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The Role Of Health & Wellness Officers In Reducing Health Inequalities In India: An Empirical Study

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Abstract

The sustainable development goals adopted by the United Nations stated that good health and wellbeing must be achieved to ensure healthy lives and promote wellbeing for all ages. The study aims to identify the health inequalities in Mizoram and address the various health inequalities that exist in rural and urban areas. It has been found that through the flagship program of the Central Government Ayushman Bharat Pradhan Mantri Jan Arogya Yojana has played a major role in reducing these health inequalities with the help of health and wellness officers in health and wellness centres. On the basis of census method**,** all 197 Health and wellness officers in the state were taken as the respondents for the data collection. The questionnaire was administered through online software Google forms due to the ongoing pandemic. The health and wellness centres through its health and wellness officers have played a pivotal role in fair distribution of health services in Mizoram.

Keywords: Health inequalities, Ayushman Bharat health & wellness centres (AB-HWC), primary health centres (PHC), health and wellness officers (HWO), health sub-centres (HSC)

Introduction

Health inequalities have been reported as the major problems faced by most of the countries in between 1980s and 1990s [1] . Despite the differences in health inequalities definitions and scale of assessment across the countries, they are commonly presented as systematic differences in the health status of different socioeconomic groups mainly causes by an unequal distribution of power, income and wealth[1]. Researchers have witnessed health inequalities are mainly suffered by the underprivileged and that people of lower status are constantly experiencing poor health outcomes [2]. Such research findings have awakened the health promotion of the poor and reducing health inequalities has become a significant area for policy

research and action worldwide. Tackling health inequalities have been the aim of all public health policy and most of the countries have developed an ambitious goal for reducing health inequalities.

Apparently, Indian health policies and programmes were designed to reduce health inequalities and the Government of India has setup Government Primary Health Care Facilities (GPHCF) in both urban and rural areas which have evolved since independence[3]. Between 1990 and 2015, attaining Millennium Development Goals became the priority of the national and state programme which mainly emphasized on addressing the given state of maternal, infant and new born mortality[4]. Nearly 200000 Government Primary Health Care Facilities were existed across the country over the past years[3]. However, such primary health care services put emphasis on on maternal and child health as well as a few communicable diseases such as Malaria ,leprosy, TB, , etc. Later on, it was reported that these facilities remain underutilized accounting for only 8-10% of total health services availed by the people which was mainly due to provision of narrow range of services and non-availability of provider as well [4]. In mid-2017, health service delivery index published on Lancet Journal ranked India at 154 of 195 countries[5]. In view of such challenges and as per the recommendation of the task force set up on December 2014 for the implementation of Comprehensive Primary Health Care services, the reforms on health policy was initiated by expanding its focus from a selective health care services to the comprehensive health care services addressing the rising burden of non communicable diseases such as hypertension, diabetes[6]. In continuation, the Government of India releases the National Health Policy 2017 to strengthen the primary health care system in India by investing more and allocating government funding for health at 2.5% of GDP against 1.18% in 2015-2016[3].

Later, Ayushman Bharat Program (ABP) comprising two components such as Health & Wellness Centres (HWCs) and Pradhan Mantri Jan Arogy Yojana (PMJAY) was introduced by Government of India in February 2018. After the budget announcement of Ayushman Bharat Health and Wellness Centre (AB-HWCs) on February 2018, the first AB-HWC was launch in Jangla Village of Chhattisgarh on 14th April, 2018[6]. In the first year 17,149 AB-HWCs were functionalized throughout the country and as of 14th September, 2021, 77,784 AB- HWCs were functionalized which has been planned to continue in a phase manner till the year 2022[7]. The Health & Wellness Centres intends to cover the entire population in providing primary health care services while PMJAY focuses on delivering secondary and tertiary level hospital services for the lower 40% population of India[8].

Review of Literature

Assessing health inequalities raises a question of how inequalities in health be seen in relation to the socioeconomic circumstances of the populations. Assessment done with respect to social grouping assumes the existence of meaningful social groupings and these groups reflects the unequal distribution of resources and life opportunities between different social groups[9]. Ignoring the importance of social relation and memberships can lead to negligence of many unseen causes of health inequalities[10]. Researchers have claimed that social factors outside the health domain are the root causes of many health inequalities that we observed within and

across the countries[11]. The World Health Organization defined social determinants of health as "the condition in which people are born, grow up and live in, their work and age, and states that there is ample evidence that factors including education, employment status, income level, gender, ethnicity, housing and access to health care have a marked influence on how healthy a person is"[12]. The lower an individual social economic position, the higher is their risk of poor health[13].

