HRIDAY
PROMOTING SUSTAINABLE HEALTH

HEALTHY INDIA ALLIANCE
INDIA NCD ALLIANCE
for prevention and control of NCDs

INDIAN INSTITUTE of PUBLIC HEALTH
HYDERABAD
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Report on Non-Communicable Diseases and Health Equity in India

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Grounded in the principles of equity and meaningful involvement of People Living with NCDs and communities, this Report highlights how NCDs reflect and exacerbate inequities, disproportionately affecting marginalised and vulnerable populations. Developed based on the NCD Alliance 'From ideas to action: Accelerating the NCD response through health equity, a conceptual framework', this Report underscores the need to integrate health system infrastructure and social determinants, while prioritising the meaningful involvement of people with lived experience, to advance equity in NCD prevention and care.

This Report encapsulates the guidance and insights of respondents who participated in the Key Informant Interviews, In-dept Interviews and Community Conversations. Their personal stories and resolve have enriched this Report with a powerful narrative and actionable recommendations towards an equitable response to NCDs in India.

This Report has been drafted by Ms Radhika Shrivastav (Senior Director, HRIDAY); Dr Shailaja Tetali (Dean, Research and Policy Support, IIPH-H); Dr JK Lakshmi (Professor, IIPH-H); Dr Barsa Priyadarshani Rout (Programme Manager, HRIDAY), Dr Niharika Rao (Former Research Co-ordinator, HRIDAY) and Ms Venkata Soujanya Akkiraju (Former Research Associate, IIPH-H). The Report was developed under the guidance of Dr Monika Arora (Executive Director, HRIDAY).

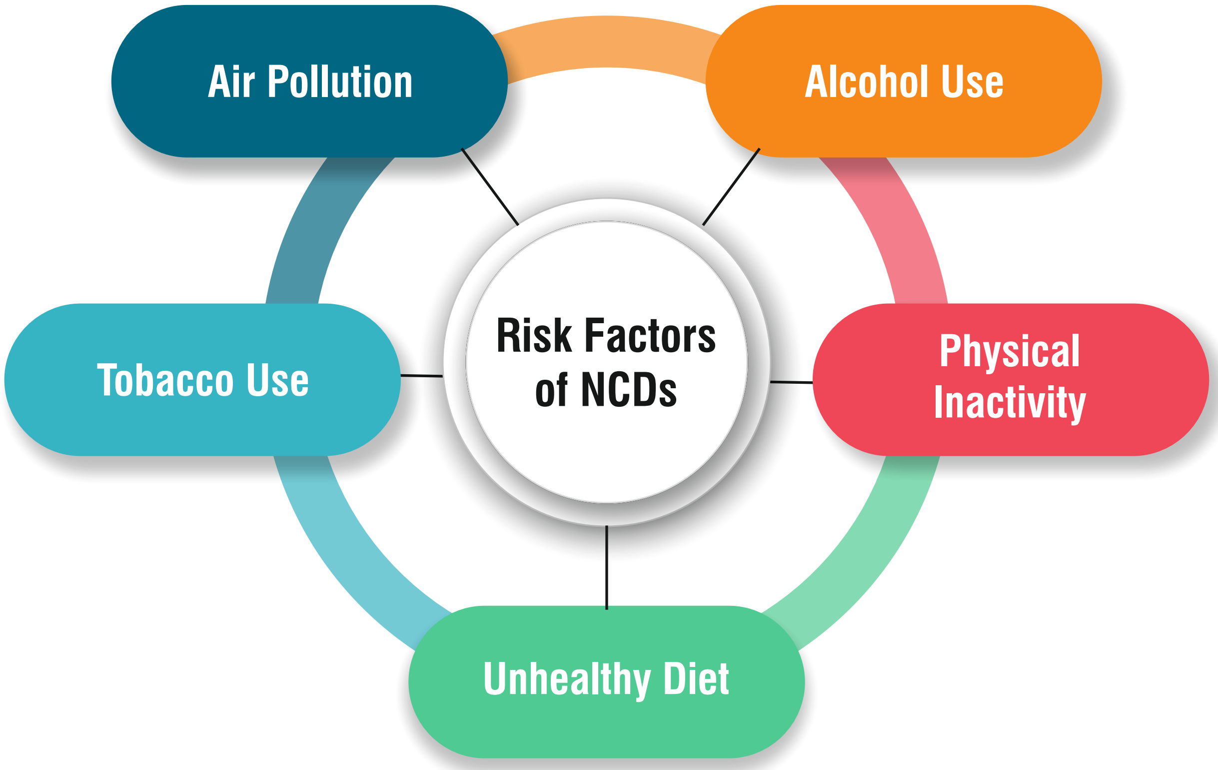
Ms Charlotte Aberdein (Capacity Development Manager, NCD Alliance) and Ms Isabelle Koeul (Capacity Development Officer, NCD Alliance) provided valuable inputs for the conceptualisation and development of this Report.

CONTENTS

1. Introduction

Non-Communicable Diseases (NCDs) are chronic health conditions and include a wide spectrum of conditions such as cancers, diabetes, hypertension, Cardiovascular Diseases (CVDs), stroke, Chronic Kidney Diseases (CKDs), Chronic Obstructive Pulmonary Diseases (COPDs) and asthma, mental health conditions, Non-Alcoholic Fatty Liver Disease (NAFLD), and numerous others.[i] According to the World Health Organization (WHO), NCDs account for over 75% of all deaths globally, with the highest mortality attributed to heart disease, stroke, cancer, chronic respiratory diseases, and diabetes. NCDs are not only a public health issue but also a significant social and economic burden, often considered the "social justice issue of our time." As both, a cause and consequence of poverty, they pose serious human rights and sustainable development challenges.[ii]

The global burden of NCDs remains alarmingly high, with NCDs responsible for 43 million (4.3 crores) deaths in 2021. Notably, in the same year, 18 million (1.8 crores) people died from an NCD before the age 70 years; 82% of these premature deaths occurred in Low- and Middle- Income Countries (LMICs). In 2021, NCDs accounted for 55% of all deaths, and contributed to 54% of the total Disability-Adjusted Life Years (DALYs) in India.[iii] NCDs are primarily associated with key modifiable risk factors, including tobacco use (both smoking and smokeless tobacco), alcohol consumption, unhealthy diets, insufficient physical activity, and exposure to both indoor and outdoor air pollution.[iv] The escalating burden of NCDs and their risk factors imposes a significant financial burden on individuals and households in India, leading to heightened catastrophic Out-of-Pocket health expenditure (OOPE). OOPE for the treatment and care of NCDs often leads to loss of household income and increased financial insecurity.[v] The average OOPE is about four times higher for formal–private providers, than the public facilities.[vi] It is estimated that India will lose approximately $4.58 trillion by 2030 due to NCDs and mental health conditions. This underscores the urgent need for sustainable and equitable NCD management.[5]



This economic strain is often felt most acutely by marginalised and vulnerable groups, who are at the greatest risk of being excluded from Universal HealthCoverage (UHC) interventions. In LMICs, many people are unable to even afford OOP health payments are forced to forgo care entirely, often with life-threatening consequences.[vii]

Hence health and illness follow a social gradient, meaning that the lower an individual's socio- economic status (SES), the higher their risk of poor health outcomes. To narrow the gap in health outcomes, it is necessary to recognise that different determinants of health (such as social determinants, health system determinants and commercial determinants) intersect and overlap to shape and influence the individual experience of health and access, across the continuum of care. Adopting an equity-focused approach and reviewing NCD programmes and policies through this lens will facilitate their effective implementation, ensuring sustainability and ensuring that no one is left behind.

Health equity is the absence of unfair, avoidable, and remediable differences in health status among groups of people. Health equity is achieved when everyone can attain their full potential for health and wellbeing irrespective of social, economic, or demographic factors.[viii]

With support from the NCD Alliance and Bristol Myers Squibb, the Healthy India Alliance (HIA)/India NCD Alliance and the Indian Institute of Public Health, Hyderabad, conducted a NCD health equity assessment in New Delhi and Hyderabad, respectively. The goal of this assessment was to apply a health equity lens to inform ongoing work on meaningful involvement of people living with NCDs (PLNCDs) and the community at-large. The findings are also intended to inform the operationalisation of the meaningful involvement component of the operational guidelines of the National Programme for NCD Prevention and Control (NP-NCD), towards equitable access to care and reducing health disparities across diverse populations. This NCDs and Health Equity Report has been developed based on the learnings and outcomes of the equity assessment. The Report highlights disparities in NCD care, with a particular focus on marginalised populations. Utilising *'From Ideas to Action: Accelerating the NCD response through health equity: A Conceptual Framework for Community Advocates'* and *'Equity in Action: Adding An Equity Lens to NCD Advocacy: A Practical Guide for NCD Community Advocates'*, developed by the NCD Alliance, this Report provides a comprehensive analysis of the barriers and challenges hindering NCD care and proposes key recommendations to promote an equitable healthcare ecosystem.

2. Methodology

2.1 Data Collection

This equity assessment comprised of two components:

A. LITERATURE REVIEW (2017-2024)

A comprehensive literature review was undertaken using various sources, including scientific publications, policy and programmatic documents, reports, and white papers, to analyse NCD health equity in the Indian context. Key documents such as the revised operational guidelines for NP-NCD (2023-2030), 75/25 Initiative (aiming to provide standard care for 75 million people with hypertension and diabetes by 2025) and Ayushman Bharat were assessed from an equity perspective. Additional reports/technical documents from think tanks, Civil Society Organisations (CSOs), and academic and research institutes on equity and UHC in India were also reviewed. Furthermore, sub-national level reports, such as the State Health Action Plan, Annual Health Action Plan for NCD care, and District/City Health Action Plans on NCD care, were examined through the lens of NCD equity.

B. QUALITATIVE EQUITY ASSESSMENT

A descriptive qualitative approach was applied, allowing for a deeper exploration of individuals' and communities' experiences, beliefs, and understanding, compared to a quantitative approach, which is more structured and numerical.

- **Key Informant Interviews (KIIs):** Eleven KIIs (five in New Delhi and six in Hyderabad) were conducted with equity experts, CSOs/Community Based Organisations (CBOs) representatives, healthcare professionals and other relevant stakeholders. These discussions highlighted their insights on the need of equitable access to NCD care, reflection of equitable approach in existing policies and programmes, challenges and barriers faced by vulnerable communities in accessing and utilising NCD services and key recommendations and priority areas to advance health equity.

- **In-Depth Interviews (IDIs) and Community Conversations (CCs):** Six IDIs (three each in New Delhi and Hyderabad) and four CCs (two each in New Delhi and Hyderabad) were conducted with individuals from underserved and/or marginalised communities, to identify the drivers of inequity in NCD care. These discussions with people with lived experience, highlighted the social and structural determinants; as well as health system and community level drivers of inequity in NCD care. Key recommendations were garnered to enhance equity in NCD prevention and care service delivery.

Qualitative guides were developed for the KIIs, IDIs and CCs in English and then translated into local languages (Hindi for New Delhi and Telugu for Hyderabad). Data collection was conducted in the local language (Hindi or Telugu) or English, as relevant. Verbatim transcriptions were undertaken in the local language and then translated into English. A priori codes were created based on the discussion guides. Thereafter, emergent codes were added after thoroughly reading the transcripts. Finally, the data was coded in relation to the derived themes and codes.

2.2 Data Analysis

A six-step inductive thematic analysis approach was followed to construct meaning and interpret experiences and perceptions among people with lived experience. In step 1, all interview recordings were heard while simultaneously reading the transcripts and field notes to understand the overall meaning of responses provided by the participants. In step 2, each transcript was read line-by-line to develop a deeper understanding of the data and drive initial coding. The initial codes were organised in MS Word to assign coding schemes inductively. Then, focused coding was applied to reduce the volume of the raw data and to identify significant patterns for categorising and assigning themes and sub-themes. Codes were identified and categorised into themes and sub-themes to compare and identify similarities and differences across themes. In steps 3 and 4 sub-themes (basic themes) and organising themes were constructed. In steps 5 and 6, the team interpreted the themes and developed a written report of the themes generated.

