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# UNIVERSAL HEALTHCARE *

Interactive Session 2A

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## Introduction

India stands at a pivotal moment in its health policy journey. The country has made significant strides toward universal health coverage and reducing poverty, but now faces a dual challenge: controlling the rising tide of non-communicable diseases (NCDs) like obesity, diabetes, and hypertension, while ensuring that vulnerable groups—including the elderly, women, and outdoor workers—are not left behind. Health system reforms, the expansion of primary care, and programs like Ayushman Bharat have improved financial protection and access, yet systemic gaps persist.

## Context

India's health landscape has undergone a profound transformation in the past decade. Public health initiatives have targeted communicable diseases, maternal and child health, and the country now faces new epidemiological realities. Universal Health Coverage (UHC) and the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY) are game-changers in reducing out-of-pocket expenditure, with over 9.5 crore admissions and an estimated $40–$50 billion in collective savings for families across the country. Recent expansions ensure coverage for those aged 70 and above, further widening the safety net.

Despite improved coverage, the nation now confronts soaring rates of lifestyle-related illnesses. Economic growth, urbanization, and changing consumption patterns have led to a new epidemic: India faces the simultaneous burdens of dietary excess in some populations, and persistent undernutrition or access barriers in others. National surveys and Time Use data highlight low levels of regular exercise and widespread gaps in nutrition knowledge, even though healthy diets are economically affordable for the vast majority.

Crucially, gender disparities prevail. Males consistently receive more outpatient care than females, with evidence showing persistent gender disparities in access, even after accounting for socioeconomic and other background factors. Recent research documenting outpatient sex ratios and time use for exercise highlights not only supply-side limitations but also deeply rooted demand-side barriers.

Climate change poses another layer of complexity. Data from multiple states indicate

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that the prevalence of hypertension and diabetes escalates during summer months, particularly among older adults, women, and those engaged in outdoor work. Vulnerability mapping shows that in districts facing high climate exposure, the odds of adverse health outcomes—including stunting, wasting, underweight in children, and reduced access to institutional care—are significantly increased.

## Policy Advances and Supply-Side Achievements

A robust public health system is essential for balancing India's growing and evolving health demands.

Recent years have seen expansion and upgrading of Primary Health Centres (PHCs) into Ayushman Bharat Health and Wellness Centres, providing a comprehensive basket of diagnostic and curative services. Government reforms have targeted major infectious and non-communicable diseases, with an explicit policy vision to cover twelve priority conditions, including mental health.

Significant investments have been made in digital public infrastructure for health, aiming to boost efficiency and reach through telemedicine, e-health records, and the use of social media for public awareness. State and city-level heat action plans in select urban centres demonstrate capacity for coordinated responses to climate-linked health risks, offering lessons for national policy.

However, persistent challenges remain. There remain endemic shortages of doctors, nurses, and beds, especially in rural and peri-urban areas. The health system remains tilted toward curative services, with insufficient focus on prevention and health promotion. The Baumol cost disease—where salaries in stagnant sectors like healthcare must keep pace with gains in dynamic sectors, causing cost inflation—contributes to growing healthcare spending even as budget constraints continue.

## Demand-Side Gaps and Behavioral Challenges

On the demand side, behavioral and social barriers slow progress against new health threats. Gender discrimination impedes women's access to timely and appropriate care, confirmed by outpatient sex ratio analyses from major referral centres and multi-state studies. Social factors such as limited time for exercise and the persistence of traditional dietary habits further compound health risks. Time Use Survey data demonstrate wide disparities in physical activity, particularly by gender, age group, and location.

Nutritional awareness, rather than affordability, is now the central obstacle. Over 90% of Indians have the financial means to afford a healthy diet, yet 99% fail to consume balanced and nutritious foods according to household consumption and expenditure data. There is substantial potential for targeted campaigns—drawing on the successful example of Japan's Department of Nutrition—to raise knowledge about locally available, culturally appropriate options.

South Asians, moreover, have higher body fat and metabolic risk at lower BMI levels compared to populations in Europe or North America. The "thin-fat" Indian phenotype, combined with quick dietary and lifestyle transitions, has led to early onset of diseases like diabetes, liver disease, and cardiovascular disorders-even among individuals who are only moderately overweight by international standards.

## Social, Economic, and Environmental Vulnerabilities

Recent research and vulnerability mapping further complicate the policy landscape. Data from the latest heat action plans and health surveys reveal sharp increases in reported cases of hypertension and diabetes among older adults and vulnerable workers during summer months. For example, the prevalence of hypertension among older Indians rises from 73.81 per thousand in non-summer months to 95.62 in summer, while diabetes rates show a similar pattern. The burden remains lower in women and outdoor workers overall, but spikes during periods of high heat.

