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Health Status of SAR Countries – An Inquest

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Abstract: The South Asian region, home to more than one-fifth of the global population (1.74 billion), is at a crucial juncture in health system evolution, where it can leverage the new social and economic order by way of reducing health disparities, enhance population health, and be crisis resilient. Health systems oriented towards Public Health Care (PHC), that integrate essential public health functions, are better positioned to detect, respond to, and recover from crises. To that end, PHC-oriented health systems will support the Universal Health Coverage (UHC) movement, and advance the wider agenda of sustainable development in the region. This paper is an exploratory study to understand the healthcare status of the countries through review of published health service data, articles, reports, and interactions with some public health professionals. Based on the same, the authors attempted to summarize the current health care status of the SAR countries and suggest the way forward.

Keywords: SAR, PHC, health care, governance, cross-sectoral initiatives.

Preface

The public healthcare system in countries of South Asian Regional Cooperation (SAR), including India, Pakistan, Bangladesh, Nepal, and Sri Lanka, places significant emphasis on Primary Health Care (PHC). On record, 1·74 billion people, corresponding to 22% of the global population, live in south Asian countries. SAR is dynamic and undergoing numerous changes. The regions capacity to reduce health disparities, enhance population health, and be crisis resilient will largely decide its place new global economic system. The effect of demographic, and epidemiological,

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transitions, such as the growth of the aging population and the escalation of the burden posed by non-communicable diseases, are also increasingly apparent in this region, with a consistent rise in population numbers, an ageing population, and a significant burden from both communicable and non-communicable diseases, and high out-of-pocket (OOP) spending. In South Asia, the core principles of PHC, such as concern for equity, community participation, intersectoral coordination, appropriate technology and health promotion, have historically been an integral part of policy intent [1, 2, 3]. All five countries were signatories to the Alma Ata Declaration in 1978 [4, 5, 6, 7] made noticeable progress since the early days of commitment to PHC. In all five countries, the foundation of a hierarchical health delivery structure in the public sector, with a broad base for PHC service delivery, has been established, though the structure varies in specifics [8]. All five countries have established Community Health Worker (CHW) programs. Overall gains in the region with regard to prevention and control of infectious diseases, and improved maternal and child health outcomes have been noted.

Objectives

This study on the current health status of South Asian Association for Regional Cooperation (SAARC/SAR) countries aims to provide a preliminary, comprehensive overview of the region's health landscape with the objectives of –

- Mapping the Current prevalence of diseases
- Analyzing primary health care performance.
- Analyzing gaps in the health system and infrastructure.
- Identifying regional similarities and disparities.
- Examining environmental and socio-economic factors.
- Considering emergency preparedness and response.
- Identifying opportunities for regional cooperation.

With the above objectives, the study attempted to analyze the current health status in SAR countries, explore the disparities in health infrastructure, focusing on the rising burden of non-communicable diseases and low public health spending.

Methods

In conceptualizing this paper, the author drew upon the Astana Declaration definition of PHC, which describes three inter-related components of PHC, including integrated health services; empowered people and communities; and multisectoral policy and

action. Although PHC performance might be reported at the provincial, regional, or national level, we have preferred the use of national estimates wherever available to facilitate comparisons across SAR countries. The methods for our review were multifold: a targeted literature review; data repositories; and appraisal of personal experience of manuscript authors. For the purpose, a targeted literature review with the use of PubMed, supplemented by a non-indexed literature search to collate the evidence on the framework-specific quantitative and qualitative indicators of the WHO-UNICEF PHC measurement framework were done. Thematic analysis of the available data, using thematic categorization to identify trends in health system, was done. Besides, media reports and health publications were analyzed. Public health professionals holding working experiences in SAR countries were interacted with to get suitable understanding of the healthcare systems prevalent in the countries.

