - disaggregated by gender, age, income, education, migratory status, disability, geographic location, and other characteristics relevant to the national context. Only then is it possible to assess inequities across population subgroups and take actions that have an impact?
- **Tackle inequities:** Adopt a whole-of-government approach to tackling the root causes of inequities and increasing primary health care investment. This approach is key to meeting today's challenges of ensuring Health for All and building tomorrow's resilience. Providing quality Comprehensive Primary Health Care services is the bedrock of Universal Health Coverage.
- **Act beyond borders:** Act beyond national borders. For example, only when we can protect, test, and treat the whole global population can we end the COVID-19 pandemic. As well as assuring an equitable supply of vaccines, tests, and treatments, we must strengthen national and international mechanisms and build community trust and participation into their delivery and uptake to ensure access for all globally.



infrastructure (as proposed under recently announced Pradhan Mantri Atma Nirbhar Swasth Bharat Yojana) will help; however, attention needs to be given merely creating infrastructure but making those functional. These should be established where the likelihood of increased utilisation is higher.

**Assured provision of services as well as medicines and diagnostics at all levels of government facilities**

There is evidence that people are more likely to attend a government health facility, which has assured the provision of services, including medicines. Similarly, assured medicines and diagnostics help in attracting people to attend government health care facilities. Therefore, increased government funding for medicines and diagnostics would reduce inequities as people who are marginalised are likely to use these facilities.

**Leadership and interventions by both union and state governments**

Everything that is intended to make health services universal helps make progress towards health equity; however, that is not given. Health is a state subject in India. Therefore, in addition to major initiatives, each of India's states should consider developing and implementing mechanisms for tackling inequities.



## Reading material, source, and references

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2. WHO Health Equity Monitor. Available at: <https://www.who.int/data/gho/health-equity>
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4. Health Equity Assessment Toolkit (HEAT and HEAT Plus). Available at: [https://www.who.int/data/gho/health-equity/assessment\\_toolkit](https://www.who.int/data/gho/health-equity/assessment_toolkit)
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