A study conducted by Joe et al observed that individuals with high income are likely to be end up with higher levels of health[14]. They further discussed the reality of health inequalities in developing countries by mentioning an array of health care expenses a patient have to incur beginning from travelling cost and medical fees and additional expenses incurred in few diagnostic tests which is unavoidable and indivisible under conditions of feeble health systems. Such difficulties faced by lower income category in accessing quality health care results in low level of health in many of the developing countries[14]. In India, health inequalities have been highly observed as Subramanian et al describes the nature of health inequalities in India by conducting a study using variables such as gender, religion, caste, wealth and urban-rural dimensions. They observed that such variables were the social causes of health inequalities in India and claimed that India is still highly unequal in terms of distribution of socio-economic resources despite the increase in economic growth rate[9].

However, Indian government have taken initiatives to address such challenges in health inequalities by implementing universal health coverage policies from time to time. The latest health policy Ayushman Bharat Program which was implemented from the year 2018 has been reviewed by Chandrakant Larahiya in terms of the concept, progress and ways forward for rapid and effective implementation of Ayushman Bharat Program Health and Wellness Centre (HWCs). Through the review, he observed that the success and effectiveness of HWCs will depend on a quick move from policy to a faster implementation stage[3]. The foremost effort to recognize service provision and their utilized time has been conducted on HWC in the block of Punjab by a group of researchers and they have observed that the community health officers play an important role in delivering services for treatment of Non Communicable Diseases[15]. Numerous studies have been conducted in the concept of health inequalities in India. However, it was believed that it has never been studied in the scenario of the recent universal health programme- Ayushman Bharat Program. To be the best of our knowledge, the role of Health and Wellness Officers in reducing health inequalities has not yet been covered by previous researches. Therefore, this paper is an attempt to fill the gap by exploring the role of Health and Wellness Officers in the reduction of health inequalities in India.

Objectives of the study

The study is carried out to achieve the following objectives-

1. To identify health services inequalities between rural and urban areas,
2. To study the health care services provided after establishment of health & wellness centers.
3. To identify the role of health & wellness officers in reducing health inequalities.

Research Methodology

The research methodology adopted for the study is descriptive in nature with cross sectional ex post facto design. The study was confined to the state of Mizoram and covers all the eleven districts of Mizoram. With the consent of Health and Family Welfare Department, the population of the study includes all the health and wellness centres in Mizoram. Currently, there are 197 Health and wellness officers who are strategically posted in different centres across rural and urban parts of Mizoram as on 31st march 2021. On the basis of census method**,** all the health and wellness officers in the state were taken as the respondents for the data collection. The questionnaire was administered through online software Google forms due to the ongoing pandemic. Therefore, the sample of the study is 197.

Findings & Analysis

i) Health Services Inequalities between rural and urban areas of Mizoram

The growth of healthcare facilities in Mizoram has been acknowledged to be slower due to its rough landscape. The history of healthcare services has been started way back to the period of Christian missionaries and was later on taken up by the public sector where the facility has been set up only in some of the areas with major populations. Mizoram has an underdeveloped modern healthcare history in the aspects of healthcare capability compared to numerous Indian states. There were only two pioneering agencies for providing healthcare services in Mizoram viz. the Christian missionaries and the state government. The participation of early Christian missionaries was commendable for the growth and development of health care system in Mizoram. Healthcare was normally started later in the northern part of the state by Presbyterian missionaries and later introduced in the southern part of the state. It is noteworthy to mention that the first healthcare establishment in the northern part is in Durtlang, Aizawl and the first healthcare establishment in the southern part is in Serkawn, Lunglei. The earlier health care facilities in Mizoram were claimed to have a trait of slow growth and unequal health service difference across the state due to lack of doctors, specialist and healthcare workers of both private and state sector hospitals in the state. It was observable that health care services provision in the state was not sufficient in all levels, and simple appraisal does not depict the true reality. Therefore, population size assessment per medical practitioner is tremendously crucial.