Outline-of the demographic and economic conditions across selected south Asian countries, the disease burden and the performance of health systems is given below (figure 1)

SAR COUNTRIES →	Bangladesh	India	Nepal	Pakistan	Sri Lanka
Demographic status					
Total population in 2021 (in millions)	169	1407	30	231	22
Urban population in 2021 (%)	39%	35%	21%	37%	19%
Population older than 65 years in 2021 (%)	6%	7%	6%	4%	11%
Life expectancy at birth in 2020	72	70	69	66	76
Fertility rate (births per woman)	2·0	2·1	2·1	3·6	2·0
Economic status[2]					
GDP per capita in 2021 (US$ PPP)	2458	2257	1208	1505	4014
GDP growth in 2023 (annual %)	6%	6·1%	5%	3·5%	−3%
Poverty headcount ratio at $2·15 a day in 2017 PPP (% population)	13·5%	10·0%	8·2%	4·9%	1·3%
Disease profile (proportional morbidity percentage)[3–8]					
Maternal disorders	0·2%	0·3%	0·3%	0·5%	0·2%
Neonatal preterm birth	1·4%	1·2%	1·3%	1·2%	0·8%
Diarrheal diseases	1·9%	1·8%	2·2%	2·1%	1·1%
Nutritional deficiencies	23·2%	32·6%	24·2%	31·8%	17·4%
Stunting among children younger than 5 years	31%	36%	36%	38%	17%
Malaria	0·0%	0·4%	0·1%	0·6%	0·0%
HIV/AIDS	0·01%	0·13%	0·09%	0·03%	0·01%
Tuberculosis	7·8%	27·6%	14·6%	15·3%	29·2%
Cardiovascular diseases	5·3%	5·2%	4·1%	4·0%	6·4%
Hypertensive heart disease	0·1%	0·1%	0·0%	0·1%	0·4%
Diabetes	4·4%	6·3%	4·8%	4·2%	11·3%
Neoplasms	2·0%	2·6%	1·9%	1·9%	5·1%
Mental disorders	11·8%	13·8%	13·5%	12·1%	11·9%
Injuries	18·7%	22·6%	20·5%	14·6%	27·2%
PHC markers (%)[9]					
Immunisation of 1-year-old children with DPT3 in 2021	98%	85%	91%	83%	96%
Skilled birth attendance in 2019	59%	89·4%	77·2%	68%	99%
Hypertension treatment coverage (by latest specified year)	34·9%	16%	9·5%	22·3%	28·2%

Figure 1: Source: The Lancet Global Health 2024 paper

The figure above provides an overview of demographic and economic conditions across SAR nations, the disease burden and performance of health systems. The color gradients highlight the highest, high, middle, low, and lowest values of indicators.

The overview of primary health care in the region from a situational perspective is projected below (figure 2)

	Bangladesh	India	Nepal	Pakistan	Sri Lanka
Community level (first contact)	Satellite clinic, outreach services, and community clinics	Outreach Services	Outreach services and community health units	Outreach services	Medical officer of health—field clinics
	Community health-care provider, family welfare visitor, family welfare assistant, health assistant, skilled birth attendant, village health worker, and community midwife	Multipurpose health worker, accredited social health activist, and Anganwadi worker	Female community health volunteer, auxiliary nurse and midwife, and auxiliary health worker	Lady health worker and lady health volunteer	Medical officer, public health midwife, public health inspector, public health nurse supervisor, supervising public health midwife, and field officer
Primary level	Union health centre, rural health centre, and family welfare centre	Subcentre—Health and Wellness Centre (now renamed as Ayushman Arogya Mandir)	Health posts	Basic health units	Primary care medical units, municipal clinics
	Medical officer, sub-assistant community medical officer, nurse, and patient care attendance	Community health officer, multipurpose health worker	Health assistant, auxiliary nurse and midwife, auxiliary health worker, senior auxiliary nurse and midwife, and senior auxiliary health worker	Medical officer, lady health volunteer, dispenser, trained birth attendant and wound dresser	Medical officer, nursing officer, dispenser, public health midwife, and attendant
Higher primary level	Upazila Health Complex	Primary Health-care Centre Ayushman Arogya Mandir, Urban Primary Health-Care Centre	Union health centre, primary health-care centre	Rural health centre	Divisional hospitals (A, B, and C)
	Maternal child welfare officer, medical officer, residential medical officer, nurse, lab technician, pharmacist, skilled birth attendant, and family planning officers	Medical officer, nurse, pharmacist, and lab technician	Medical officer, health assistant, nurse, auxiliary health worker, auxiliary nurse midwife, lab technician, and village health worker	Medical officer, nurse, lady health volunteer, nursing assistant, dental technician, vaccinator and lab technician	Medical officer, nursing officer, pharmacist, and dispenser

