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Perspective

Ethics, Discrimination, and Dignity: A Shared Institutional Failure in Indian Healthcare

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Abstract

Social position shapes healthcare access and experience in India, while Accredited Social Health Activists often work under insecure and weakly protected conditions. This perspective argues that patient-facing mistreatment and worker-facing precarity reflect linked accountability gaps rather than separate ethical problems. Evidence from childbirth care, caste- and class-linked waiting-time inequities, community health worker policy, and public insurance implementation shows that formal access does not necessarily ensure accountable care. Existing reforms have expanded standards, financing, ethics training, and digital systems, but program intent alone cannot ensure remedy when patients or workers experience harm. Dignity should therefore be treated not only as an ethical aspiration, but as a measurable, auditable, and enforceable health-system function.

Key Words: Accountability, Discrimination, Ethics, Healthcare equity, India

Introduction

India has substantially expanded public health programmes and financial-protection reforms, including the National Health Mission (NHM), Ayushman Bharat Health and Wellness Centres, now known as Ayushman Arogya Mandirs, and Pradhan Mantri Jan Arogya Yojana (PM-JAY).[1-4] National data also show persistent inequities in health and service-use indicators.[5] The National Family Health Survey-5 documents variation by caste, sex, residence, and wealth; for example, 97% of births to mothers in the highest wealth quintile were delivered in a health facility, compared with 76% of births to mothers in the lowest wealth quintile.[5] National Health Accounts estimates for 2022–23 show that out-of-pocket expenditure has declined but remains a major component of health financing.[6] This perspective argues that coverage expansion alone cannot address the accountability gap examined here. Discrimination in Indian healthcare has been described as something that can "mask itself," appearing as routine administrative or clinical practice rather than as a named violation.[7] Structural inequality is also reproduced through policy and financing arrangements, while patient-facing mistreatment is shaped by professional hierarchy, supervision, and training environments.[7-10]

Read together, literatures on patient mistreatment and community health worker precarity suggest a shared institutional problem: India has developed standards, financing mechanisms, and digital systems, but accountability for dignity, respectful care, and worker protection remains uneven and weakly enforceable.[4,8,10-16]

Patient-Facing Discrimination Is Documented, but Often Context-Specific

Shaikh et al.[17], using India Human Development Survey data, found that caste/social class was associated with waiting time at health facilities, with the association mainly observed in private rather than government facilities. Pol A.[18] (2020), in a critical review, described casteism as a professional concern in medical education, collegial relationships, and patient care.

Childbirth is one of the better-documented settings for mistreatment in the Indian literature.[19-21] A systematic review of India-based studies reported disrespect and abuse estimates ranging from 10% to 77.3%, depending on setting, measurement, and study design.[19] Among slum-resident women in Lucknow, Uttar Pradesh, more than 57% reported at least one form of mistreatment during facility delivery.[20] In rural Varanasi district, 28.8% of women reported abusive behaviour when inappropriate payment demands were excluded; payment demands were reported by 90.5% of women and were analysed separately because of their high frequency.[21] These findings should not be read as national prevalence estimates, but they show that mistreatment is not merely anecdotal.[19-21]

Policy and normative frameworks also recognize these concerns.[22,23] The Labour Room Quality Improvement Initiative, LaQshya, names respectful maternity care and positive birthing experience as program goals.[22] WHO

recommends respectful maternity care that maintains dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth.[23] In routine outpatient and inpatient encounters, accountability gaps may appear as longer waits, limited explanation of entitlements or care processes, and inadequate attention to consent, privacy, or respectful communication.[15,17,23] Program intent, however, should not be treated as evidence that mistreatment is consistently measured, independently investigated, or remedied.

The available evidence also points to institutional mechanisms rather than only individual misconduct. [8,10] A study in two public teaching hospitals in Southern India suggests that practical medical training, supervision gaps, hierarchy, reliance on overworked peers, and clinical-outcome prioritization can shape how respectful intrapartum care is learned.[10] Interviews with midwifery and nursing leaders similarly identified workload, medical hierarchy, bullying, and powerlessness as contributors to disrespect and abuse during childbirth.[8] India's Attitude, Ethics and Communication (AETCOM) framework identifies ethics, communication, respect, and accountability as competencies for medical graduates.[11] The central problem is therefore not the absence of ethical language, but the limited enforceability of that language in everyday care.[8,10,11]

Worker-Facing Precarity Reflects a Parallel Accountability Gap

Accredited Social Health Activists, or ASHAs, are India's nearly one-million-strong female community health workforce and are central to public health outreach, maternal and child health, immunization linkage, and community-level health promotion.[12,13] Evidence and policy analyses describe delayed or inadequate incentives, work expenses, task-based remuneration that does not fully reflect actual workload, limited labour protections, and safety concerns.[12-14]

The designation of ASHAs as volunteers rather than regular employees contributes to weak access to standard employment protections, even as the health system relies on their labour for essential public health functions.[12,13] Policy adaptations have improved some areas, including access to income, knowledge, career pathways, and recognition, but they have not fully resolved concerns about employment status, timely payment, occupational safety, and enforceable rights.[13]

The parallel with patient mistreatment is conceptual but policy-relevant. In both cases, people with limited institutional leverage absorb costs that the system has not adequately internalized: women and marginalized patients may absorb disrespect or denial of information, while ASHAs may absorb delayed payment, unpaid expenses, or safety risk.[12-14,19-21] The common issue is not that every facility or provider behaves abusively, but that obligations on paper are not consistently connected to consequences in practice.