2.3 Ethical considerations

Ethics approval was obtained from the Institutional Ethics Committee of the Indian Institute of Public Health-Hyderabad / Public Health Foundation of India. The approval was granted under IEC number IIPHH/TRCIEC/402/2024.

3. Results

3.1 Literature Review

Disparities in NCD risk factors, diagnosis, treatment, and outcomes

India is witnessing a rising burden of NCDs, including mental health conditions and chronic conditions such as diabetes, CVDs, chronic respiratory diseases, cancer, and other endocrine conditions.[ix] These diseases exhibit a higher prevalence among vulnerable groups, including women, marginalised and underserved communities, and older adults.[x] [xi] Intersecting factors such as stigma, discrimination, and systemic health inequities significantly intensify the challenges associated with NCD prevention and control, impeding equitable health outcomes.

Health equity in the context of NCDs/health is the absence of unfair, avoidable, and remediable disparities in health status among different population groups. Health equity entails ensuring equitable access to the complete continuum of NCD care from prevention to palliative care services, across all levels of the healthcare system, including primary, secondary, and tertiary care. It encompasses the guaranteed availability of essential health services such as medicines and diagnostics, the provision of financial risk protection to minimise OOPE, and the removal of barriers to care related to gender, age, geographic location, education, or occupation.[xii] Achieving health equity also requires the meaningful engagement of individuals living with NCDs, as well as the active participation of youth and older adults in health-related decision-making processes, to ensure that their needs and priorities are reflected in both programmatic strategies and policy frameworks.

Burden of NCDs and Inequities

A study which derived nationally representative data from the Sample Registration System (SRS) and the National Sample Survey (NSS) to examine the disease burden and economic burden due to NCDs in India, highlighted the catastrophic burden of NCDs. 60th National Sample Survey (NSS) in India highlighted that public hospitals are more frequently utilised by poorer segments, while wealthier populations predominantly use private facilities, incurring higher out-of-pocket expenses.[xiii] Hospitalisation for NCDs pushed 47% of the households to Catastrophic Health Expenditure (CHE). Treatment in private health facilities pushed more households to CHE (66.3%) as compared to public health facilities (17.1%). [xiv] Nearly half (47.1%) of India's Total Health Expenditure in 2019-20 was borne directly by households as OOPE.[xv]

Studies from India reveal extensive inequities in NCD care and healthcare access that disproportionately affect rural residents, low-income populations, elderly individuals, women, and marginalised communities, including Scheduled Tribes (STs) and Scheduled Casts (STs). A national study indicates a pro-rich pattern in NCD hospitalisations across India, with private healthcare facilities predominantly serving wealthier populations and public facilities more accessible and affordable to poorer groups. State-level analyses, however, show that some public facilities, particularly in Gujarat, Maharashtra, and Southern states, are utilised more by poorer populations. Reviewing socio-economic disparities, the assessment delves into the financial strain caused by multi-morbidities in India, highlighting the substantial financial burdens of OOP costs in private care, varying significantly by state, underscoring the urgent need for equitable healthcare financing and a robust public healthcare infrastructure.[xvi] To reduce these disparities, comprehensive Health and Wellness Centres (HWCs) (under the Ayushman Bharat programme), tailored subsidies, and improved insurance coverage are vital for improving access.[xvii]

Further, examining the socio-economic burden of NCDs, highlighting significant socio- economic disparities, studies highlighted that households affected by NCDs face higher OOPEand CHE, compared to those with non-NCD-related hospitalisations, especially in private healthcare settings. The burden is greater among poorer, rural, and larger households, as well as those with elderly members. Despite government efforts through social insurance schemes, many households, particularly from lower economic strata, continue to experience financial hardships due to NCDs. The assessment calls for targeted policies, such as affordable, disease-specific health insurance, and redistribution measures to alleviate the economic impact on vulnerable populations, aligning with the Sustainable Development Goal (SDGS) to reduce health inequities and achieve financial protection and leaving no one behind.[xviii]

Barriers to Healthcare Access

In rural settings, barriers to care for chronic conditions such as CKDs, further exacerbate health inequities, highlighting the barriers to care, including limited awareness of CKD among both people with lived experience and healthcare providers, resource shortages in Primary Health Centres (PHCs), and reliance on informal healthcare, shaped by cultural practices. High-cost treatments like dialysis impose heavy financial burdens on marginalised groups, deepening existing inequities. Equity-focused interventions, such as training community health workers in CKD care, strengthening rural healthcare infrastructure, and using mobile health technologies, are vital for improving access and continuity of care.[xix]

For chronic conditions like diabetes, studies from Delhi and Maharashtra underline significant health equity gaps, even in government-subsidised care settings. Despite the availability of free diabetes care, OOPEs, long waiting periods, and travel constraints continue to burden lower-income populations. These findings reinforce the need for decentralised and accessible diabetes care, at local health centres, PHCs, and district hospitals, especially for marginalised groups, particularly those with co-morbidities. Further, the studies also suggest collaboration with the private sector and CSOs is essential to make care more affordable and equitable.[xx] [xxi]

While rural populations face unique healthcare access challenges, urban areas also grapple with complex barriers to care. A study on hypertension and diabetes care-seeking behaviours among low-income residents in Bengaluru, Karnataka, revealed a complex web of economic, cultural, and healthcare system barriers. Many residents delay care or switch between providers due to financial constraints, reliance on traditional remedies, and inconsistent treatment options. These findings underline the need for health system strengthening in urban areas, especially for continuity of care for vulnerable populations with comorbid conditions.[xxii]

Expanding the scope of access-related issues, another study on eye care access for marginalised groups revealed that while gender equity is generally observed in service utilisation, rural women continue to face significant barriers to care. Fewer women attend services, especially in mobile camps and secondary hospitals. Barriers such as heavy workloads, low literacy, and limited-service hours, hinder women's access to care. Strategies like flexible timings at vision centres and community mobilisation, can help address these issues. Delayed cataract surgery, especially among rural women, underscores the need for targeted interventions to reduce gender disparities and improve outcomes.[xxiii]

Another study explored socio-economic inequalities in self-reported NCDs in India, with a focus on gender disparities. Women are disproportionately affected by NCDs, challenging the belief that these diseases predominantly affect men. This disparity is attributed to biological, social, and cultural factors, including neglect due to India's predominant patriarchal set-up. Socio-economic predictors, such as age, wealth, and urban residence, with wealthier individuals more likely to have NCDs due to exposure to Westernised lifestyles, were also identified. Behavioural factors like smoking (tobacco use) and alcohol use contribute to the findings, prompting a call for gender-sensitive policies to address these disparities, particularly for women and vulnerable populations.[xxiv]

In addition to gender disparities, health equity gaps were also evident in the oral health care of children with hearing impairments. A study in Hyderabad, Telangana, revealed that children with hearing impairments suffer from a higher prevalence of caries and poorer oral healthpractices, largely due to communication barriers and limited access to care. This highlights the need for equitable health policies to address the specific oral health needs of children with disabilities.[xxv]

Health Inequity among Aging Populations with Multi-morbidity

Multi-morbidity among older adults in India, particularly from NCDs, is a growing concern, with nearly one-fourth of the elderly population affected. Multi-morbidity rates were higher among women, urban dwellers, wealthier and more educated individuals, and working older adults, showing health inequities faced by aging populations. Factors such as urbanisation, SES, and lifestyle, contribute significantly to the risks of developing NCDs. Targeted geriatric healthcare, disease management, and preventive strategies tailored to vulnerable groups, particularly working, urban, and educated older adults, need to be prioritised to address these challenges and ensure more equitable healthcare access.[xxvi]

A study on chronic illness among older Indian adults emphasised the role of socio-economic factors, including age, gender, marital status, education, and economic status. Older women and wealthier individuals reported higher illness rates, often due to better healthcare access and lifestyle factors. In contrast, marginalised groups, including SC/ST populations, tend to under-report illness or face significant barriers in accessing healthcare, contributing to health disparities. Additionally, urban residents showed higher rates of illness compared to their rural counterparts, which further highlighted the need for public health policies addressing structural inequities and improving access to care for vulnerable older adults across the country.[xxvii]

In the context of oral health, the under-utilisation of dental care among the elderly, revealed significant barriers such as fear, lack of awareness, and socio-economic factors. Despite high treatment needs, especially in rural areas, many older adults perceived oral health as less important. This issue exacerbates broader NCD risks and contributes to health inequities, particularly in rural settings. This study advocated for the integration of oral health servicesinto the broader healthcare system, alongside programmes that improve access and raise awareness, to ensure equitable care for elderly populations.[xxviii]

The COVID-19 pandemic further highlighted the vulnerabilities of older adults, particularly those living with NCDs. Studies showed how disruptions in public healthcare services and limited access to affordable private care worsened health outcomes for the elderly, especially those in lower socio-economic groups. Financial dependency, food insecurity, and social isolation compounded these challenges, increasing suffering and mortality. The pandemic underscored the urgent need to strengthen public healthcare systems and initiatives such as HWCs to provide continuous and equitable primary care for marginalised elderly populations.[xxix]

Urban-rural disparities in multi-morbidities were also evident, with higher rates of illness in urban areas linked to lifestyle factors like obesity and physical inactivity, as well as greater healthcare access. Higher education and wealth were associated with better healthcare utilisation, further exacerbating disparities for those with lower education and SES. Gender and work status emerged as key factors, with women and non-working older adults experiencing higher rates of multi-morbidity. Regional differences, particularly in Southern India, emphasised the need for policies that address these socio-economic and lifestyle- related disparities to manage NCDs effectively among older adults.[xxx]

In addition, analysis of healthcare utilisation and public subsidy distribution for NCD treatments among the elderly showed significant inequities in access. While the elderly experienced high rates of NCDs, healthcare utilisation was skewed towards wealthier groups, with public subsidies for inpatient care disproportionately benefiting the richest. In rural areas, however, the poorest made greater use of public outpatient care, likely due to government programmes like the National Health Mission (NHM) and NP-NCD. Despite these efforts, OOPE, especially for medications, remained high, particularly in rural areas, exacerbating the financial burden on vulnerable populations. There is an urgent need for targeted policies to improve equitable access to healthcare and reduce financial barriers, ensuring that the elderly, especially the poor, are not left behind.[xxxi]

Stigma, Mental Health Conditions, and Socio-demographic Factors:

Stigma and discrimination associated with mental health and chronic conditions significantly impact health equity, hindering access to care and exacerbating health disparities. A study showed that individuals with Serious Mental Illness (SMI), particularly women and marginalised groups, experienced higher levels of multi-dimensional poverty due to lack of employment and income. Stigma, compounded by gender and caste discrimination, worsened both poverty and mental health.[xxxii] People with SMI faced significant disparities in employment, income, and food security, with the most severe effects on women and marginalised groups. A "negative feedback loop" exists, where stigma leads to unemployment, deepening poverty, and worsening mental health conditions. The link between perceived stigma toward mental health conditions and socio-demographic factors such as gender, age, education, and religion in India, revealed high stigma levels, particularly among women, linked to social rejection and traditional gender roles. Limited mental healthcare access, especially for marginalised populations, exacerbated this issue, leading to delayed help-seeking and discrimination. Family support played a key role in reducing stigma, but the system faced challenges due to a shortage of mental health professionals.[xxxiii]

The high burden of multi-morbidities among vulnerable older adults in India, particularly women, certain castes, and religious minorities, was driven by factors such as age, income, and geography. Common outcomes like depression and age-related dementia emphasised the need for integrated care that addressed both physical and mental health. To achieve health equity, policies must expand healthcare access, promote inter-generational living, and addressed structural inequities to help vulnerable populations better manage chronic conditions, as India's older population grows.[xxxiv] The financial impact of mental health conditions revealed that it disproportionately affected economically productive age groups (19- 55 years), with households spending, 18.1% of their consumption on mental healthcare.Higher financial burden was seen in urban and more educated populations, with 60% of households experiencing CHE and 20% falling below the poverty line. These findings highlighted the need for policies to reduce financial barriers and address the link between mental health conditions and poverty, ensuring equitable access to care for vulnerable groups.[xxxv]

The intersection of stigma, mental health, and multi-morbidities highlights the need for comprehensive strategies to address NCDs in India. This includes reducing stigma, improving access to mental health and chronic care, and addressing social determinants of health. Such measures are essential to achieving health equity and improving outcomes for vulnerable populations.

