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Socio-Economic Inequality and its Effect on Healthcare Delivery in India: Inequality and Healthcare

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KEYWORDS

Introduction

Most proposals aimed at reducing socioeconomic inequalities in health are based on complementary interventions: those focusing on the proximal determinants of inequalities and those whose objective is to change the distribution of basic socioeconomic conditions. Proposals for the first type of intervention are based on the idea that socioeconomic conditions affect health largely by means of diverse material, psychosocial, and behavioral risk factors, which are more prevalent in lower socioeconomic groups. Proposals for the second type of intervention involve the implicit assumption that health inequalities will be reduced if the health of individuals in lower socioeconomic groups is improved. It is assumed that fiscal and socioeconomic policies aimed at distribution of income, employment, and family welfare and provision of public services such as health care and education are justified because they cushion the effects of inequalities in the labor market and improve the material conditions of individuals who are socioeconomically disadvantaged, thereby improving their health status.

However, a more egalitarian distribution of the socioeconomic determinants of health is not necessarily accompanied by smaller socioeconomic inequalities in health. A study comparing socioeconomic inequalities in health in the 1980s in various European countries revealed smaller relative health inequalities in countries such as Spain and Switzerland, which had greater income inequalities during that period; the Nordic countries, which are traditionally more egalitarian, exhibited the largest inequalities in health. A cross-sectional study comparing different regions in Spain during the 1980s did not show any relationship between income inequality and inequality in disability. Increased inequalities in mortality in the Nordic countries were observed in the final decades of the 20th century, a period during which levels of income inequality remained constant. Nevertheless, some authors have criticized the isolated use of relative measures to compare health inequalities and are in favor instead of incorporating absolute measures to evaluate the effects of public policies.

In any case, little research has been conducted comparing the evolution of socioeconomic inequalities and inequalities in health, even though "natural experiments" have offered many opportunities for such studies during periods that have produced changes in the distribution of socioeconomic determinants of health for reasons other than the association of those determinants with health. This was the strategy followed in the present study, in which we estimated health inequalities in Spain in the mid-1980s and the interval surrounding the year 2000, a 15-year period characterized by major social and economic investments resulting from Spain's entry into the European Union. In 2000, the richest 5% of the population was wealthier than in the mid-1980s, but the 50% of the population at lower income levels had increased in terms of its share of total incomes as well, and consequently there was no increase in income inequality. Also, regional per capita income in Spain moved closer to the European Union average during this period, and inequalities in regional per capita income were reduced.

"In the beginning, there was desire which was the first seed of mind," says Rig-Veda, which probably is the earliest piece of literature known to mankind. This desire for a healthy family, healthy society and a healthy country drives individuals and governments alike. The government is supposed to create settings that will provide equal opportunity for an individual to fulfill these desires. There is an undisputed association between this social equality, social integration and health. The effect of social integration on health is conclusively documented in the theory of 'social support'. The effect of social and economic inequality on health is profound too. Poverty, which is a result of social and economic inequality in a society, is detrimental to the health of population. The outcome indicators of health are all directly influenced by the standards of living of a given population. More so, it is not the absolute deprivation of income that matters, but the relative distribution of income. Various international studies have documented a strong association between income inequality and excess mortality. In a study by Kennedy et al, income inequality was shown to directly affect the total mortality in a given population. The same study measure income inequality by 'Robin Hood Index', which is the part of income that needs to be redistributed from the rich to the poor to achieve economic equality. 1% rise in this index led to 21.7 excess deaths per 100,000 populations. This shows the profound effect income inequality has on the health of a population.

When applied to Indian context these social theories translate into millions of lives that perish due to a lack of socio-economic equality. Since the emergence of free India in 1947, economic egalitarianism dominated the economic policies. Socialism and government-centered economic policies were favored over the profit-making private enterprise and capitalism. Though admirable for its motives, these policies led to over-dependence on the bureaucracy and stifled the growth of free enterprise. Slow and unequal social mobilization in various parts of India led to an uneven economic growth. Caste and social polarization, literacy and educational levels, natural resources, levels of corruption and role of political leadership has resulted in some Indian states doing better than others on the economic front. This basic inequality was magnified by the rapid but unequal economic growth that India has witnessed in the last two decades. Amidst the rising standards of living, lie pockets of terrible poverty and deprivation.

Unequal Distribution of Healthcare Resources India.

Healthcare resources in India though not adequate, are ample. There has been a definite growth in the overall healthcare resources and health related manpower in the last decade. The number of hospitals grew from 11,174 hospitals in 1991 (57% private) to 18,218 (75% private) in 2007. In 2000, the country had 1.25 million doctors and 0.8 million nurses. That translates into one doctor for every 1800 people. If other systems including Indigenous System of Medicine (ISM) and homeopathic medicine are considered, there is one doctor per

800 people. It not only satisfies but also betters the required estimate of one doctor for 1500 population. Approximately 15,000 new graduate doctors and 5,000 postgraduate doctors are trained every year. The country has an annual pharmaceutical production of about 260 billion (INR) and a large proportion of these medicines are exported.

