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AN OVERVIEW OF BARRIERS TO PUBLIC HEALTHCARE ACCESS IN INDIA

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ABSTRACT

The Government of India claims to provide free healthcare to all citizens who lie below the poverty line through public hospitals. This paper has analyzed the barriers that prevent access to certain communities to public healthcare. It has been found that the stigma around the healthcare of women and the prevalence of caste discrimination in rural areas makes healthcare inaccessible to the most vulnerable communities. Even though intergroup disparities in health outcomes such as infant mortality, maternal mortality, nutritional status, and institutional delivery exist across India, they are more unfavorable towards caste minorities in states including Bihar and Uttar Pradesh. Given that private healthcare continues to be unaffordable for these groups in India, there is an urgent need to make public healthcare more accessible and conducive. Lastly, this paper provides policy recommendations on making public healthcare more accessible to oppressed groups, centered around greater inclusion of oppressed castes in the medical workforce and an enhanced focus on social inclusion in public health initiatives.

Keywords: Healthcare, Hospitals, Women, Maternal mortality, Nutritional status

INTRODUCTION

Nation-States across the world has assumed the role of parental bodies that take on the responsibility of the holistic development of its citizens, especially those that have been historically marginalized and oppressed. To fulfill this role, public institutions have been created that provide 'public' utilities to those in need. This includes the provision of subsidized or free healthcare, education, and vocational training. The public health system across nations is a conglomeration of all organized activities that prevent disease, prolong life and promote the health and efficiency of its people. The provision of quality adequate health care not only impacts individual well being, but also the productivity of society and economic development. The public healthcare system in India has been historically neglected (Gupta, 2005).

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The federal system of governance in India puts the responsibility of providing public healthcare on individual states and not on the central government. This has created a major variation in the quality of healthcare available in different states of India. Moreover, state spending on healthcare in India has been variable and insufficient, which has led to the systematic neglect of public health in India (Peters, 2002). Moreover, Public health funding has been directed towards helping the middle and upper classes of society. Some of the most renowned medical institutions in the country, such as the All India Institute of Medical Sciences (AIIMS), are state-owned. This has led to the creation of unequal access to health care for economically and socially backward communities who do not receive the benefits of this funding (Gupta, 2005). The disproportionate funding of public healthcare in India has had a detrimental impact on the community health of the most marginalized communities in India. According to the findings of research conducted by Balarajan, et. al., in 2011, 20% of all maternal deaths and 25% of all child deaths in the world occur in India. Moreover, 34 out of 1000 children in India die before they are 5 years old (Balarajan, et. al., 2011). The immunization rates in India are also very low. Only 58% of Indians are immunized in urban areas compared to only 39% in rural areas (Balarajan, et. al., 2011). Even though these statistics cover the whole of the Indian population, the prevalence of unnatural deaths and prolonged illness is much higher in socially and economically backward communities because of the presence of barriers in access to public healthcare.

Beyond disproportionate funding, socially barriers have also blocked the access of healthcare in certain communities in India. Research has suggested that people's health outcomes are significantly affected by their social group and there is a ‘social gradient’ to health outcomes in India (Borooah, 2010). Communities across India follow traditional patriarchal norms, because of which there is a social stigma around women’s health. Social barriers and structural failures continue to block women’s access to public healthcare. Moreover, the basic healthcare needs of the transgender community have been completely ignored, even in the most recent legislation (Sharma, 2019). The Indian society has also been hierarchized into four distinct castes since the Vedic era, which has perpetuated systemic discrimination against certain social groups, that exist at the ‘bottom’ of the caste hierarchy. Even though most discriminatory caste practices have been outlawed in India, practices including untouchability continue to be prevalent, especially in rural areas (Ram, et. al., 1998). This has led to the creation of social and cultural barriers that prevent the access of the Scheduled Tribe and Scheduled Caste communities to public healthcare (Shivkumar, et. al., 2010).