Health Inequities and Socio-economic and Cultural Factors

Health inequities in India are influenced by geographic, social, and cultural barriers, as shown in studies across the country, reporting limited access to secondary care and diagnostics due to isolation. Traditional healers were often preferred for their proximity, flexible payment options, and community trust, though biomedical treatments were acknowledged. Social dynamics, including gender and caste, further restricted healthcare access: women faced limited autonomy, and Dalit individuals reported discrimination.

The literature further highlighted how health outcomes in India were significantly influenced by social status, with a clear "social gradient" affecting health.[xxxvi] Studies consistently showed disparities in healthcare access and health status between Dalit and Adivasi children and other groups across various states[xxxvii] perpetuating inequalities in both health outcomes and healthcare access[xxxviii]. Research indicates that Dalits in rural India have lower rates of healthcare utilisation compared to non-Dalits.[xxxix] [xl] Caste acts as a substantial barrier, particularly in maternal healthcare among rural women.[xli]

Awareness of healthcare disparities based on race, ethnicity, and SES has been growing within the healthcare sector, yet efforts to address these disparities have been slow.[xlii] Aspopulations become more diverse, it was emphasised that culturally competent healthcare practitioners were essential for delivering high-quality care.[xliii] This competence requires healthcare providers to understand cultural health beliefs and practices, enabling them to provide treatment that is both appropriate and culturally sensitive. Cultural competence was described as a means to ensure equal access to quality care for all patients by removing structural barriers and respecting each individual's cultural context.[xliv] [xlv] Integrating cultural competence programmes and policies into India's public healthcare system is essential to address disparities and inequities that negatively impact minority communities. By recruiting and retaining minority staff and implementing cultural competence training for healthcare providers, communication can be improved, fostering a more inclusive environment and enhancing health outcomes for these communities. Additionally, incorporating cultural competence education into medical training has shown significant positive effects on healthcare delivery and has helped cultivate a more empathetic and effective approach among providers when treating diverse patient populations.[xlvi]

Improving Health Equity

To address health inequities among marginalised and rural populations, decentralising healthcare services, such as primary care, through local health centres was highlighted in the reviewed literature. Community-based approaches, including community mobilisation, health literacy initiatives, and flexible service hours, could enhance healthcare utilisation, especially for women and elderly populations. Public health programmes should focus on the unique needs of vulnerable groups, with strategies tailored for women, the elderly, and marginalised communities, to promote health equity. Targeted public policies are also needed to tackle structural and socio-economic barriers, ensure equitable access to oral and mental health services, and improving healthcare infrastructure, particularly in rural regions. Key recommendations include, strengthening public healthcare systems, strengthening HWCs for accessible NCD care, and implementing equitable healthcare financing policies with affordable services, subsidies, and expanded insurance coverage to mitigate health disparities.

3.2 Governmental Initiatives to Reach the Unreached

National programmes and policies in India, including the NP-NCD, 75/25 initiative and Ayushman Bharat, are strategically incorporating an equity-focused approach to address the growing burden of NCDs and their risk factors. Through targeted interventions such as integrated care pathways and financial protection mechanisms, these initiatives prioritise the provision of equitable healthcare services, particularly targeting vulnerable and underserved populations. Table 1 provides a synthesis from key policies and programmes related to NCDs.

Table 1: Key policies and programmes related to NCDs

Programme/Policy	Key Components	Equity-Focused Strategies	Impact on Vulnerable Populations
National Programme for Prevention and Control of NCDs (NP-NCD)[xlvii]	- NP-NCD encompasses a wide spectrum of conditions, including cancers, diabetes, hypertension, cardiovascular diseases and stroke, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD) and asthma, non-alcoholic fatty liver disease (NAFLD), along with several other disorders. - Community level screening (CBAC) and emphasis on meaningful involvement of people with lived experiences - Inclusion of PM National Dialysis Programme	- Landmark testament of this programme is inclusion of the concept of meaningful involvement of PLNCDs as agents of change to ensure effective operationalisation of the programme - Programme is currently focusing on an equity-focused and sustained communication strategy to disseminate informative messages about the disease burden, its risk factors, diagnosis, and management, ensuring that the information reaches all segments of society, particularly marginalised communities - Community-level risk assessment using Community Based Assessment Checklist (CBAC) followed by referrals and facility level screening is a critical component of this programme	- Early detection & referral for underserved - Tailored interventions through lived experiences - Better access to health information in marginalised communities
Ayushman Bharat – Health and Wellness Centres (ABHWCs) [xlviii]	- First component of AB pertains to creation of 1,79,321 AB-HWCs, now renamed as Ayushman Arogya Mandir, by upgrading the Sub Health Centres (SHCs) and rural and urban Primary Health Centres (PHCs), in both urban and rural areas, to bring health care closer to the community	- Integration of NP-NCD with AB-HWCs, universal screening of common NCDs was identified as a functionality criterion for primary level facilities - Availability of free medicines & diagnostics	- Brings preventive and primary care closer to rural & urban-poor populations - Reduces logistical and economic barriers
Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (Prime Minister's Public Health Insurance Scheme for the People)[xlix]	- Significantly reduced the economic burden of healthcare for beneficiaries. Without the scheme, the cost of medical treatments would have been 1.5 to 2 times higher, resulting in savings of over ₹1.25 lakh crore in OOPE and facilitating 7.37 crore free hospital admissions.	- Expansion of AB PM-JAY was approved by GoI extending comprehensive health insurance to all senior citizens aged 70 and above. - Massive financial protection - AB PM-JAY has ensured gender equity in access to healthcare services as women account for approximately 49% of the total Ayushman cards created and approximately 48% of total authorised hospital admissions.	- ₹1.25 lakh crore saved in OOPE - 7.37 crore hospital admissions - Access to care for over 55 crore people

Programme/Policy	Key Components	Equity-Focused Strategies	Impact on Vulnerable Populations
Ayushman Bharat Digital Mission (ABDM)[l]	- Creation of ABHA IDs (Unique IDs) - Unified digital health records system	- Secure identity and digital access - Equity in data continuity across facilities	- 76.26 crore IDs created - Enhances health access and tracking for mobile, remote populations
eSanjeevani (National Telemedicine Service)[li]	- eSanjeevani AB-HWC: A hub and spoke model is used where the HWCs act as spokes and are linked with hubs set up in Medical Colleges/District-Level Hospitals, etc. with doctors and specialists. - eSanjeevaniOPD: eSanjeevaniOPD was launched during the COVID-19 pandemic and is a Patient-to-Doctor, telemedicine system to enable people to get outpatient services from their homes. Since then, it very has been popular among the citizens as it allows them to directly consult doctors by eliminating avoidable factors such as travel, waiting time and is cost-effective. However, in hard-to-reach areas, internet connectivity and digital literacy have been a challenge to fully utilise these virtual services.	- Remote consultations- Reduces cost, time, and travel barriers - Over 57% of Sanjeevani beneficiaries are women; around 12% beneficiaries are senior citizens	- Extends specialist services to digitally connected but underserved areas
Pradhan Mantri Bhartiya Janaushadhi Pariyojana (PMBJP) (Prime Minister's Indian Generic Medicines Project)[lii]**:**	- As of 2024, over 14,000 Janaushadhi Kendras have been opened across the country in which 2047 types of medicines (including cardiovascular, anti-cancer, and anti-diabetic drugs) and 300 surgical devices have been brought under the basket of this scheme. - Under PMBJP, in collaboration with the State Governments, Affordable Medicines and Reliable Implants for Treatment (AMRIT) Pharmacy stores have been set up in some hospitals/institutions.	- Generic medicines at 50% lower rates - Equitable access through nationwide reach	- Major reduction in drug costs for poor - Access to essential medicines in both rural and urban areas
75/25 Initiative[liii]	- Screening 75 million people for diabetes & hypertension by 2025	- Mass screening via primary health system - Workforce capacity building	- Early detection in low-resource settings - Community awareness on healthy living and risk factors

4. Qualitative Equity Assessment

- **Demographic Overview of Respondents:** The study included a total of 54 participants (30 from New Delhi and 24 from Hyderabad) representing diverse SES, occupational backgrounds, age groups, and genders (Figure 1)

- **Gender Distribution:** The sample comprised 25 females (15 from New Delhi and 10 from Hyderabad); 26 males (12 from New Delhi and 14 from Hyderabad) and 1 LGBTQA+ respondent (from New Delhi).

- **Age Range:** Participants' ages ranged from 35 to 78 years.

- **Socio-economic Characteristics:** The respondents included homemakers, retired individuals, service sector employees, social workers, painter, mechanic, Medical Officers, Social Scientists, Public Health Specialists, CSO representatives, Community Leader working with People Living with HIV and NCDs.

This diverse respondent pool included individuals from both formal and informal employment sectors, medical and academic professionals, as well as community leaders and representatives from CSOs (Figure 2). Their varied perspectives help highlight the systemic challenges and lived experiences related to healthcare access, stigma, and discrimination (Figure 3).