From the above framework it is noticeable that in SAR nations, public health services are delivered by clearly defined government agencies. Public Health Care structures are arranged in a hierarchical fashion at the community, primary (first point of facility contact), and higher primary (first referral point) levels. Even though things vary quite a bit between different countries in South Asia, when it comes to how they deliver primary health care (PHC) services in rural versus urban areas, there's a noticeable trend. In rural areas, community health workers are really woven into the fabric of the PHC services, making everything run smoothly. However, in the bustling urban settings, things tend to be more improvised and less organized. The operation of primary healthcare in rural and urban regions significantly differs due to several important factors. It depends on how accessible these locations are geographically, the level of trust and acceptance people have for community health workers, and presence of medical doctors and health facilities. Additionally, the distinct cultural elements and varying health requirements influence the manner in which activities are conducted in each region.

Observations

Based on the above methodology adopted, the essential PHC domains of health protection, health improvement, and health service status of the SAR countries, as analyzed, can be enumerated briefly as follows-

Decentralized Administration: The countries typically have a three-tiered governance structure with policy making and oversight at the central level, and responsibility of service delivery delegated to the lower tiers of the government [9]. A few studies have shown a positive effect of devolution of PHC governance on service utilization in Pakistan, India, and Nepal, [10,11] whereas the potential benefits of decentralization on the reduction in inequities does not appear to have been fully realized due to differential political and bureaucratic support, local capacities, clarity in responsibilities, and the perceived autonomy of community representatives in decision making and the degree to which the locally made decisions are accepted for planning, budgeting, human resource management, and service delivery.

Governing with community involvement: Community engagement in the region is facilitated through the institutionalization of statutory health committees, hospital boards, and councils for oversight, advocacy, and social mobilization [12, 13]. The SAR has examples of models of successful community empowerment, such as BRAC's Shasthya Shebika community health worker programme in Bangladesh, the Self-Employed Women's Association's Shakti Kendras in India, Sarvodaya programmes in Sri Lanka, and many more [14,15]. These civil society-run models have played a crucial role in accelerating integrated human development with the focus on social factors influencing health, fostering social mobilisation and community action for health, raising awareness on socially important issues, delivering health-care services, and promoting equity [16, 17]. However, they have had a poor effect as a governance structure [18, 19]. The ambiguity in roles and function, constrained financial resources and administrative skills, absence of power to enforce decisions, and low recognition and incentivisation are important explanatory factors that cripple meaningful participation of members in the health committees through these health committees.

Initiatives with cross-sectoral governance: Multisectoral action is one of the three pillars of PHC to address social, behavioural, environmental, and commercial determinants of health [20,21]. Although multisectoral action has been featured in national health policies [22], its full potential remains under-utilized in the region due to political and technical factors. First, PHC and the factors influencing health

outcomes have not been adequately framed in political agendas. Second, instead of adopting a leadership role, the health sector tends to play a minimal supporting role for cross-sectoral policies, due to implicit ministerial hierarchies. Third, different departments and ministries have distinct mandates and priorities, undermining coordination for multisectoral action [23, 24].

