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Building Resilient Systems to Address Hidden Inequities in Health: Towards equitable, adaptive, and inclusive health systems for India's future

WH-03-ISSUE BRIEF
December, 2025

Introduction

Good health is the fundamental right of every citizen. The World Health Organization (WHO) defines the right to health as access to Universal Health Coverage (UHC), through timely, affordable, appropriate, acceptable and of good quality care.[1,2]

The National Health Mission (NHM) aims to advance towards the goals and targets set out in the National Health Policy, 2017 to ensure *"universal access to equitable, affordable and quality health care services, accountable and responsive to people's needs."* However, the target of NHP's national public health investment of 2.5% GDP and states to spend more than 8% of GDP on health remain as an objective yet to be fully realized. Despite India's notable progress towards universal health coverage through AB-PMJAY, persistent hidden health inequities continue to disproportionately affect the most marginalized populations.[3,4] Data from the National Family and Health Survey (NFHS)-5 shows that vulnerable groups such as Scheduled Castes (SC) and Scheduled Tribes (STs) are more likely to experience a higher disease burden and poorer service coverage. Wide intra-state variations observed in health outcomes such as infant and maternal mortality, as per the NFHS-5, further march progress towards Sustainable development Goals (SDGs).

Social determinants, such as geographies, environments, living and work conditions, access to transportation, education and employment, and social and political contexts, significantly contribute to inequitable health outcomes, in addition to individual biologies.[1] Urban slums, rural, hilly, forest and tribal locations, migrant labour camps, and disaster-prone regions illustrate how health vulnerabilities tend to be spatially and socially clustered.

Pandemics such as the Covid-19 further demonstrate how newer threats and emergencies exacerbate exiting inequalities, invariably straining the available, but overburdened public healthcare infrastructure. With emerging threats of climate, pollution, and anti-microbial resistance (AMR), and the limited ability and preparedness of the public health system to respond these challenges, these inequalities are set to widen, particularly for populations located at the margins.

Against this context, this knowledge brief discusses strategies for building a resilient and equitable health system, that can offer every individual the right to achieve their full potential of health and wellbeing. Based on an expert panel on *"Building Resilient Systems to Address Hidden Inequities in Health:* A Multidimensional View", organized at the **World Health Summit Regional Meeting 2025,** this brief is organized in two parts: (i) in the first part we highlight the multiple and hidden dimensions of inequity that hinder progress towards health for all; (ii) in part two, we present the recommendations made by the expert panel towards developing resilient and equitable health systems.

A. The Hidden Dimensions of Health Inequity

Severe local and population-level inequities remain hidden or masked when aggregate gains inform decision-making. The expert panel presented important inputs on the analysis and use of data for planning, as follows:

- **Understanding absolute differences in outcomes** between advantaged and disadvantaged groups at a given point in time.
- **Understanding differences in the speed of progress towards achievement of health outcomes—** i.e., widening gaps where privileged groups improve faster than marginalized groups.
- **Attention to inequities in health service coverage–** Although public health programs and service delivery infrastructure have been decentralized, planning and decision making processes largely remain centralized and siloed. Despite expansion of services, specific marginalized groups continue to be unreached due to short comes in integrated, local planning and limited fiscal devolution. While these inequities due to coverage gaps may be smaller than outcome-related gaps, they nevertheless contribute to overall health inequities
- **Analysing unequal outcomes despite similar reach of or access to services –** e.g., despite similarities in immunization rates child mortality outcomes may sharply differ due to other social determinants such as nutrition, sanitation, or women's autonomy.
- **Accounting for digital inequities –** despite the positive impacts of digital technologies (i.e., ~50% increase in population enumerated in comparison using paper records), inappropriate application of digital technologies can also exclude populations from services, when mobile phones continue to be shared, internet connectivity remains intermittent, and data portability remains a challenge across jurisdictions.

The Challenge of the 'non-stable' citizen

Further, research and policy have privileged the 'stable resident'. Groups with unstable domicile status, for example, de-notified tribes, temporary migrants, homeless families, and informal and seasonal workers with transient residence, have routinely been excluded from counting, and consequently within planning and resource allocation. Women who migrate for work are frequently classified as *"marriage migrants,"* obscuring their health needs and reinforcing gendered invisibility.

Figure 1: Key Drivers of Health Inequities

B. Building Equitable and Resilient Health Systems

The expert panel provided important recommendations for the way forward for progressively achieving health equity and resilience through a wide range of systemic responses.

- **Progressive deepening of data, research and learning for targeted action**
  - Largescale quantitative surveys must be complemented through mixed methods studies, and qualitative micro-studies. Purposeful oversampling must be undertaken to ensure statistical power for small groups. Survey and sampling methods must be redesigned when studying rare or hidden populations.
  - Data must offer a nuanced understanding of intersectional vulnerabilities (e.g., poor + tribal + migrant) or within-group heterogeneity (e.g., many tribal groups have diverse histories and needs) and their effects on health outcomes.
  - Research and learning must further guide adaptive policymaking and provide practical guidance on retrofitting infrastructure, improving migrant inclusion, and integrating equity into digital systems.