Figure 1: Summary of qualitative data collection

Respondent Characteristics - New Delhi and Hyderabad

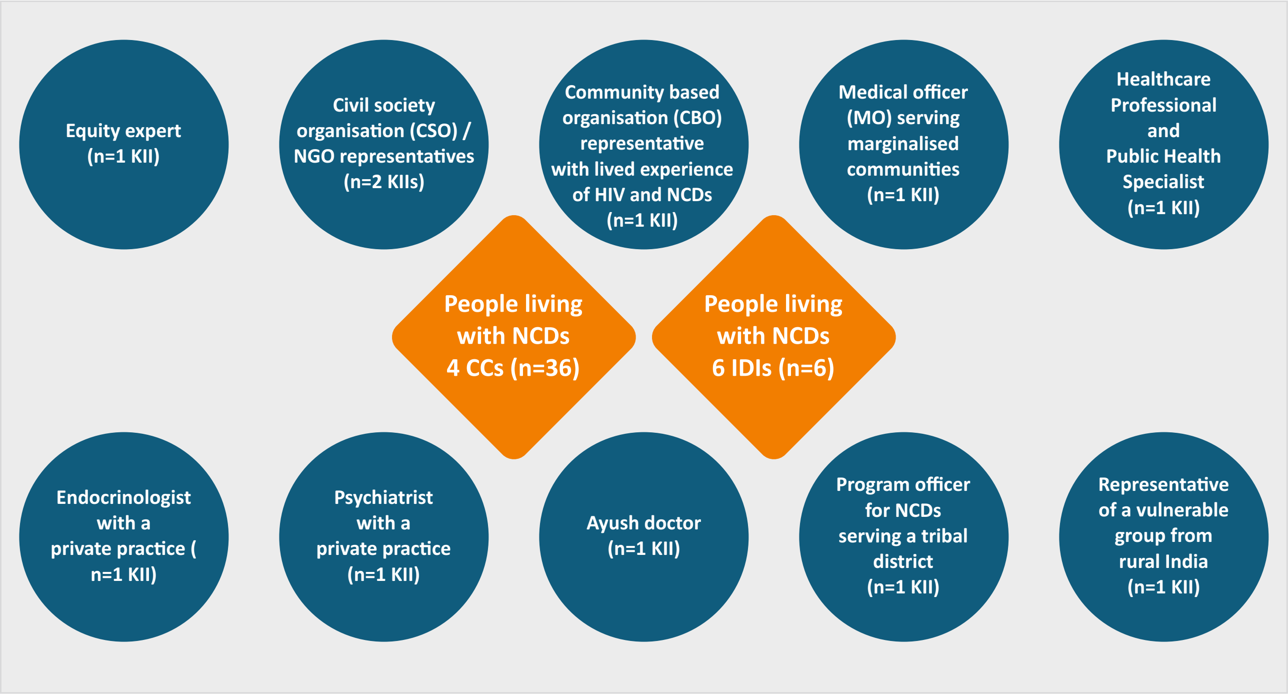


Figure 2: Respondent characteristics

Themes

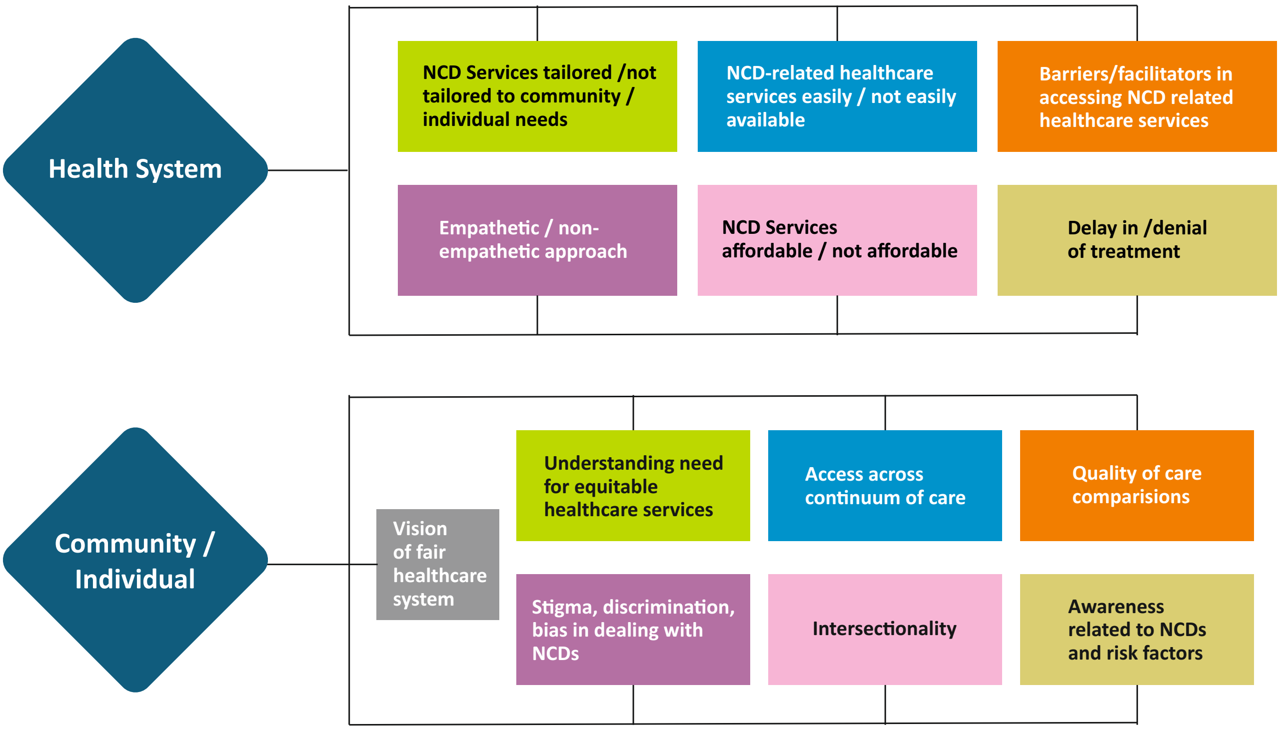
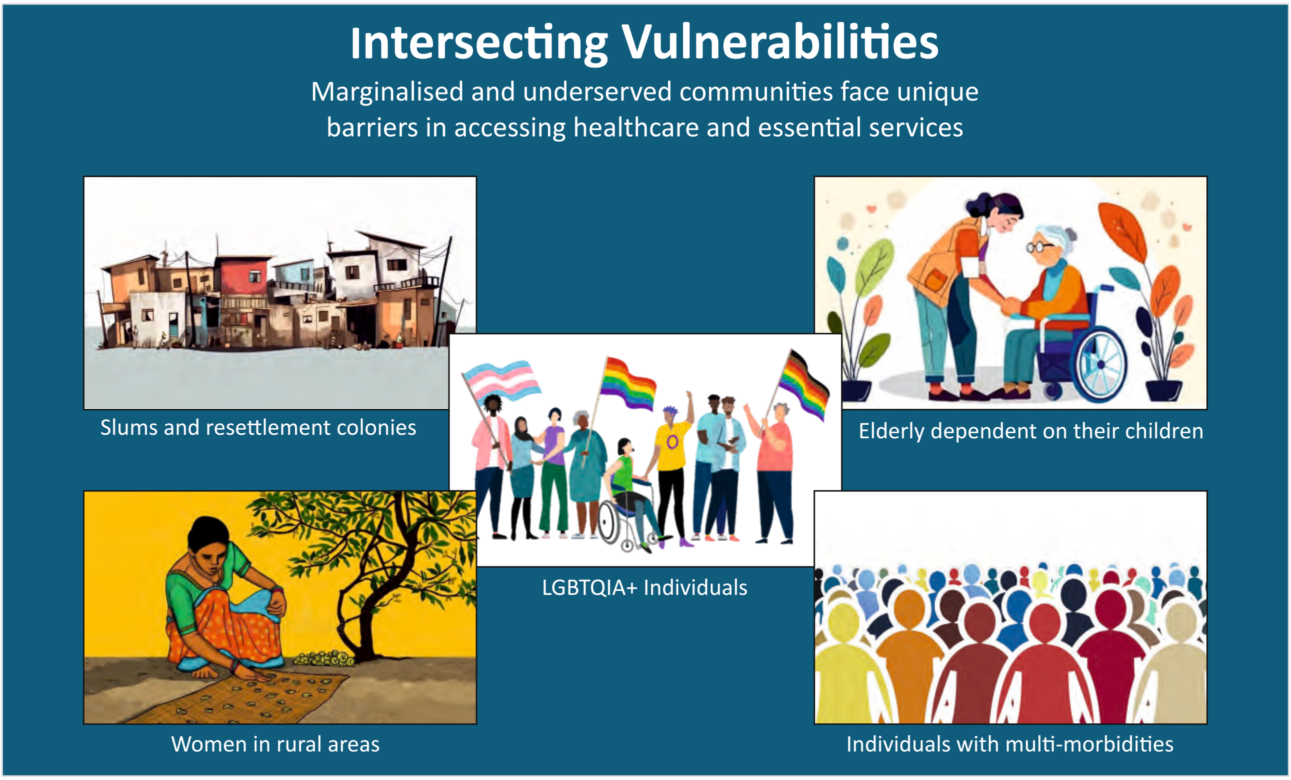


Figure 3: Key themes identified and analysed

Key Findings from Qualitative Equity Assessment

A. Who is being left behind?

Marginalised and underserved communities, including those living in resettlement colonies, urban slums, and migrant populations, are often left behind due to systemic barriers in accessing healthcare and essential services. Women, particularly those in rural areas with lower educational attainment, face additional challenges due to socio-economic dependence and limited decision-making power. The elderly, especially those reliant on their children for financial and healthcare support, often experience neglect and inadequate care. Individuals with multiple chronic conditions (multi-morbidities) struggle with fragmented healthcare systems that are unable to address their complex needs. LGBTQIA+ individuals, particularly those with limited employment opportunities, face discrimination that restricts their access to healthcare, housing, and economic stability. The inter-sectionality of these vulnerabilities exacerbates exclusion, leaving many without the support they need to lead healthy and dignified lives. Addressing these gaps requires targeted policies and inclusiveln interventions that prioritise equity and accessibility.


Intersecting Vulnerabilities

Marginalised and underserved communities face unique barriers in accessing healthcare and essential services

Slums and resettlement colonies

Elderly dependent on their children

LGBTQIA+ Individuals

Women in rural areas

Individuals with multi-morbidities

Figure 4: Intersecting Vulnerabilities

A1. Understanding of equity:

Understanding and conceptualisation of equity in healthcare varied across respondents and were shaped by various factors such as place of residence (urban/rural), educational attainment, personal experiences of living with NCDs and dealing with the healthcare system.

> “*A person who has an NCD should be able to get equal access to the required healthcare as much as a person without any NCD.*”
>
> **— Female, public health professional, New Delhi.**

Another female participant from rural Hyderabad described equity as being able to visit the health centre and get medicines. Many respondents viewed equity through the lens of availability, emphasising that services should be accessible to everyone regardless of income.

A respondent from urban Hyderabad shared about being excluded from the Arogyasri scheme (state-sponsored health insurance programme) because he was a tax-payer and not classified as below-poverty-line, despite his limited income and current unemployment, underscoring how rigid eligibility criteria can leave vulnerable populations unsupported.

Equity in healthcare refers to the need-based distribution of resources, ensuring that individuals receive support according to their specific requirements. One participant highlighted the importance of equity by explaining that economically disadvantaged individuals require greater assistance during medical emergencies.

> “*In the case of a heart attack, timely intervention is crucial, yet access to appropriate healthcare remains a significant challenge, particularly in rural and remote areas.*”
>
> **— Male, healthcare professional, New Delhi.**

Further, the respondents noted that public health facilities need better infrastructure and specialised care for management of major NCDs like CVDs, especially heart attack and other health emergencies. Given that the chances of survival increase significantly if treatment is provided within the first hour, individuals living in rural regions face a disproportionate burden due to delayed access to healthcare. This gap in timely care underscores the urgent need for equitable resource distribution to bridge disparities in healthcare accessibility.

B. Why are they being left behind?

B1. Health system determinants:

a. Delay in accurate diagnosis:

Delayed diagnosis and lack of proper guidance often led to unnecessary suffering for PLNCDs. One respondent shared how navigating multiple hospitals and departments only complicated their situation further:

> “*My condition was not diagnosed immediately when I first went to the hospital. I had already spent about two weeks at home without proper treatment. Despite visiting multiple hospitals, none could accurately diagnose my condition or direct me to the right specialist. When I was finally admitted, I was placed in the gastroenterology ward, where doctors failed to recognise my actual condition. They dismissed my symptoms, claiming I was making-up stories to avoid studying. My parents insisted that I had been doing well in college, but the doctors only began taking me seriously after I lost all movement, fine motor control, and bladder function. Even then, they did not consult other specialists. It was only when I became completely bedridden that they suspected a neurological condition and finally called a neurologist. Why could they have not done this in the initial days instead of waiting until my condition had severely worsened?*”
>
> **— Female, PLNCD, New Delhi.**

This case underscores the urgent need for greater awareness, sensitivity, and proactive collaboration among doctors. The failure to consult relevant specialists in a timely manner can lead to severe consequences, including permanent disability. A similar issue arose when doctors were unable to diagnose fluid accumulation in a patient’s abdomen, overlooking the possibility of cancer recurrence.

> “*When my mother developed fluid accumulation in her abdomen, we had no idea what it was. Even the doctors could not figure it out. They were unable to determine if her cancer had returned. As her condition worsened, we had no choice but to seek treatment at a private hospital.*”
>
> **— Male, Caregiver of PLNCD, New Delhi.**

Inadequate diagnosis and prolonged waiting times in government hospitals often forced PLNCDs to turn to private healthcare facilties, which remains unaffordable for many middle- and low-income families. Addressing these gaps in the healthcare system is crucial to ensuring timely and effective treatment for all.

b. Delay in service delivery:

PLNCDs faced significant delays in receiving chemotherapy/other treatment, often waiting for hours or being asked to return the next day due to unavailability of services due to several reasons. Despite arriving early in the morning, treatment was sometimes delayed until late evening or postponed entirely. The lack of immediate services forced many to seek care in private hospitals, where appointments are often scheduled weeks later, with little regard for the severity of their condition.

