

NITI Aayog's Health Index

The NITI Aayog has come up with its Health Index for Indian states. The latest Health Index released in June 2019 titled “Healthy States, Progressive India,” provides a snapshot of the current status of the health sector across Indian states and union territories.

Details:

- It is the Second Edition of “Healthy States, Progressive India” report.
- The first round of the Health Index was released in 2018, which measured the annual and incremental performances of states and UTs for period 2014-15 (base year) to 2015-16 (reference year).
- The report has been prepared in collaboration with the Ministry of Health and Family Welfare with technical assistance from the World Bank.
- The Index ranks the States and Union Territories based on 23 health-related indicators, including neonatal mortality rate, under-five mortality rate, proportion of low birth weight among new-borns, proportion of districts with functional Cardiac Care Units, full immunisation coverage and proportion of specialist positions vacant at district hospitals.
- These 23 indicators were divided into three broad domains:
 - Health outcomes (10 indicators);
 - Governance and information (3 indicators); and
 - Key inputs/processes (10 indicators).
- The ranking is done under three categories — larger states, smaller states and Union territories (UTs). This ensures comparison among similar entities.

Findings of the report:

- Kerala has occupied the top slot in terms of health performance while Uttar Pradesh retained the worst performer tag.
- Kerala is followed by Andhra Pradesh, Maharashtra, Gujarat, Punjab, Himachal Pradesh, Jammu and Kashmir, Karnataka and Tamil Nadu.
- States at the bottom of the list were Uttar Pradesh, Bihar, Odisha and Madhya Pradesh.
- Only about half the States and UTs have showed an improvement in the overall score between 2015-16 and 2017-18.
- Kerala and Tamil Nadu have already reached the 2030 SDG target for neonatal mortality rate (NMR), which is 12 neonatal deaths per 1,000 live births.
- The general positive correlation between the Health Index scores and the economic development levels of states and UTs as measured by per-capita net state domestic product (NSDP) has been highlighted in the report.

Significance of the Index

- Health Index has been developed as a tool to leverage co-operative and competitive federalism to

accelerate the pace of achieving health outcomes.

- It would also serve as an instrument for “nudging” States & Union Territories (UTs) and the Central Ministries to a much greater focus on output and outcome-based measurement of annual performance than is currently the practice.
- With the annual publication of the Index and its availability on public domain on a dynamic basis, it is expected to keep every stakeholder alert to the achievement of Sustainable Development Goals (SDGs) Goal number 3.

Criticisms:

- Weightage assigned to the three domains while calculating the index is different for each of the category i.e, larger states, smaller states and Union territories (UTs). This distorts the understanding of the index.
- The data source for constructing the index is based on departmental reporting, the Health Management Information System (HMIS), and the state-run vertical disease control programme. HMIS, notoriously known for over-reporting, misreporting, and time lags.
- The report acknowledges that there are huge disparities in the data integrity measures across states and UTs.

Problems with Indicators:

- Crucial indicators of health outcomes are missing or are not considered for constructing the index.
 - For example, indicators widely used as “health outcomes” in World Health Statistics of WHO, such as life expectancy at birth, maternal mortality, disability adjusted life years, including incidence of malaria, are not considered.
 - Redundant indicators such as sex ratio at birth (SRB) are included in constructing the index. The SRB is an outcome indicator for gender disparity, but certainly not for health attainment. Thus, even if a population suffers from poor health, the natural ratio would not alter without human intervention.
 - Similarly, the health of a population cannot be judged based on its total fertility rate (TFR) which is another indicator that is considered.
- Further, the health input domain does not consider crucial indicators.
 - For example, indicators widely used as “inputs” in the World Health Statistics, such as doctors per thousand population, hospital beds per thousand population, nursing and midwifery personnel per thousand population, people with potable drinking water supply, per capita government spending on health, percentage of people with health insurance, and percentage of population using clean fuel were not considered.
- Also, the out-of-pocket expenses and per capita health expenditure, which are widely used in constructing indices, have not been considered.
- There is a lot of multicollinearity within a group of indicators. Tuberculosis (TB) and HIV are correlated, and then there are two similar indicators for TB (notification rate + success rate, whereas only prevalence of TB in a population would suffice as a health outcome indicator).
- The indicators do not justify the overcrowding in public health facilities and access to healthcare. While other standard reports would use these ratios as input indicators, this report does not.

Inferences Drawn:

- The time window in the report for measuring incremental change is extremely small. 2015–16 (base year) against 2017–18 (reference year). Most of the health outcomes do not have a direct intervention to response rate in one year.
- To conclude with some degree of confidence about improvement or decline, at least three consecutive data points are needed. The inference, therefore, is grossly misleading.

Conclusion:

The report would come handy in understanding how the states are doing in public health at any given point. However, to assess whether the state is making progress or not (as this report does) would be erroneous, as no time-series data is available.