- **Designing health systems to meet the margins**
  - Though universal programmes are recognized as politically more sustainable and reduce stigma, a 'one-size-fits-all' approach overlooks people at the margins who experience different forms of exclusions:
    - Physical (i.e., access) exclusion: e.g., persons with disability experience exclusion through design of products and services (e.g., medicines without visual assists such as QR codes; disability unfriendly infrastructures at primary health care centres; inadequate understanding of disability and health needs through national surveys such as NFHS).
    - Social (i.e., norm-, or stigma-based): e.g., migrant populations are often discriminated or excluded within local neighbourhoods and institutions on account of the kinds of work they do, which is perceived to be dirty, dangerous, difficult and demeaning.
  - Universal programmes with targeted approaches and room for local adaptations are therefore required to cater to specific populations that may otherwise be excluded.

- **Decentralization of health planning and devolution of funds**
  - Effective implementation of programmes requires location-specific responses to reach marginalized groups. Decentralized planning, and devolution of funds, functions and functionaries to local governments are thus critical. Lessons offered by the experts on the panel from Kerala's experiences in decentralization pointed to the need for
    - formula-based devolution and earmarking of funds to local governments to address health for all, and particularly for underserved populations.
    - transfer of personnel and authority to local bodies to design micro-plans (e.g., household-level plans).
    - mandatory inclusion of marginalised groups in planning forums.
    - integration of multiple departments (e.g., health, labour, social welfare, women and child development, planning, and so on) in local plans.
    - institutional platforms to coordinate with civil society partners, private and government providers to reach the last mile.
    - Equity planning units within district health societies with participation from women's groups, civil-society organisations, and Panchayati Raj institutions, along with community-led monitoring and surveillance mechanisms.

- **Set-up of an Equity and Resilience Fund**
  - Under the National Health Mission and equity and resilience fund can be set-up to address the identified barriers to equity and the climate crisis.
  - Seperate funds can be allocated to the Aspirational Districts Programme (ADP) for health under NHM as direct allocation ensures clarity, reduces complexity in fund management, and strengthens implementation outcomes.
  - Priority allocations for districts with high vulnerability indices rather than only population size can be planned.
  - Opportunities to retrofit existing infrastructure and facilities with climate-resilient, inclusive design features (e.g., solar, cooling, water harvesting, fire safety options) and accessibility at lower cost, can be supported through this fund.

- **Social-purpose public-private partnerships for underserved regions**
  - Existing government programs and infrastructure, such as critical care blocks, and integrated public health laboratories, must be strengthened through carefully designed public-private partnerships with explicit equity-focused goals, to make them effective at local level.

- **Develop Capability (Workforce and Capacity)**
  - Capacity building programmes must focus on *empowerment* — equipping workers and communities to claim rights and adapt to crises.
  - Greater inclusion of marginalised communities and persons with disabilities within the frontline workforce cadres is important to provide more sensitive and empathetic care to marginalized communities.
  - Local grassroots community leadership must be strengthened for continuous resilience planning.
  - Community health workers must be empowered to collect and act on data for their catchment populations in order to strengthen surveillance.

Conclusion

India's commitment to UHC through national programmes such as the AB-PMJAY has not borne out adequately in terms of achieving health equity. A key factor marring progress towards health equity is the lack of data and planning to address hidden inequalities, locally-driven, resilient and adaptive health systems, and contextually-responsive solutions to address intersectional marginalization. Progress towards health equity will critically depend on measures conceptualized and established for data disaggregation, decentralization, localization, and retrofitting local infrastructures, community participation and monitoring, and public-private partnerships to reach underserved populations.

Key Takeaways

1. Health inequities persist as health systems are designed for the general population, not the most vulnerable.
2. Aggregate gains in health can mask severe local and population-level inequities
3. Policy choices and investment patterns have the potential to address inequalities - thus health systems should be designed with equity as a central objective.
4. Policies must be tested against lived realities of marginalized groups and co-designed with communities.
5. Resilience is multi-dimensional, and require attention to infrastructure, human-resource capacity, and advocacy/behavioural memory (e.g., learnings from pandemics like COVID-19)
6. Universal programs are politically sustainable and reduce stigma, but targeted approaches, decentralized health planning, and local adaptation can bring universal programs to underserved pockets.
7. Innovative solutions such as set-up of Equity and Resilience Funds, social purpose public-private partnerships for underserved regions, and challenges such as climate, must be explored.

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Suggested Citation: Maithreyi, R., Nawal, Dipty, (2025). Building Resilient Systems to Address Hidden Inequities in Health: Towards equitable, adaptive, and inclusive health systems for India's future. Issue Brief WH-03. Bengaluru, KHPT.

Acknowledgements:

We acknowledge the contributions of the expert panel who have helped to shape this brief: Dr. Himanshu Bhushan, Ms. Chandrika Bahadur, Dr. Bevin Vinay Kumar V N, Dr. Abha Subba Rao, Dr. Aruna Bhattacharya, and Prof. Jiju P Alex.

We also thank our colleagues at KHPT: Mohan H.L., Dr. Mallika Tharakan, Dr. Prarthana B.S., Dr. Sanghamitra Savadatti, Dr. Manoj Kumar Pati, Dr. Swaroop N., and Dr. Satyanarayana Ramanaik, for their comments and inputs.

We are grateful to HCL Foundation and Wipro Foundation for their support in organizing this panel, and to NIMS University, Rajasthan for the opportunity to curate this panel.

Design and layout: Anilkumar Rampur

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