> “*The doctors there [government facility] are good, but I face a lot of problems with chemotherapy. I do not get it on time and keep encountering difficulties. I go back and forth.*”
>
> **– Female, PLNCD, New Delhi.**

> “*Yes, she has to wait. They tell her to sit, and by 11:00 AM, they say, ‘Wait until 2:00 PM. If it (treatment) is available, you’ll get it. If not, come tomorrow.’ She arrives at 9:00 AM, stands in line by 8:00-9:00 AM, and sometimes gets treatment by 2:00 PM. But if her turn still does not come, they keep saying, ‘Wait, you are next.’ By 5:00 or 6:00 PM, when I call to ask, ‘Where are you?’ she says, ‘I’m still at the hospital, and the treatment has not been given yet.’ Then she has to Tcome back.*”
>
> **– Female, Caregiver of PLNCD, New Delhi.**

These testimonials highlight delays in accessing essential NCD care within government facilities, where prolonged waiting times, uncertainty of treatment availability, and repeated hospital visits placed a heavy emotional and physical burden on both PLNCDs and caregivers.

PLNCDs irrespective of having free treatment cards frequently faced discrimination, experiencing unnecessary delays or outright denial of admission despite available beds in hospitals. Financial constraints further exacerbated the situation, as hospitals often prioritised those who could afford to pay. Essential diagnostic tests were frequently postponed for arbitrary reasons, such as designated testing days, causing further treatment delays. In government hospitals, CT scans and other crucial tests had waiting lists of six months to a year, leaving critically ill PLNCDs uncertain about their chances of survival before receiving necessary care.

> “*We have the free card, and once they told us to stand in line at 4:00 PM. We got there at 2:00 PM, brought the card, and everything seemed fine. But just when I was about to be admitted, despite my serious condition, they completely rejected us and told us to wait. Even though there were available beds, they refused. They said, ‘If you don’t have money, you will be left out.’ I was sick and had no one to help, so we somehow managed to get in.*”
>
> **– Female, PLNCD, New Delhi.**

This is the harsh reality for those from lower-income backgrounds. Doctors sometimes delayed tests with excuses, such as saying,

> “*Today is Wednesday, come back on Friday.*”
>
> **– Female, PLNCD, Hyderabad.**

Government hospitals imposed long waiting periods for six to seven months for CT scans and even a year for other diagnostics. Critically ill PLNCDs with severe conditions like kidney or liver diseases were given appointments months later, leaving them uncertain about whether they will survive the wait.

c. Delay due to billing formalities and delayed insurance claim approvals:

Many hospitals prioritised billing over immediate treatment, requiring PLNCDs to complete payment before starting any medical procedures, regardless of the severity of their condition. This practice delayed treatment and added unnecessary stress, especially when the PLNCDs were in urgent need of care. Insurance approval delays further exacerbated the situation, as hospitals at times refused to proceed with procedures until they received approval, even when the claim was fully covered. Furthermore, the back-and-forth between insurance representatives and hospital staff over charges could delay discharge, with PLNCDs and families facing even more stress. Ultimately, administrative processes should not interfere with healthcare; the focus should be on ensuring timely treatment and recovery.

> *“I have seen this in hospitals where the first step is billing. They (hospital staff) tell you, ‘Get the billing done, and then we will start the treatment.’ They do not consider the condition of the person who has come with such difficulty.”*
>
> **- Female, Caregiver of PLNCD, New Delhi.**

> *“The first step should always be to start the treatment because it is not like the patient will leave without paying the bill. Hospitals already have rules in place that no one gets discharged without clearing the dues.”*
>
> **- Female, Caregiver of PLNCD, New Delhi.**

Even for serious conditions like heart problems, some hospitals moved PLNCDs to general wards without consulting the family, causing additional distress.

> *“I asked them, ‘How can you move him when our insurance is covering the full ₹5,00,000 claim?’ It felt wrong that just because insurance approval was delayed, they thought it was acceptable to move him without consulting us.”*
>
> **- Female, Caregiver of PLNCD, New Delhi.**

d. Scheduling and Operational Challenges

Scheduling appointments in government hospitals was another hurdle. PLNCDs often arrived early in the morning but did not receive treatment until late in the afternoon or were turned down at the end of the working day. Outpatient Department (OPD) timings were also restrictive, with many dispensaries operating only in the morning, making it difficult for working individuals to seek care. The long waiting times, coupled with inefficient scheduling, discouraged people from seeking timely medical attention.

e. Ineffective Communication with Healthcare Providers

PLNCDs frequently experienced ineffective and unempathetic communication with healthcare providers. Many were not informed about their diagnoses or treatment plans. Doctors, pressed for time, often wrote prescriptions hurriedly without explaining which medicines were for what condition and what could be some potential side-effects of medication. Changes in prescriptions further confused PLNCDs and their caregivers, especially those with low literacy, who may struggle to understand new medication regimens. In many cases, they had to visit the hospital multiple times just to clarify how to take their medicines. Often, even the purpose of prescribed examinations or tests remained unexplained, leaving individuals unsure of why they are being conducted.

f. Inadequate Human Resources

Government hospitals were often faced with inadequate staffing, resulting in rushed consultations where doctors barely engaged with PLNCDs before moving to the next case. Long queues for medications further burdened PLNCDs, with waiting times stretching for hours. Additionally, palliative care and oncology departments were reported to be critically understaffed, with only one or two specialists handling large case loads, leading to compromised quality of care.

g. Preference for Government or Private Healthcare services:

Some participants opined that the quality of medication is the same between private and government services, especially when it comes to the dosage. However, others reported that government facilities often had limited medications or were unable to provide adequate alternatives. Participants shared that private healthcare is more expensive, leading some individuals to prefer government services, especially when they could not afford the higher costs. On the other hand, government hospitals were perceived as being more affordable by some participants, but often come with long wait times, queues, and chaos, making them less appealing for those who need timely treatment for serious health conditions. This was particularly important for people who needed to get back to work quickly, like daily-wagers and farm labourers. A male participant from urban Hyderabad shared that private hospitals tended to be more recognisable and well-branded, with visible infrastructure and multiple available services. In contrast, government hospitals did not have clear signage or appeared less well-maintained. A few participants expressed a preference for government healthcare because it is seen as more reliable and less exploitative. They expressed scepticism towards private healthcare, claiming that private doctors may manipulate PLNCDs into unnecessary procedures to increase costs.

For many, private healthcare was the preferred choice, especially for children, as it offered faster treatment compared to government facilities, where long wait times were a common issue. While private care was more expensive, the speed and efficiency make it an attractive option.

> “*In government facilities, they have to wait longer. Although private treatment is more expensive, it is faster.*”
>
> **- Female, PLNCD, New Delhi.**

One of the major challenges in public healthcare facilities was overcrowding. Many PLNCDs experienced delays due to the sheer number of people seeking care. Additionally, inadequate infrastructure, such as limited sanitation workers, further impacted the hospital environment. For instance, waste management in some public hospitals is inadequate, with sanitation services often being delayed due to external factors like festivals or labour shortages. In contrast, private hospitals had better staffing and maintenance, ensuring a cleaner and more organised setting.

While private healthcare likely offered faster and cleaner services, systemic discrimination persisted across both sectors. Addressing these issues requires comprehensive policy measures, increased accountability in healthcare settings, and empathy training for medical professionals and frontline health workers, to ensure equitable treatment for all.

Discrimination also played a significant role in pushing people towards private healthcare. Many individuals, particularly from marginalised communities, preferred private hospitals in the hope of receiving unbiased treatment. However, this expectation was not always met. When people living with HIV (PLHIV) disclosed their status, some private hospitals refused to treat them, particularly for procedures like kidney stone removal. Instead of outright denial, hospitals often delayed surgeries indefinitely, forcing PLHIV to seek alternative options:

> “*Many times, when individuals face discrimination, they choose to spend money at private hospitals in an attempt to receive better or unbiased treatment. However, when they disclose that they are HIV+, many private hospitals either outright deny treatment or keep postponing it.*”
>
> **- Male, PLHIV, New Delhi.**

h. NP-NCD Implementation

NP-NCD implementation faced multiple challenges, from inadequate human resources to insufficient medicine supply chains. Additionally, population-based screening for NCDs faced resistance, as many individuals feared that a diagnosis of an NCD would lead to further complications in their lives. Addressing misconceptions and improving sensitisation of PLNCDs and communities, is crucial for the success of NCD prevention and control interventions.

B2. Barriers in accessing NCD-related healthcare services

a. Inadequate Awareness

A major barrier to effective NCD management was the lack of awareness regarding the necessity of consistent treatment and the availability of appropriate care at healthcare facilities. Even though all NCDs demand consistent medication and regular monitoring, many individuals failed to recognise this need, leading to poor adherence. Sustaining treatment compliance remained a persistent challenge, further undermining disease control and long-term outcomes.

> “*For example, in our area, there is no facility to check blood pressure or diabetes. Only when we fall sick and go to the big hospital and get checked we find out that we have BP [hypertension]. People in my area are not aware that one should get a general check-up for these diseases once a month or something like that.*”
>
> **- Male, Caregiver, Hyderabad.**

b. Transportation and Distance Barriers

Accessibility to healthcare facilities remained a critical issue, especially in rural, hilly, and North-Eastern regions, where long distances made timely medical intervention difficult. Many communities lacked nearby healthcare centres that could adequately manage chronic conditions like diabetes and hypertension, let alone respond to emergencies such as cardiac events. The absence of accessible healthcare services forced individuals to either travel long distances or forego essential care.

> “*The transportation challenges from some villages in Adilabad district are extremely severe. When patients talk to me, they often mention the names of very small villages—names most people have not even heard of. It really makes me realise how limited their access to healthcare is. Many of these villages are deep in the forest, in hilly and mountainous terrain, where there are no proper roads. Patients have to first walk long distances—sometimes using bullock carts, from their village to the nearest place that has a road. From there, they take an auto-rickshaw or a private tempo, and only then can they reach the main urban hospital in Adilabad.*”
>
> **– KII, Private Psychiatrist, Hyderabad**

c. Barriers linked to demographic factors

a. **Language Barriers -** Language barriers further complicated healthcare access. PLNCDs who did not speak the local language often struggled to communicate their symptoms or understand medical instructions. For example, in Hyderabad, non -Telugu speakers faced difficulties in interacting with healthcare providers. Additionally, individuals with lower literacy levels struggled with hospital paperwork, making it harder to navigate the healthcare system. Essential health information, such as blood pressure awareness materials, was often available only in English, further alienating non-English speakers. This was particularly true for migrant populations who shift to urban areas in search of better livelihood.

b. **Gender Inequities in Healthcare Access -** Gender played a significant role in healthcare access. Women often faced barriers due to cultural and social norms requiring a male family member to accompany them to hospitals. Even when they managed to visit healthcare facilities, many lacked the confidence or knowledge to navigate the system, leading to missed opportunities for care. Despite their education levels, women unfamiliar with government procedures often struggled to access essential services. Transgender individuals also faced barriers in both public and private healthcare settings. In some cases, doctors asked inappropriate or intrusive questions, making them feel uncomfortable and unwelcome. This repeated experience of discrimination discouraged them from seeking medical care altogether, leading many to pay for private treatment to avoid public hospitals.

c. **Disparities in Healthcare Access for Marginalised Communities -** In government hospitals, PLNCDs from marginalised communities frequently encountered dismissive attitudes from healthcare providers. Doctors, overwhelmed by high case volumes, often provided minimal explanations, simply handing over prescriptions without discussing diagnoses or treatment plans. This lack of engagement fostered distrust in the healthcare system. Additionally, multiple government-issued health cards, such as Ayushman Bharat, NHM service cards, and Employees' State Insurance (ESI) cards, created confusion among PLNCDs, further complicating healthcare access.