Partnership with the private sector: The private sector delivers about 50–69% of outpatient treatment across the SAR countries and owns a substantial pool of health-care resources in the region. Various models of engagement with private sector providers, such as contracting-in, contracting-out, voucher systems, mobile health services, ambulances, insurance, subsidies, legal dual practice for doctors, private sector and community involvement in the management of PHC facilities, and participation of informal providers in poliovirus vaccination drives and treatment for tuberculosis have been implemented [25,26,27]. However, different conceptual understandings of public–private partnerships among stakeholders, political affinities, antipathy from government PHC staff due to apprehension of job loss, increased accountability under private sector management, and delayed payments have led to sub-optimal implementation of public–private partnerships.

Funding: Actual expenditure on PHC as a proportion of total public health financing is much lower than the aspirational commitments in policy documents. SAR countries have helped spur innovation in negative user fees through the introduction of demand-side conditional cash transfers in the social sectors including nutrition, education, women's development, and health [28, 29]. Such interventions have typically been put in place to promote health-care utilisation by offsetting financial costs and incentivising healthy behaviours. They hold a unique relevance in the SAR, a region with extant multidimensional deprivations and have been associated with increased PHC utilization. However, health financing systems are negatively affected by high fragmentation, low-risk pooling, and passive purchasing with predominantly input-based resource allocation and rigid vertically oriented financial flows. Devolution has improved financing in a few areas. However, inefficiencies due to delayed funding release from the central level, and weak budget planning and fund absorption capacities at provincial and district level remain [30, 31].

Human Resources in health care: The region has substantially expanded the pool of human resources, with 3–17 community health workers per 10 000 citizens. However, the region is yet to attain WHO's density threshold of 44·5 health workers per 10 000 population [32]. SAR countries have adopted different measures to ensure

equitable access to quality health-care workforce, such as strengthening health workforce governance through formation of human resources for health units and accreditation bodies, development of related policies and plans, such as decentralised recruitment, and development of workforce information systems. However, the region struggles to achieve an appropriate skill-mix and concentration of human resources is skewed towards urban areas, which implies a need for innovative strategies to retain PHC providers particularly in rural areas.

Availability of medications and medical supplies: The essential service packages at PHC level list medicines and diagnostics to be provided at no cost to the population. The SAR countries list a number of medicines varying from 91 to 228 drugs in their essential medicine lists, which are to be provided at first point-of-care health facilities. The medicines for maternal and child health are widely available at public PHC facilities in the SAR. However, availability of drugs for NCDs in these health facilities is sub-optimal in the countries, except for Sri Lanka [33]. Despite the existence of standard treatment guidelines, unnecessary use of medicines is widespread in the region due to non-adherence to the guidelines and infrequency of clinical and prescription audits. The mean percent of prescriptions with antibiotics at PHC facilities in SAR countries was reported to be 50·6%, with the lowest antibiotic prescription rate of 23·6% in Sri Lanka [34]. The governments in SAR have established price control mechanisms for a range of medicines (60–376 drugs) across nations, but this initiative has not been sufficient to remove financial barriers for access to medicines [35]. Notably, adequate budgetary allocations, scientific demand estimation and inventory management, well maintained distribution systems, and digitally enabled quality control mechanisms have improved the availability of medicines at PHC facilities in a few provinces across the sub-continent [36].