To a casual observer this looks like a good proportion, however on further study, unequal distribution of resources becomes apparent. The ratio of hospital beds to population in rural areas is fifteen times lower than that for urban areas. The ratio of doctors to population in rural areas is almost six times lower than that in the urban population. Per capita expenditure on public health is seven times lower in rural areas, compared to government health spending for urban areas. Though the spending on healthcare is 6% of gross domestic product (GDP), the state expenditure is only 0.9% of the total spending. People using their own resources spend rest of it. Thus only 17% of all health expenditure in the country is borne by the state, and 82% comes as 'out of pocket payments' by the people. This makes the Indian public health system grossly inadequate and under-funded. Only five other countries in the world are worse off than India regarding public health spending (Burundi, Myanmar, Pakistan, Sudan, Cambodia). As a result of this dismal and unequal spending on public health, the infrastructure of health system itself is becoming ineffective. The most peripheral and most vital unit of India's public health infrastructure is a primary health centre (PHC). In a recent survey it was noticed that only 38% of all PHCs have all the essential manpower and only 31% have all the essential supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs.

The reduction on public health spending and the growing inequalities in health and health care are taking its toll on the marginalized and socially disadvantaged population. The Infant Mortality Rate in the poorest 20% of the population is 2.5 times higher than that in the richest 20% of the population. In other words, an infant born in a poor family is two and half times more likely to die in infancy, than an infant in a better off family. A child in the 'Low standard of living' economic group is almost four times more likely to die in childhood than a child in the 'High standard of living' group. Child born in the tribal belt is one and half times more likely to die before the fifth birthday than children of other groups. Female child is 1.5 times more likely to die before reaching her fifth birthday as compared to a male child 11. The female to male ratios for children are rapidly declining, from 945 girls per 1000 boys in 1991, to just 927 girls per 1000 boys in 200112. Children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups. A person from the poorest quintile of the population, despite more health problems, is six times less likely to access hospitalization than a person from the richest quintile. This means that the poor are unable to afford and access hospitalization in a very large proportion of illness episodes, even when it is required. The delivery of a mother, from the poorest quintile of the population is over six times less likely to be attended by a medically trained person than the delivery of a well off mother, from the richest quintile of the population. A tribal mother is over 12 times less likely to be delivered by a medically trained person . A tribal woman is one and a half times more likely to suffer the consequences of chronic malnutrition as compared to women from other social categories. These figures speak for themselves and bring to the fore unequal distribution of resources and the effect of it on public health parameters. This unequal distribution of resources is further complimented by inability of universal access to healthcare due to various access difficulties.

Access Difficulties to Health Care.

Universal access to healthcare is a norm in most of the developed countries and some developing countries (Cuba, Thailand and others). In India though, pre-existing inequality in the healthcare provisions is further enhanced by difficulties in accessing it. These access difficulties can be either due to

- Geographical distance
- Socio-economic distance
- Gender distance

The issue of geographic distance is important in a large country like India with limited means of communication. Direct effect of distance of a given population from primary healthcare centre on the childhood mortality is well documented. It has been shown that the effect of difficult access to health centers is more pronounced for mothers with less education. The same study also states that distance from private hospitals does not affect the health parameters but the distance from public health centre does. Those who live in remote areas with poor transportation facilities are often removed from the reach of health systems. Incentives for doctors and nurses to move to rural locations are generally insufficient and ineffective. Equipping and re-supply of remote healthcare facilities is difficult and inadequacies due to poor supply deter people from using the existent facilities. Maternal mortality is clearly much higher in rural areas as trained medical or paramedical staff attends fewer births and transport in case of pregnancy complications is difficult. Geographical difficulties in accessing healthcare facilities thus is an important factor, along with gender discrimination, that contributes to higher maternal mortality in women who live in remote areas especially the tribal women in India.

A different aspect of healthcare access problem is noticed in cases of 'urban poor'. Data from urban slums show that infant and under-five mortality rates for the poorest 40% of the urban population are as high as the rural areas. Urban residents are extremely vulnerable to macroeconomic shocks that undermine their earning capacity and lead to substitution towards less nutritious, cheaper foods. People in urban slums are particularly affected due to lack of good housing, proper sanitation, and proper education. Economically they do not have back-up savings, large food stocks that they can draw down over time. Urban slums are also home to a wide array of infectious diseases (including HIV/AIDS, tuberculosis, hepatitis, dengue fever, pneumonia, cholera, and malaria) that easily spread in highly concentrated populations where water and sanitation services are non-existent. Poor housing conditions, exposure to excessive heat or cold, diseases, air, soil and water pollution along with industrial and commercial occupational risks, exacerbate the already high environmental health risks for the urban poor. Lack of safety nets and social support systems, such as health insurance, as well as lack of property rights and tenure, further contribute to the health vulnerability of the urban poor. Though the healthcare facilities are overwhelmingly concentrated in urban areas, the 'socio-economic distance' prevents access for the urban poor. These socio-economic barriers include cost of healthcare, social factors, such as the lack of culturally appropriate services, language/ethnic barriers, and prejudices on the part of providers. There is also significant lack of health education in slums. All these factors lead to an inability to identify symptoms and seek appropriate care on the part of the poor.