Odds ratio analysis illustrates how climate vulnerability—especially exposure to extreme weather— raises the likelihood of stunting, wasting, low birth weight, and difficulty accessing healthcare. These findings underscore the intersection between traditional health system challenges and new, climateinduced risks. Urban centers are now piloting heat alert systems, indoor heat reduction programs, and group-specific support for high-risk populations.

The economic costs are staggering: direct healthcare spending, productivity losses, and premature mortality from obesity-linked diseases are estimated to account for 2–3% of GDP, and may rise further without robust intervention. Notably, the economic cost curve for chronic disease shows a much earlier inflection for South Asians, with significant increases in cost and risk starting at BMI 24-well below the global obesity benchmark of BMI 30.

## Evidence and Findings

1. Primary health care expansion via Ayushman Bharat has reduced out-of-pocket health expenses and increased admissions but is not a panacea for behavior-driven NCDs.
2. Older adults, women, and outdoor workers are vulnerable to climate-driven surges in chronic illness, requiring seasonally adaptive policy measures.
3. Gender disparity is both an ethical and public health concern: initiatives must ensure equitable access to institutional and preventive care for women.
4. Supply-side gaps include continued shortage of skilled health professionals, inadequate investment in prevention, and over-reliance on curative services.
5. Demand-side challenges relate to nutrition awareness, exercise habits, and social norms— domains where policy, public education, and local leadership are critical. It is often neglected in the policy discourse.

6. Heat action plans in cities provide actionable models for integrating environmental and health interventions at the community level.

7. Vulnerability mapping and odds ratio analyses should be embedded within national policy to prioritize the most at-risk groups and target interventions where marginal returns on investment are highest.

## Policy Recommendations

### 1. Strengthen Primary Health Systems and Diagnostics

- Continue expansion and upgrading of PHCs and Ayushman Bharat Health and Wellness Centres.
- Ensure coverage of the twelve priority disease groups, including a robust mental health component.
- Invest in modern laboratory and point-of-care diagnostics, especially in rural and periurban regions.

### 2. Bridge Supply-Side Gaps

- Increase the recruitment, training, and retention of doctors, nurses, and allied health professionals.
- Invest in health infrastructure—beds, equipment, digital tools—with a strong focus on under-served districts.
- Address the Baumol cost disease by efficient resource allocation and periodic wage reviews.

### 3. Integrate Vulnerability and Climate Risk Assessments

- Institutionalize odds ratio and vulnerability mapping within health ministry planning.
- Mandate seasonal health surveillance, especially for chronic conditions in the elderly, women, and outdoor workers.
- Scale up heat action plans nationally with targeted funding for cities and climate-exposed regions.

### 4. Promote Prevention and Behavior Change

- Launch large-scale, locally-tailored campaigns on healthy eating and regular exercise, leveraging mass media, schools, and community leaders. The Japanese model can be referred to for this.
- Update program thresholds for overweight /obesity (BMI 24+) for South Asian populations.
- Encourage regular screening for diabetes, hypertension, and obesity, especially in highrisk and low-awareness communities.

### 5. Advance Gender Equity and Social Inclusion

- Monitor and address gender disparities in access and outcomes through outreach, incentives, and institutional accountability.
- Train front-line health workers in gender-sensitive care delivery.
- Promote women's participation in all levels of community health leadership and

program design.

### 6. Leverage Digital Health and Evidence-Based Action

- Expand health information systems, electronic medical records, and real-time monitoring platforms.
- Support research and data-driven planning for both chronic and climate-related health risks.
- Develop interoperable health registries linking PHCs, hospitals, and environmental surveillance.

### 7. Improve Financial Protection and Sustainability

- Continue efforts to further reduce out-of-pocket expenditures, especially for vulnerable populations.
- Pilot and scale insurance models for climate-sensitive and NCD care for high-risk groups.
- Monitor and address changing patterns of catastrophic expenditure in response to climate and epidemiological shocks.

## Conclusions

India's progress in expanding access and financial protection is commendable, but cannot alone contain the evolving epidemic of NCDs or the new threats posed by climate change. To ensure future health and prosperity, policy must move beyond incrementalism. Success depends on a multi-pronged approach: expanding and modernizing primary care, addressing demand-side behavioral and awareness gaps, tackling supply-side and equity concerns, and factoring seasonal and environmental vulnerability into all levels of health planning.

The intersection of chronic disease, climate risk, and social inequality requires new models of integrated, community-based action. Prevention, awareness, and empowerment of local leaders-alongside robust surveillance, increased investments, and policy flexibility-will be the keys to a resilient, people-centered health system built for India's present and future.


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