> ***"When I talk about vulnerability, particularly among the bottom socioeconomic groups, I am referring to people like TB patients, migrant labourers, and communities living in the old city, which is predominantly inhabited by a certain minority community. In these areas, the definition of vulnerability is shaped by multiple overlapping factors: daily wage dependence among migrant workers, large family sizes, high illiteracy rates, widespread poverty, and poor hygiene and sanitation conditions. All of these create a deadly combination that heightens vulnerability. We tend to focus more on the old city areas because we believe they are among the most at-risk populations. The combination of limited income, overcrowded households, lack of education, and inadequate living conditions makes it extremely challenging and leaves these communities particularly exposed."***
>
> **– KII, NGO representative, Hyderabad.**

d) **Cultural and Traditional Beliefs about Health Conditions -** Cultural and religious beliefs also shaped attitudes toward NCDs. Many individuals believed that spirituality or faith would protect them from NCDs like diabetes and hypertension, leading to delays in seeking diagnosis and treatment. This mindset was particularly prevalent among uneducated populations and severely impacted NCD management, as these conditions required long-term medical intervention rather than reliance on faith alone.

e) **Educational Status -** Less-educated individuals faced challenges such as language barriers and unclear instructions, in hospitals, making it difficult for them to understand paperwork and procedures. Those who were educated felt that being educated allowed them to navigate the system and ensure proper care for their family member.

> ***"I am educated and familiar with hospital rules and regulations. If I had not assured them of full payment, the hospital authorities would have decided to move my father. However, since my insurance company is providing full support, how can the hospital decide to shift him just because approval was delayed? I completely understand that this challenge becomes even more difficult when we are less educated or do not know English, as it leads to issues in understanding paperwork and the required documents at the hospital."***
>
> **- Female, Caregiver, PLNCD, New Delhi.**

> ***"The language used by hospital staff is often dismissive, like 'I have explained it to you,' 'Go do this,' or 'Yes, do this.' If you do not understand, they simply say, 'Ask the guard sitting there.' This is especially common in gynaecology."***
>
> **- Female, PLNCDs, New Delhi.**

The Ayushman Bharat card, which could be crucial for those in need, was often ineffective for many uneducated individuals who lacked the knowledge or resources to access or use it properly.

> *"Listen, you are educated, I am educated, so we know what an Ayushman card is. But the uneducated people, who actually need it the most, do not. Why? Because they do not have the money or the knowledge."*
>
> **- Male, PLNCD, New Delhi.**

> *"The Ayushman card will only be useful if it works positively; otherwise, it is pointless. Suppose I, as a literate person with knowledge, I have correct cards and I go to the counter. I know where to go, which hospital to visit, and how the system works. If the prescribed medicines are indented, they will be dispensed at the hospital."*
>
> **- Male, PLNCD, New Delhi.**

Even when educated individuals knew how to navigate the system, issues like delayed processing or incomplete support could render the card useless, forcing PLNCDs to buy medicines themselves. Illiteracy and functional illiteracy were prevalent, limiting many people's ability to access healthcare services effectively.

> *"They (hospitals) tell you that if you stand in line at 5:00 PM, you willl get the medicine for free, but when you go, they say the line is closed. This is just a scam to fool the public. There is no real service."*
>
> **- Male, PLNCD, New Delhi.**

Furthermore, free medicine schemes in hospitals were often unreliable, with PLNCDs finding out the lines were closed or being told to go elsewhere. Government hospitals, while offering low-cost care, are plagued by long waiting times and a lack of urgency in treating serious conditions, leaving PLNCDs uncertain about their health and survival. In contrast, private healthcare is faster and offers more personalised, though it is often out of reach for many due to high cost of treatment and medication.

> *"In government hospitals, they give dates for everything, like 6 months, 7 months for a CT scan, and a year-long waiting list. Meanwhile, patients do not even know if they will survive the wait. For those with serious conditions like kidney or liver problems, they are given appointments 6 months later. In that time, they do not know what will happen to them."*
>
> **- Male, PLNCD, New Delhi.**

In government facilities, many a times doctors were unable to provide thorough check-ups or guidance and wrote prescriptions without explaining the treatment or medication. This lack of communication and inadequate attention contributed to a frustrating experience for PLNCDs, especially when combined with long wait times and overcrowding.

> *"They only ask, 'What happened to you? What is the problem?' That is all they ask, but they do not really do a check-up. They just give us pills. But they should check, why is the illness happening, why is the sugar rising so much? They do not look into it."*
>
> **- Male, PLNCD, New Delhi.**

While some doctors offered good care, the overall quality varied greatly, leaving PLNCDs feeling neglected and stressed, which worsened their mental and physical health.

> *"Some are good, it is not like all doctors are bad. Listen to me, we are not saying all doctors are bad. Some are good, and some are like this. Like you are saying, but where do we even meet the doctor? They just write it (prescription) and give it to us. We just take the medicine and go home. They should at least explain how to take it, but they do not. The conversation ends there. In the afternoon, we are eating (medicies) without any real guidance."*
>
> **- Male, PLNCD, New Delhi.**

f. **Age:** A considerable proportion of older adults, particularly those aged 70 years and above, experienced difficulties arising from inadequate family support. Only a minority received active assistance from relatives, while the rest either lived alone or had family members who are unable to provide care due to other commitments. This created a gap in care, as many senior citizens were physically inactive and required additional support. To better serve this demographic, hospitals, especially government-run, should have dedicated services/ counters for senior citizens, ensuring they receive the specialised care and attention they deserve.

g. **Inter-sectionality:** Inter-sectionality plays a significant role in shaping healthcare access and outcomes, especially for individuals facing multiple challenges. A low SES woman or child with conditions like multiple sclerosis were often neglected, with little to no support systems available to them. In contrast, individuals from higher socio-economic background, whether male or female, had more options for care due to better financial resources, literacy, and support systems. Gender and socio-economic constraints further complicated care, as seen in cases where caregivers, such as mothers, had to work and could not provide the necessary care for their children. An instance was shared by an NGO representative:

> “*The mother of a sick child could not stay with the child because she had to go to work. As a result, the child’s health worsened and lead to being bedridden and developing bedsores, eventually leading to her death. She was studying in the 10th standard and was supposed to take her exams. She had been looking forward to writing her 10th standard exams, but unfortunately, this was not to be.*”
>
> **– Female, NGO representative, New Delhi.**

Such disparities highlighted the inter-section of gender, SES, literacy, and location (rural-urban disparity), all of which contributed to unequal healthcare experiences, especially for those in rural areas.

> “*Sometimes, even middle-class families face issues where they cannot manage. This (Ayushman Bharat) card can give them some hope, showing that the government has created something beneficial for them. Think about situations where someone’s husband has passed away, or a mother, or a wife. For them, it becomes vital. When I went back for the medicines, I was scolded. At home, I had a small child to take care of, and I could not buy medicines immediately.*”
>
> **– Female, Caregiver of PLNCDs, New Delhi.**

d. Barriers linked to socio-economic factors

The financial strain of healthcare was a major concern. Hospitals sometimes imposed additional charges for small consumable items, while prescribed medicines were often unavailable in government facilities, forcing PLNCDs to buy them at high prices from private pharmacies. Many private hospitals pushed unnecessary treatments and medications, and PLNCDs frequently did not receive clear explanations about their prescriptions. Billing transparency was a major issue, with PLNCDs realising the costs only after treatment was complete. This lack of accountability left marginalised communities, particularly vulnerable and at-risk groups, of being exploited. For daily wagers, visiting a healthcare facility often meant loss of wages which was a demotivating factor for seeking timely and regular healthcare.

> “*In a state if there is only one hospital, where they stand in a queue - mornings and nights only then they get medicines, and outside also it is not available and, if available, it is costly. I feel there should be a link with government for that, because there are many cases and many people who are suffering with depression like even the young, educated officers also. The services are not available elsewhere, apart from government hospital, if they seek (care) outside it is too costly.*”
>
> **- Female, PLNCDs, Hyderabad.**

Marginalised communities faced continuous disruptions due to economic necessities, making adherence to NCD care challenging. This included, regular medication, diet, follow-ups, and testing, among other issues. For migrant workers, the lack of healthcare portability across states exacerbated these barriers. Without portable medical records and seamless access to primary healthcare services across regions, consistent treatment became difficult. Healthcare providers must acknowledge these structural constraints rather than labelling PLNCDs as defaulters. A comprehensive approach is needed, ensuring adequate human resources, consistent drug availability, and robust monitoring mechanisms. Without these, PLNCDs, regardless of SES, are at risk of substandard care, particularly from unregulated private healthcare providers.

The disparity related to access to healthcare, between middle-class and poor families, was substantial. For middle-class families, having insurance or workplace coverage allow them to manage expenses, even if they faced significant costs. In contrast, poor families struggled to gather even small amounts like ₹10,000 for treatment, and private hospitals sometimes turned them away, suggesting they go to a government hospital instead.

> “*Let me tell you something profound. Nowadays, education and healthcare are for the wealthy. For the poor, it is a constant problem.*”
>
> **- Female, Caregiver, PLNCD, New Delhi.**

> “*If a very poor person seeks treatment at such a (private) hospital, they may be told, “This place is not for you. Go to a government hospital.*”
>
> **- Female, Caregiver, PLNCD, New Delhi.**

> “*For middle-class people like us, we can somehow manage and say, “Alright, it is a ₹ 1 lakh expense; no problem, let us get it done.” We prefer to manage. But for poor families who cannot even gather ₹10,000, such a (Ayushman Bharat) card is crucial.*”
>
> **- Female, Caregiver, PLNCD, New Delhi.**

They also expressed concerns that healthcare and education had become privileges for the wealthy, creating a significant divide, while the poor continued to face constant barriers in accessing both.

e. Lack of empathy in NCD care

A severe lack of empathy and respect from healthcare providers for PLNCDs and care providers during the treatment process, was highlighted. Delays in procedures, coupled with the hospital’s attempt to move the PLNCD to a general ward despite full insurance coverage, demonstrated a disregard for individual rights and respect.

> “*But later, they started delaying procedures, saying, ‘We can not proceed without insurance approval.’ They even tried shifting him to a general ward, which angered me.*”
>
> **– Male, PLNCD, New Delhi.**

> “*It feels like they believe, ‘You have come here because you need us. We will do our job, but you will have to compromise; we will not compromise.’ The patient is the one who has to adjust.*”
>
> **– Male, PLNCD, New Delhi.**

It was also found that poor communication between healthcare providers and PLNCDs could lead to confusion and erode trust, highlighting the need for transparency and clarity in all interactions. PLNCDs must be treated with dignity and respect, with their concerns given proper consideration by all healthcare team members. The delivery of a diagnosis should be done with sensitivity, ensuring PLNCDs, including care providers, are not only communicated medical information but also offered the emotional support they need. In addition to addressing physical health, healthcare systems must prioritise emotional and psychological well-being by offering counselling and other support services, particularly for those dealing with chronic conditions.