The third most important access difficulty is due to gender related distance. It is said that health of society is reflected from the health of its female population. That is completely disregarded in many of the south Asian countries including India. Gender discrimination makes women more vulnerable to various diseases and associated morbidity and mortality. From socio-cultural and economic perspectives women in India find themselves in subordinate positions to men. They are socially, culturally, and economically dependent on men. Women are largely excluded from making decisions, have limited access to and control over resources, are restricted in their mobility, and are often under threat of violence from male relatives. Sons are perceived to have economic, social, or religious utility; daughters are often felt to be an economic liability because of the dowry system. In general an Indian woman is less likely to seek appropriate and early care for disease, whatever the socio-economic status of family might be. This gender discrimination in healthcare access becomes more obvious when the

women are illiterate, unemployed, widowed or dependent on others. The combination of perceived ill health and lack of support mechanisms contributes to a poor quality of life.

Effect on Health Outcome Indicators Due to Economic Inequality

Health standards of a country reflect the social, economic, political and moral well being of its ordinary citizen. Economic and social growth of a society and country is directly dependant on the health of its constituents. Healthy living conditions and access to good quality health care for all citizens are not only basic human rights, but also essential prerequisites for social and economic development. Any inequality in social, economical or political context between various population groups in a given society will affect the health indicators of that particular society. The most sensitive indicators of health of the society are infant and maternal mortality rates (IMR and MMR). IMR is still significantly high in India. Around 2.2 million infants die every year. In fact the National Health Policy 1983 target to reduce Infant Mortality Rate to less than 60 per 1000 live births has still not been achieved. The National Health Policy had also set a target for 2000 to reduce Maternal Mortality Rate to less than 200 per 100,000 live births. However, 407 mothers die due to pregnancy related causes, for every 100,000 live births even today. In fact, as per the NFHS surveys in the last decade Maternal Mortality Rate has increased from 424 maternal deaths per 100,000 live births to 540 maternal deaths per 100,000 live births. Apart from these avoidable deaths, India has seen persistence and resurgence of many infectious diseases. About 0.5 million people die from tuberculosis every year in India and this number has hardly changed in last five decades. Other communicable diseases like Malaria, Encephalitis, Kala Azar, Dengue and Leptospirosis to name a few, are far from being eradicated. The number of reported cases of Malaria has remained at a high level of around 2 million cases annually since the mid eighties. The outbreak of Dengue in India in 1996-97 saw 16,517 cases and claimed 545 lives26. Simple curable diseases like diarrhea, dysentery, acute respiratory infections and asthma also take their toll due to weak public health system and lack of awareness. Around 0.6 million children die each year from an ordinary illness like diarrhea. While diarrhea itself could be largely prevented by universal provision of safe drinking water and sanitary conditions, these deaths can be prevented by timely administration of Oral Re-hydration Solution (ORS), which is presently administered in only 27% of cases . Cancer claims over 0.3 million lives per year and tobacco related cancers contribute to 50% of the overall cancer burden, which means that such deaths might be prevented by tobacco control measures.

These health outcome indicators reflect a very disappointing state of public healthcare. The unfortunate fact is, these indicators have failed to improve in spite of various state run programs, mushrooming of private healthcare and a perceptible increase in the GDP. This underscores the importance of social and economic inequality as the stumbling block.

Private Healthcare and Economic Inequality

The growth of private healthcare sector has been largely seen as a boon, however it adds to ever-increasing social dichotomy. The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards urban-biased, tertiary level health services with profitability overriding equality, and rationality of care often taking a back seat. The increasing cost of healthcare that is paid by 'out of pocket' payments is making healthcare unaffordable for a growing number of people. The number of people who could not seek medical care because of lack of money has increased significantly between 1986 and 199527. The proportion of people unable to afford basic healthcare has doubled in last decade. One in three people who need hospitalization and are paying out of pocket are forced to borrow money or sell assets to cover expenses. Over 20 million Indians are pushed below the poverty line every year because of the effect of out of pocket spending on health care. In the absence of an effective regulatory authority over the private healthcare sector the quality of medical care is constantly deteriorating. Powerful medical lobbies prevent government from formulating effective legislation or enforcing the existing ones. A recent World Bank report acknowledges the facts that doctors over-prescribe drugs, recommend unnecessary investigations and treatment and fail to provide appropriate information for patients even in private healthcare sector. The same report also states the relation between quality and price that exists in the private healthcare system. The services offered at a very high price are excellent but are unaffordable for a common man. This re-emphasizes the role socio-economic inequality plays in healthcare delivery.

Conclusions

Effects of social and economic inequality on health of a society are profound. In a large, overpopulated country like India with its complex social architecture and economic extremes, the effect on health system is multifold. Unequal distribution of resources is a reflection of this inequality and adversely affects the health of under-privileged population. The socially under-privileged are unable to access the healthcare due to geographical, social, economic or gender related distances. Burgeoning but unregulated private healthcare sector makes the gap between rich and poor more apparent.

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