In these difficult times of pandemic the society plays a very important role in enforcement of certain rules formulated by the government in efforts to contain the Corona virus from spreading. The state government in all its efforts to bridge the gap in health care that exists between rural and urban areas in Mizoram is moving forward by implementing the flagship program of the central government Ayushman Bharat Pradhan Mantri Jan Arogya Yojana through the provision of Health and wellness centres in rural parts of the State. The society along with the health and welfare department of the state work hand in hand in various capacities to ensure the safety and welfare of the citizen’s in Mizoram which is an example to many other states in India.

ii) Differences in health care services provided after the establishment of Health & Wellness Centres

The accomplishment of Ayushman Bharat- Health and Wellness Centres (AB-HWCs) had created profound changes and expanded the existing services provided by Primary Health Centres (PHCs) and Sub Health Centres (SHCs). This transformation had been undertaken by the Government of India to ensure universal access of the comprehensive primary health care services. The expanded health care services provided after the establishment of Health and Wellness Centres are listed below;

a) Selective primary health care services with limited focus on Reproduction and Child Health (RCH) and Communicable diseases has been expanded to comprehensive primary health care services including chronic disease conditions and non communicable diseases.
b) The existing RCH orientation limited services has been replaced with an approach addressing all the life cycle stages of all men and women in preventive, curative, promotive, palliative and rehabilitative aspect of care.
c) The expenses incurred due to non availability of medicines at the centres known as Out of pocket expenditures are reduced as the comprehensive health services ensure the increased availability of medicines and diagnostic equipments at the peripheral centres. The transformation of PHC/SCH into AB-HWCs reduces patient hardships in transportation cost.
d) The limited human resources available have been strengthened by the appointment of Health & Wellness officers at every SHC-AB-HWC to lead the team and provide a comprehensive range of services.
e) Tele-consultation services have been introduced at AB-HWC with an improved network and referral linkages for the community.
f) Manual reporting and monitoring have been replaced with the availability of IT Platform and standardized digitalized health records ensuring the smooth flow of information through all levels of care.
g) Existing limited focus on wellness component were addressed by mainstreaming Yoga wellness activities in the health care delivery system.
h) Lack of preventive care and promotive care on chronic diseases were addressed by the Health and Wellness Centres with a focus on risk factors of chronic diseases and other conditions.

iii) Role played by Health and Wellness Officers in reducing Health Inequalities in India

Health Inequalities in India had been addressed by the establishment of Health and Wellness Centres from 2018. As mentioned above, 77,784 AB-HWCs have been functionalized in India as of September 14, 2021. In Mizoram, there are 370 Health Sub centres as per the National Identification Number list (NIN). As per ministry of Health &Family Welfare Department criteria for up gradation of sub centre’s into Health and wellness centres .Sub centres that are co located with primary health centre are not to be upgraded into health and wellness centres.

Since there are 57 primary health centres in Mizoram, the total number of target health centres for conversion in to Health and Wellness Centres is 313.Out of the 313 target centres 15% (N=38) are to be upgraded as Ayush Health and Wellness Centres. Currently there are 197 Health and wellness officers who are strategically posted in different centres across rural and urban parts of Mizoram as on 31st march 2021 in reducing health inequalities in the state. The following table 1 shows that the mean age of the HWOs are 29.14 years with a standard deviation of 3.74, having an average work experienced for 3.43 years. Moreover, their average experience as HWOs are 11.67 months and the data shows that the recruitment of HWOs is done in different batches.

Table 1: Demographic profile of the respondents

Profile	Mean	Standard Deviation
Age of the respondents	29.14	3.74
Work experience (in years)	3.43	3.24
Experience as Health & Wellness Officer (in months)	11.67	6.90

Source: Primary online survey

The comprehensive health care services implemented by HWO were highlighted in the table 2. The respondents were advised to choose the services which they had provided so far and it has been observed that all the HWOs have carried out various health care services out of which care in pregnancy and childbirth and management of common communicable diseases and outpatient care for acute simple illnesses and minor ailments, were claimed to be the highest services provided in the AB-HWC with a percentage of both 91.88%. Reproductive health care services and management of communicable diseases were next in line to have been claimed the common services provided by the HWO through AB-HWC. However, services rate were found to be lower on ophthalmic, ear problems and mental health.