Financing and Digital Reforms Do Not Automatically Produce Accountability

PM-JAY illustrates the limits of a financing-only strategy.[15] The scheme was designed to provide publicly funded inpatient insurance for a very large eligible population, but implementation studies in selected states describe beneficiary-identification problems, information gaps, hospital-process barriers, claims-processing challenges, and variation in beneficiary experience.[4,15] Empanelment analyses also show uneven availability of specialties across states and facility types.[24] These findings are relevant to public-private purchasing: when private-sector participation is unevenly distributed or selective in the services offered, insurance expansion may shift inequity into provider availability, referral pathways, and administrative navigation rather than eliminate it.[15,17,24] These findings do not negate PM-JAY's importance for financial protection. Rather, they show that coverage is not the same as accountable care.[4,15]

Available PM-JAY implementation studies focus heavily on eligibility, information, claims, hospital processes, satisfaction, and out-of-pocket payments.[4,15] These are important indicators, but they do not by themselves establish whether patients receive care that meets standards of communication, consent, dignity, privacy, and non-discrimination. Respectful care must be measured directly rather than assumed from enrolment or utilization.[23]

Digital health infrastructure faces a similar limitation. India's Ayushman Bharat Digital Mission (ABDM) seeks to create interoperable digital health records through tools such as Ayushman Bharat Health Accounts and personal health records, but digital health strategy also raises concerns about infrastructure, rural connectivity, digital literacy, and privacy/security.[16] Digital systems may improve continuity and documentation, but they may also reproduce inequity when connectivity, digital literacy, documentation requirements, or privacy protections are uneven across populations and facilities.[16] A digital record of a transaction is not evidence that the transaction was respectful.[16,23]

Financing and digital reforms should therefore be evaluated not only by coverage, utilization, and claims indicators, but also by whether they create enforceable routes for patients and workers to report harm, obtain

remedy, and trigger institutional correction.

Toward Enforceable Accountability

If the shared failure is an accountability gap, the policy response should focus on enforceable mechanisms rather than only additional training modules, wider eligibility, or more digital infrastructure. Three changes follow.

First, grievance redressal for disrespect, denied entitlements, privacy violations, and informal payment demands should be independently auditable and should not depend solely on the hierarchy of the treating facility. Evidence from childbirth mistreatment studies and PM-JAY beneficiary-experience studies shows that harms and access barriers can occur even when services formally exist.[15,21] WHO's respectful-care framing also emphasizes dignity, informed choice, privacy, confidentiality, and freedom from harm and mistreatment.[23] Facility satisfaction data may be useful, but they should not be the only measure of accountability.[23]

Second, ASHA compensation and safety protections should be monitored through transparent indicators, including payment timeliness, unpaid work expenses, safety incidents, and complaint resolution. Ved et al.[13] (2019) and Sarin et al.[14] (2016) show that incentive design and payment arrangements are not merely administrative issues; they shape the fairness and sustainability of community health work. Shanthosh et al.[12] (2021) further argues that ASHA rights, labour protections, and occupational safety are central to universal health coverage rather than peripheral workforce concerns.

Third, AETCOM competencies should be linked more clearly to institutional consequences. Curriculum statements on respect, consent, communication, and accountability are necessary, but they are insufficient if violations are not visible in credentialing, supervision, and accreditation systems. [11] Critical concerns about casteism in medical education and patient care, together with evidence on training culture in intrapartum care, support the need to connect ethics teaching with measurable institutional accountability.[10,18]

These proposals build on existing standards and some reporting systems, although implementation may require regulatory, accreditation, or administrative changes.[11,15,22,23] The key shift is conceptual: accountability should be treated as a measurable health-system function, not as an assumed by-product of coverage, training, or digitization.

Conclusion

India does not lack ethical standards, financing reforms, or digital-health ambition. The more persistent gap is enforceability. Evidence on childbirth mistreatment, caste/class-linked waiting time, PM-JAY implementation barriers, and ASHA precarity points toward a shared problem between stated obligation and practical remedy. Patient-facing mistreatment and worker-facing precarity should therefore not be treated as unrelated policy issues. Both reveal how dignity can remain weakly protected when standards exist, but accountability is diffuse. Continued expansion of coverage, curricula, and digital systems without stronger accountability risks reproducing documented patterns of disrespect, exclusion, and precarity. Making accountability auditable, external, and consequential is a narrower and more testable reform target than invoking equity as a general aspiration.

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