> “ *And then in the late evening, these PG (Post-Graduate) students would come, and nobody told us they were students and not part of the Unit 3 doctors. They just come in the same manner, with a case sheet, scrolling through it and doing the diagnosis again. How many diagnoses do I have to undergo?* ”
>
> **– Female, PLNCD, New Delhi.**

> “ *The next day, when they (medical team) were discussing my case, I was made to sit before a lot of doctors, including senior doctors. My unit doctor was explaining my case and making mistakes. I immediately corrected him, but the junior doctors looked at me with judgmental eyes, and the chief doctors just said, Stop.* ”
>
> **– Female, PLNCD, New Delhi.**

> “ *The way hospitals sometimes operate only aggravates the disability, both physically and mentally. After visiting the doctor, you feel even more depressed.* ”
>
> **– Male, PLNCD, New Delhi.**

A holistic approach to care was vital, requiring collaboration among healthcare providers, including specialists, to ensure comprehensive treatment and improvement in the experience of PLNCDs. When the healthcare environment failed to support both physical and mental health, it exacerbated the challenges PLNCDs face, leaving them feeling neglected and unsupported.

f. Stigma, discrimination, and bias

Stigma and discrimination remained significant barriers to equitable healthcare access, particularly for marginalised communities. Deep-seated biases often dictated the quality-of-care individuals received, making it challenging for them to avail timely and appropriate treatment. For instance, transgender individuals frequently encounter stigma in healthcare settings. A Kinnar (local term for transgender) visiting a hospital may be denied entry or dismissed with excuses like, "Doctor Sahab (Sir) is not available." These discriminatory attitudes created an environment where many feel unwelcomed or ignored. As a result, vital services such as palliative care remained out of reach for those who need them the most. Limited awareness further exacerbated the issue, as individuals did not even know that such services exist within the healthcare system.

Similarly, when transgender people seek medical attention, they often felt uncomfortable waiting in general queues due to the judgmental attitudes of others. To avoid this humiliation, those who could afford private care preferred it, assuming that paying for services will ensure better treatment. However, even in private hospitals, many healthcare providers lack awareness about conditions like HIV. While doctors may not outright refuse treatment, they often create indirect barriers, subtly avoiding certain cases.

For PLHIV, discrimination in hospitals began the moment they disclosed their status. Though disclosure is necessary for treatment, it frequently lead to sub-optimal care. Some doctors imposed additional charges for treating PLHIV, justifying these costs by claiming the need for extra sanitation and specialised equipment. A surgery that would typically cost ₹1,00,000 could increase by ₹25,000 to ₹30,000 solely due to an individual’s HIV+ status. This was an unfair financial burden rooted in stigma rather than medical necessity.

Beyond institutional discrimination, self-stigma also affected individuals with NCDs. Many hesitate to disclose conditions like diabetes or hypertension, fearing they would be constantly labelled by their illness.

This labelling could take a toll on mental health, as individuals felt defined by their disease rather than seen as whole people. The social perception of vulnerability reinforced this stigma, making many reluctant to seek medical help or openly discuss their health concerns.

> *“I have also seen a young boy in my village, I noticed and asked him why he lost so much weight and became so thin, he said “Yes, Anna [elder brother], I have sugar [diabetes]”. Then I asked him how come he never told us. He said “How can I tell that to anyone Anna? I am so young and already have diabetes, what would people think?” He said it was hereditary, but I think it is because he was drinking alcohol.”*
>
> **– Male, PLNCD, Hyderabad.**

To create a more inclusive healthcare system, it is crucial to address both structural and social biases. This requires training healthcare providers to be more empathetic and eliminate discriminatory practices, increasing awareness about available services, and fostering an environment where all individuals—regardless of gender identity, HIV status, or NCD diagnosis—receive good quality, dignified and equitable care.

Ayushman Bharat Programme

The most important strength of Ayushman Bharat is its reach and focus on the continuum of care, with prevention being prioritised. A key component of prevention focusses on population-based screening for NCDs (diabetes and hypertension), and specific cancers (oral, breast and cervical). Screening for risk factors through the Community-Based Assessment Checklist (CBAC) form by Accredited Social Health Activist (ASHA) workers is significant. Moreover, the wellness component of Ayushman Bharat is crucial for addressing NCDs. These interventions and facilities through Ayushman Bharat are successfully reaching rural India, bringing care closer to the people. Hence, through Ayushman Bharat urban-rural inequities are being addressed to some extent. Economically marginalised sections in rural areas are availing services near their homes through ASHA workers and other frontline health workers. They are getting tested and those diagnosed are being put on standard care. However, the health system needs to be geared-up to accommodate the influx of PLNCDs diagnosed and ensure that health facilities can provide accessible, affordable and equitable care to all beneficiaries. Existing insurance schemes primarily focus on inpatient care, leaving individuals with chronic conditions, who need frequent outpatient check-ups and daily medications, without sufficient coverage. There is also a need to sensitise communities about the scope of the Ayushman Bharat Programme, including eligibility, coverage, services provided and process to avail services. It was strongly suggested to have dedicated counters for Ayushman Bharat beneficiaries, for streamlined uptake and delivery of services. This will support a rationalised utilisation and impact of this flagship initiative of the government and minimise stress of PLNCDs and the health workers.

g. Satisfaction with quality of NCD care:

Analysing satisfaction among PLNCDs highlighted the perspectives of both people with lived experience and caregivers. Quality of care extended beyond just clinical outcomes to encompass whether individuals felt respected, valued, and treated with dignity.

a. **Long waiting times:** It was highlighted by the respondents that there was dissatisfaction with healthcare services due to long waiting times.

> *“Many times, when seeking healthcare services, I experienced discrimination. Despite having a severe illness and a disabling condition, I was not provided equal opportunities. Forget about equity, I was made to stand in long queues while others bypassed them. Even when I was in critical condition, no priority was given to me, and I had to wait behind people who arrived after me. This kind of treatment occurred repeatedly in different healthcare settings.”*
>
> **- Female, PLNCD, New Delhi.**

> “*My daughter often stands in line for one to two hours, yet we still do not receive the medicines on time.*”
>
> **- Male, PLNCD, New Delhi.**

b. **Limited PLNCD and caregiver involvement in treatment decisions:** Healthcare providers often assume that PLNCDs lack the capacity to understand their treatment, leading to a disregard for informed consent and individual autonomy and rights. In one instance, as pointed out by a person with lived experience:

> “*Once I was actually given a psychiatric drug then I did not know that it was a psychiatric drug and after taking it I was feeling totally helpless and totally, what to say, unorganised and I did not know what I was up to. And I was in a kind of sedative state. Then I Googled and I figured out that this tablet is the reason and my friend only told me. Then I Googled more and figured out why I was struggling and very soon I went back to the doctor and I asked him why you have given me this drug and he simply said that drug will help ease your nervous system. The withdrawal process was equally distressing, causing symptoms like shivering, making it difficult to stop the medication even after the doctor discontinued it.*”
>
> **- Female, PLNCD, New Delhi.**

This situation reflects a broader issue in healthcare, where a bureaucratic mindset fosters a power imbalance, assuming that doctors know everything while PLNCDs know nothing—even though it is their own bodies at stake. Such practices violate PLNCDs' rights to autonomy, informed choice, and complete access to information about their healthcare pathway.

c. **Financial constraints:** The cost of treatment was a significant burden, as doctors often prescribed expensive medications that were unavailable in the hospital pharmacy, forcing PLNCDs to buy them from outside pharmacies, which many could not afford. Transportation costs further added to the financial strain, with one trip to the hospital costing around ₹ 500, and low-income families spending at least ₹ 1,000 per week on travel alone which they could ill-afford.

Additionally, the special dietary requirements for PLNCDs, add more expenses, as recommended food items like fruits, vegetables and whole grains, are expensive and not always affordable for families already struggling with healthcare and related costs.

d. **Unavailability of medicines:** Accessing medicines, particularly in government facilities was a key barrier, as PLNCDs often had to visit multiple facilities to find prescribed medications This was especially exhausting for those with limited resources.

> “*Getting medicines in government hospitals is frustrating. Doctors prescribe them, but then I have to run from one place to another to find them. As a poor man, this is exhausting. If I cannot find the medicine, I simply stop taking it, which causes my blood pressure to spike again. Sometimes, I am told to buy medicines from outside, but if they are unavailable, I skip my treatment. My BP then rises dangerously, sometimes reaching 190, and I end up returning to the doctor.*”
>
> **- Female, PLNCD, New Delhi.**

> “*These are the tablets that I need [showing prescription], but they are not available here in the government dispensary, they are not even suggesting any other available tablets either.*”
>
> **- Male, PLNCDs, Hyderabad.**

C. Lived Experiences Case Studies

Case Study (New Delhi)

The healthcare journey of a 40-year-old individual from New Delhi, India who has been living with HIV, hypertension, and high cholesterol for 24 years.

I identify as bisexual and am a member of the MSM (Men who have Sex with Men) community. I am actively involved with a Community-Based Organisation (CBO) Love Life Society, dedicated to advocating for and providing support to MSM, transgender individuals, and People Living with HIV (PLHIV) in India.

I have been living with HIV and chronic NCDs like hypertension and high cholesterol for the past 24 years, and my wife has also been living with similar health conditions. The dual burden of managing both HIV and NCDs, compounded by the prolonged use of Anti-Retroviral Therapy (ART) and the social stigma associated with being part of the MSM and transgender communities, creates significant barriers to equitable access to NCD care services. I am not alone in this; as many people in my community, particularly those who have been on HIV medication and are living with chronic NCD conditions, experience similar challenges.

Among the nearly 50 individuals I interact with during ART visits, about half are prescribed cholesterol medications like Atorvastatin. My wife and I are no exception; as we have been on cholesterol medication for the past 5-6 years, with our cholesterol levels remaining controlled only while we are taking the medicines. Discontinuing the treatment causes the levels to rise again. On the other hand, co-managing both HIV and chronic NCDs has significantly increased my stress levels and worsened my mental health. The constant need to stay on top of my medication, regular check-ups, and monitoring health markers creates a persistent sense of pressure. The ongoing concerns about my health and the potential long-term effects of both conditions often leads to anxiety and mental fatigue.

The stress we experience is often **worsened by the stigma and discrimination** because of our sexual identity as an MSM or a transgender. Seeking treatment often leads to challenges in accessing equitable healthcare. At ART centres, we receive our prescribed medications, but for other issues like gynaecological concerns or chronic NCDs, we are referred to specialists. Government hospitals present a different experience, where disclosing our HIV+ status often results in discrimination. Although some doctors are compassionate, many provide limited support, and the care provided, often fails to meet expectations. However, in private healthcare settings, treatment is generally better if we can afford it, but stigma persists, even in these environments. Many private hospitals **impose additional fees when they learn that a patient is HIV+,** justifying the extra costs by claiming that they need to use special kits or sanitise equipments differently. I have experienced this myself. If I were to undergo a surgery, the hospital would charge an additional ₹25,000 to ₹30,000 for a special kit simply because I am HIV+. The surgery itself would already cost ₹1,00,000, and this extra charge would just add to the financial burden. Many people in the community who are **financially strained** do not have the option of private hospitals.

There is also the issue of healthcare professionals who, without proper knowledge, may make assumptions about my health. For example, when I have to deal with Sexually Transmitted Infections (STIs), some doctors might unfairly associate these diseases with being transgender or bisexual, assuming I am the one spreading them. There is a misconception that people like me, are more likely to contract and spread STIs. This stigma often leaves me feeling even more marginalised, and to make matters worse, some doctors ask intrusive, inappropriate questions that make me feel uncomfortable and unsafe. It gets to a point where I, and many others like me, start avoiding hospitals altogether. The frustration can be overwhelming, especially when you know that care is essential.

This journey is not easy, and it is hard not to feel exhausted from the constant fight for decent healthcare. It is a harsh reality many of us in the MSM, transgender, and PLHIV communities live with every day. We need a healthcare system that recognises our unique challenges and provides care that is not just accessible but compassionate and free from judgment. We **deserve healthcare that treats us with dignity** and provides comprehensive support for both our physical and mental health.

Case Study (Hyderabad, Telangana)

Healthcare access and quality, and preference for private healthcare in a 54-year-old male with diabetes, who is currently relying on government healthcare services.

I have been living with diabetes mellitus for some time now, without any other co-morbid conditions. Over the years, I have started experiencing severe pain in my legs and a burning sensation in the soles of my feet, symptoms I attribute to my diabetes. For a long time, I was getting treated at a private facility, but the costs were becoming difficult to manage.

Two months ago, an ASHA worker (frontline health worker) advised me to switch to government health services, where diagnosis, consultations, and medicines are provided free of charge. Taking her advice, I began visiting the Urban Primary Health Centre (UPHC) in my area. Since then, I have been relying on the government facility for my diabetes care.