Table 2: Services provided by Health & Wellness Officers

Comprehensive health Care Services provided in the Health and Wellness Centres	No of Respondents	Percentage
Care in pregnancy and childbirth	181	91.88
Neonatal and infant health-care services	153	77.66
Childhood and adolescent health-care services	153	77.66
Family planning, contraceptive services and other reproductive health-care services	172	87.31
Management of communicable diseases, including national health programmes	167	84.77
Management of common communicable diseases and outpatient care for acute simple illnesses and minor ailments	181	91.88
Screening, prevention, control and management of chronic communicable diseases like tuberculosis and leprosy	145	73.60

Care for common ophthalmic and ear, nose and throat problems	134	68.02
Basic oral health care	146	74.11
Elderly and palliative health-care services	132	67.01
Emergency medical services	172	87.31
Screening and basic management of mental health conditions	104	52.79

Source: Primary online survey

The time spent by each HWO were recorded for the purpose of finding an average mean working hours (per week) of HWOs in the all their respective posting (Table 3). Majority of the time i.e. 5 hours were spent on the treatment of communicable diseases and simple illness and minor ailment, followed by care in pregnancy and childbirth and communicable diseases for an average 4.9 hours per week, emergency medical services were provided for an average 4.5 hours per week, reproductive health services and infant health care services for an average 4 hours per week. Furthermore, the study observed that all the 12 services proposed under AB-HWC were successfully delivered by the HWO on the basis of the mean hours spent on activities displayed which ensure that the health inequalities have been addressed equally across the state irrespective of their location. The location barrier of availing health services were believed to be reduced through the services of HWOs.

Table 3: Time spent on activities in hours (Per Week)

Activities under health packages and service type	Mean Hours	SD	Percentage of time
Care in pregnancy and childbirth	4.9	1.1	10.25
Neonatal and infant health-care services	4.0	1.0	8.37
Childhood and adolescent health-care services	3.3	1.0	6.90
Family planning, contraceptive services and other reproductive health-care services	4.0	1.0	8.37
Management of communicable diseases, including national health programmes	4.9	1.1	10.25
Management of common communicable diseases and outpatient care for acute simple illnesses and minor ailments	5.0	1.2	10.46
Screening, prevention, control and management of chronic communicable diseases like tuberculosis and leprosy	4.2	1.1	8.79
Care for common ophthalmic and ear, nose and throat problems	3.2	0.96	6.69
Basic oral health care	3.4	1.0	7.11
Elderly and palliative health-care services	3.4	1.0	7.11
Emergency medical services	4.5	1.1	9.41

Screening and basic management of mental health conditions	3.0	0.94	6.28

Source: Primary online survey

Table 4 depicts the time distribution particularly at NCD camp or vaccination drive carried out on a regular basis. A large amount of time was spent on vaccination process (12.56%). The screening and counseling of patient were found to be carried out for 4.4 hours in an average per week followed by measurement of blood sugar and blood pressure with an average 4.2 hours. A good amount of time with average of more than 3 hours were also spent on recording patient background, checking report, measurement of weight, dispensation of medicine and travelling to different locations within their territory.

Table 4: Time spent at NCD Camp or Vaccination Drive

Activity	No of Hours (week)	SD	Percentage of time
Recording patient background	3.8	0.98	9.74
Checking report	3.6	1.04	9.23
Screening of Patient	4.4	1.18	11.28
Measurement of weight	3.2	1.11	8.21
Measurement of blood pressure	4.2	1.12	10.77
Measurement of random blood sugar	4.2	1.19	10.77
Counselling	4.4	1.08	11.28
Dispensation of medicine	3.2	0.99	8.21
vaccination	4.9	1.16	12.56
Travel	3.1	1.08	7.95

Source: Primary online survey

Conclusion

It can be concluded from the findings of the study that, there exists inequalities in health care across the state. Progress of health care facility in Mizoram is usually slow temporal growth and spatial difference exists across the state due to lack of doctors, specialist and health care workers in both private and public sector which is noticeable in all levels of establishment in health care especially in the rural areas. However, the health and wellness centres through its health and wellness officers have played a pivotal role in fair distribution of health services in Mizoram. It can be observed that the comprehensive twelve new services proposed under AB-HWC were successfully delivered by the HWO which ensure that the health inequalities have been addressed equally across the state irrespective of their location. The location barrier of availing health services were believed to be reduced through the services of HWOs. Moreover, there exists a massive scope for future research and studies to have a better insight and in-depth analysis in regards to those availing health services and all the beneficiaries of health care services in the state.

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