Health information systems and digital technologies: The SAR countries already have non-digital systems in place, but there are a few noteworthy challenges that limit the use of data in evidence-based decision making for PHC. First, there is a varied degree of completeness and quality of data [37]. Second, the private sector, which provides more than half of outpatient primary care, is not mandated to provide information via standard health information system tools, leading to incomplete data on available resources, overall utilisation of PHC services, and related performance in terms of quality of care (access, continuity of care, comprehensiveness, effectiveness, safety, and efficiency). Third, infrastructural constraints and poor digital literacy among community health workers in SAR restricts the uptake and use of digital

information systems [38]. Fourth, insufficient coordination and interoperability within and between various tiers of healthcare (primary, secondary, and tertiary care) leads to fragmented and duplicate data [39]. Nevertheless, the countries are moving steadily to promote interoperability through policies and standards for the adoption of digital technologies, with addition of digital initiatives, such as virtual healthcare services, digitized point-of-care testing, disease surveillance and monitoring, supply chain management, e-prescriptions, decision support systems, and artificial intelligence, have been deployed in the region to bridge the gaps in PHC service delivery [40,41].

Care models: The region has three-tiered government health systems with multi-tasking PHC teams in defined catchment areas, partly integrated with the secondary and tertiary care facilities, to promote care continuity. But the sub-continent falls short of establishing a gatekeeping mechanism through the PHC system, due to challenges at the PHC, level including resource constraints, inconvenient consultation hours, staff absenteeism, and absence of a functional referral system, which, combined, lead to low utilization of the government PHC system for treatment of outpatients, with the exception of in Sri Lanka [42, 43]. Cultural competency i.e. the ability to interact effectively with individuals from diverse cultures with suitable awareness to meet others' cultural, and linguistic needs, in the health-care workforce is also constrained by high workload, minimal exposure to PHC settings during pre-service period of the medical professionals, and doctors' disinterest in PHC roles as opposed to specialist roles [44].The fragmentation of service, siloed organization across sectors, and few channels of communication between care providers poses additional challenges for the care continuum. The countries have initiated modest steps to strengthen management and accountability systems through developing cadres that manage healthcare delivery at the district or cluster levels (Sri Lanka and India), team-based incentives in PHC (India), and the generation of unique patient identifiers to integrate health care in Bangladesh, India, and Sri Lanka [45]. The evidence suggests there is inadequate outpatient consultation time per patient in the region, ranging from 48 s to 4 min, augmented with substantial scope to improve respectful care to increase people's satisfaction with the public health system [46].

The path ahead

SAR is home to more than one-fifth of the world's population. This region accounts for 27% of global communicable, maternal, neonatal, and nutritional diseases, and

23% of global NCDs. The SAR also reports 21% of the global mortality due to all causes, with 25% of premature deaths. The region is currently challenged with health inequalities that persist across provinces and economic strata, healthcare set ups location and waiting times, and economic instability in some countries that make advocating for increased healthcare investment difficult. The region, therefore, needs to bolster its actions to alleviate disease heavy load for both social and economic development. PHC provides a cost-effective strategy to close the equity and efficiency gaps, especially during the current poor financial situation in the region. SAR countries have initiated reforms to strengthen the building blocks for PHC between 2018 and 2023 [47], however there is a need to rethink strategies around the philosophy of PHC and to act beyond established frameworks. The overall pathway emphasizes moving beyond traditional facility-base care to a comprehensive, whole-of-society approach to achieve universal health coverage (UHC).

To bridge the gap between academic frameworks and field-level implementation, the surfaced evidence strongly supports practical, context-sensitive policy actions based on successful regional experiences. For example, scaling up India's AB-PMJAY model, which has effectively improved healthcare access for millions through nationwide portability and simplified beneficiary processes, would significantly strengthen financial protection. Nepal's community-involved national health insurance initiative provides another actionable blueprint, demonstrating improved PHC coverage outcomes through active stakeholder engagement. Meanwhile, Bhutan and Sri Lanka offer proven tax-funded universal healthcare models that significantly reduce out-of-pocket spending and ensure equitable access. Thus, policy measures emerging out of stakeholder engagement and learnings from regional best practices should offer a workable route that could secure suitable gains in health outcomes and fair PHC implementation throughout south Asia region countries. South Asia is confronted with a critical issue that requires confronting both persistent infectious diseases and the rising tide of NCDs while also strengthening foundational health.

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