At home, I receive enough support from my family. They accommodate my dietary needs. Even on days when no one else in the family is eating roti (Indian bread made of wheat flour), they make sure there is a roti prepared just for me. I stick to my medication and dietary regimen diligently. My day starts with tea, without sugar, and an insulin shot before breakfast. After breakfast, I take two tablets. Lunch typically consists of roti with a small portion of rice, and I have only roti for dinner.

Since I shifted to government healthcare, I have faced serious challenges in accessing consistent care. One of the biggest issues is the ***shortage of essential medicines.*** For example, the government pharmacy rarely has the 1000 mg dosage tablets prescribed by my private doctor. Even when the medication is technically available, they only stock 500 mg doses, which is not sufficient. On several occasions, they did not have the tablets at all and did not even suggest alternatives.

Another major concern is the ***lack of doctor availability***. Despite repeated visits over the last two months, I have not seen a doctor at the UPHC. It is frustrating to visit a large health centre only to find it run entirely by ASHA workers, who, while well-meaning, do not have the expertise to understand or manage my condition. I have come to a point where I do not feel like visiting the government hospital again.

There are also ***barriers when it comes to accessing government health schemes.*** I am eligible for the Ayushman Bharat scheme, and healthcare workers even collected my details for enrollment. But it has been two months, and I have not received any updates. I still do not know whether I am officially enrolled or not. Because I do not have a 'white card', even though I qualify for other government benefits, I am excluded from other schemes like Arogyasri (Universal Health Coverage Programme in Telangana). It feels like the system does not accommodate people like me who own small property or pay taxes.

Given these challenges, I find myself leaning back toward private healthcare despite the cost. At least there, I can count on seeing a doctor and getting the medications I need on time. My experience with the public health system has left me disappointed.

If there is one thing I believe strongly in, it is that the government should focus on making ***quality education and healthcare free for everyone*** in the country. That would help more than any number of fragmented health schemes. Right now, we have big health centres but no doctors, and government programmes that promise support but don not reach people like me.

D. What recommendations can help achieve equity in NCD care?

This NCD health equity assessment provided rich insights from powerful lived experience voices that spotlighted the resilience of PLNCDs and communities in dealing with deep-rooted inequities that stem from complex challenges attributed to NCDs. Chronic health conditions not just depleted their physical and mental health, but also, bore a devastating impact on their economic, emotional, and social wellbeing. This narrative was further amplified by the inputs from multiple stakeholders working on NCDs, across the care continuum and care cascade. This, triangulated with data from the literature review, led to the identification of multi-pronged recommendations that can facilitate equity oriented NCD care in the Indian context. Aligned to ongoing governmental efforts, these recommendations call on multiple partners to act towards enhancing equity in NCD care (Figure 5).

1. Meaningfully involving people living with NCDs and caregivers from diverse population sub-groups

a. Mobilising multi-stakeholder action to strengthen holistic participation of PLNCDs and caregivers in the operationalisation of NP-NCD and the 75/25 initiative, through tailored approaches for vulnerable and marginalised population groups (women; LGBTQIA+ groups; children and young people; aged and geriatric population; socio-economically disadvantaged groups and others).

b. Recognising the expertise of lived experience and grassroots champions as key stakeholders and experts for an equitable NCD response.

c. Adopting a rights-based and equity-promoting approach to co-create people-led solutions for a comprehensive response to NCDs.

d. Incentivising lived experience and community champions to be motivated and committed for leading and supporting the health system and civil society in augmenting outreach and impact of NCD care and services.

e. Sensitising diverse segments of PLNCDs to augment health literacy through evidence-based health promotion strategies to plug information gaps on key issues including, minimising exposure to NCD risk factors; impact of NCDs on physical and mental health, socio-economic well-being; screening and early detection; adherence to treatment advice; self-care and regular follow-up for control.

f. Amplifying multi-sectoral action to thwart societal barriers, such as stigma, discrimination, judgemental approach, and socio-cultural insensitivity, which hamper access to and uptake of NCD services, education and employment opportunities, further exacerbating societal inequities that impact health status.

2. Augmenting participation of vulnerable and marginalised community groups and civil society organisations across the NCD care continuum

a. Fostering community leadership through meaningful engagement and involvement, for co-creation and implementation of contextualised solutions for NCD prevention and control, as envisaged in the NP-NCD, 75/25 initiative and Ayushman Bharat programme.

b. Providing fair opportunities through leadership-oriented capacity building of lived experience champions to steer community ownership of health issues; strengthen health-seeking behaviours and generate demand for high quality and streamlined healthcare services, deployed to minimise OOPE, CHE and opportunity cost (i.e., loss of wages) while seeking healthcare.

c. Institutionalising meaningful involvement of lived experience community champions through existing platforms such as, NP-NCD, 75/25 initiative, Jan Arogya Samiti, Mahila Arogya Samiti, community-based groups/organisations, and others.

d. Promoting comprehensive socio-economic development of communities as an enabler for addressing inequities in NCD care, enhancing quality of life, through better education, employment, empowerment, and engagement in healthcare and developmental processes.

e. Leveraging the outreach and impact of CSOs as a bridge between PLNCDs, communities and the health system, to foster bi-directional coordination for tailored and equitable NCD care services for all segments of society.

f. Establishing evidence-based, social science and public health driven models for meaningful community involvement, including impact assessment, cost-effectiveness, and contextualised scalability and sustainability potential.

3. Strengthening people-centred health systems for equitable NCD care

a. Shifting from a predominantly medical/clinical/patient-oriented approach to a balanced people-centric approach that promotes holistic health wellbeing and equitable access of quality NCD services to all segments of the population.

b. Making health systems more empathetic to the needs and challenges of PLNCDs and the community at-large, and promoting respect, dignity, and confidentiality in NCD care.

c. Upgrading/introducing 'empathy and equity in care' component in the curriculum/capacity building programmes/ on-the-job trainings for all cadres of healthcare providers through an integrated medical science and social science approach.

d. Enhancing capacity of health facilities particularly Health and Wellness Centres/Primary Health Centres, Community Health Centres, tertiary care hospitals to streamline administrative processes/ documentation to maximise time- and resource-efficient utilisation of services.

e. Expanding a comprehensive and holistic NCD continuum of care through a life-course approach with special focus on timely detection of NCDs in early years; efficient management of NCDs during adulthood and; optimal quality of life in old age.

f. Standardising clinical NCD management protocols across all healthcare settings to enhance quality, consistency and continuity of long-term chronic care.

g. Prioritising provision of doorstep services and care (Comprehensive Primary Health Care) to vulnerable/marginalised groups with special needs particularly those with serious health conditions and special needs (e.g., physical needs in case of geriatric groups, psychosocial needs for LGBTQIA+ groups etc.) and working population who defer timely care due to loss of precious wages.

h. Maximising technology integration to amplify outreach of NCD care targeted at hard-to-reach communities, leveraging the complete potential of tele-medicine services being provided through eSanjeevani – the National Telemedicine Service.

i. Ensuring that populations with limited technological access and digital literacy are not left behind in accessing digital health services thereby exacerbating inequities through the digital divide.

j. Optimising NCD data accessibility and portability from the NCD portal, Ayushman Bharat Health Account (ABHA ID) and other platforms to consolidate health data for people accessing different healthcare services to streamline comprehensive and long-term care pathways.

k. Synergising inter-disciplinary NCD care between different systems of medicine such as allopathy and alternate and traditional systems including AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homoeopathy), with a focus on safety and efficacy of chronic care.

4. Enabling a protective policy environment to address NCD risk

a. Formulating and enforcing comprehensive policies to shield vulnerable and marginalised communities from commercially determined NCD risk factors that exacerbate inequities such as, tobacco use; vaping; alcohol use; unhealthy diets; physical inactivity and exposure to indoor and outdoor air pollution.

b. Garnering multi-pronged support for the operationalisation of the Government of India's National Multisectoral Action Plan for the Prevention and Control of NCDs; enforcement of the Cigarettes and Other Tobacco Products Act 2003 (COTPA), Prohibition of Electronic Cigarettes Act 2019 (PECA) and other policy measures such as the Eat Right and Fit India campaigns.

c. Evaluating the impact of policy measures in minimising NCD risk particularly among children, adolescents and youth and other vulnerable groups (e.g., girls and women; low socio-economic strata; rural and semi-urban populations).

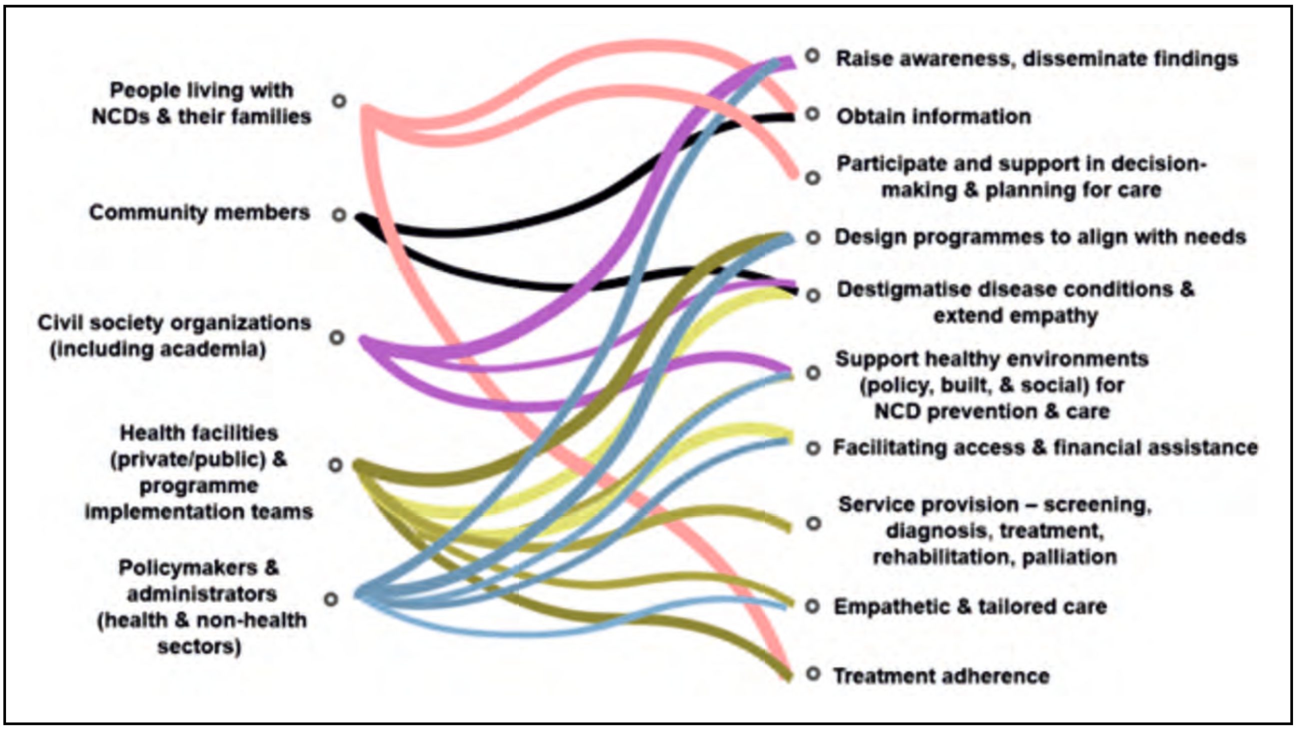


Figure 5: Actions recommended for actors/stakeholders to enhance equity in NCD care

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Secretariat

Healthy India Alliance [India NCD Alliance]

N-25, 2nd Floor, Green Park Extension,
New Delhi 110016, India
☎ +91 11 41031191
fb.com/HealthyIndiaAlliance
https://x.com/HIA_NCD
https://healthyindiaalliance.org/
hiasecretariat@hriday-shan.org