In the absence of access to public healthcare, individuals are forced to avail healthcare from expensive private hospitals. Private medical insurance is only accessible by select communities due to higher costs. This causes economically backward communities to opt-out of healthcare altogether, except in cases of serious illnesses. Even then, the out-of-pocket health expenditure

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by households comprises of 60.6% of the total health expenditure of India (NHA, 2018). Healthcare costs push a large number of households below the poverty line every year. Moreover, the long term productivity of individuals also decreases in the long run. There is a need to study the systemic barriers that prevent access to healthcare to specific communities and groups in India and reevaluate the system so that it better serves its purpose of being 'public'.

BACKGROUND

Public health systems first came into existence during the British Raj. The British developed these systems to carter to the needs of British citizens living in India. Even though, this period was marked by the creation of research institutes, public health legislation, and sanitation departments, the benefits of investment and research were restricted to the British and the elite amongst India's population. Research suggests that public health in India was so abysmal at the time of Indian independence that only 3% of households had functioning toilets (Gupta, 2005). Even though systems and access have significantly improved since independence, unequal access to developments continues to characterize public healthcare in India.

During the Early Vedic Age Indian society followed a system known as the Varna System in which society was divided amongst different communities based on their occupations. The aim of creating this system was not stratification but efficiency and convenience. However, by the Later Vedic Age, this stratification was rigidified into the Caste System. The most powerful social groups, the Brahmins and the Kshatriyas hierarchized society and forced certain communities to only perform menial labor and serve other sections of society. Social mobility was absent and inter-caste marriages were shunned for centuries. Moreover, the Scheduled Castes and Scheduled Tribe communities were kept outside the public domain and systematically denied access to public education and healthcare. Practices such as untouchability led to overt forms of discrimination against certain Dalit communities. There was significant consolidation of the 'backward' castes during the independence era under leaders including Dr. B.R. Ambedkar. Discriminatory practices of the caste system, including untouchability, were outlawed and historically oppressed communities were protected and provided special reservations as a form of affirmative action. However, these provisions continue to only exist on paper for many historically marginalized groups, who continue to face discrimination at the hands of public officials in attempts to access public healthcare (Shivkumar, et. al. 2010). Studies have highlighted the lower level of utilization of health services among the Dalits as compared to the 'Upper-Caste' communities (Kulkarni & Baraik, 2003).

There also exists a gap between investment in healthcare in rural and urban regions. Even though the majority of India's population lives in rural India, the healthcare of these regions continues to

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be neglected. The government has not been able to adequately invest in a comprehensive healthcare system for the sparsely spread out population of rural India Statistics show that the number of health professionals in India is less than the average number for other developing nations. In rural Bihar, the number of doctors is 0.3 for every 10,000 individuals (Peters, 2002). Moreover, well-trained doctors and medical professionals have been found to be reluctant to practice in rural India which creates a stark difference between the quality of healthcare available in rural and urban regions (Hammer, 2017). There is also a lack of accountability of doctors employed in rural clinics. Not only does this reduce the effectiveness of medical regulations, but also allows doctors to discriminate amongst their patients based on caste, religion, and gender.

DISCUSSION

The gross domestic product of India has increased by more than 50% over the past three decades. However, this growth has been exclusive to some communities since this growth has been characterized by the widening of economic inequalities. Private healthcare in a few urban cities is as advanced as efficient due to high rates of private investment since the economic liberalization of 1991. On the other hand, the public healthcare system, which caters to more than a billion people in India has been underfunded. Drawbacks in this system also include low-quality care, corruption, a lack of accountability, unethical care, overcrowding of clinics, the presence of social barriers of access to services and medicines, and a lack of public health knowledge. Moreover, during times of shortage, public clinics supply medicines at excessively high prices, resulting in large out of pocket costs (even for those with insurance coverage). Large distances prevent Indians from getting care, and if families travel the far distance there is a low assurance of them receiving adequate medical attention at that particular time (Planning Commission, 2012). These drawbacks push wealthier Indians to use the private healthcare system, which is less accessible to low-income families, creating unequal medical treatment between classes (Hammer, et. al., 2019).

The Indian health landscape is very complex due to the multiple layers of exclusion and oppression that certain groups of the population face which eventually leads to poor nutrition, poor hygienic environment and ecological conditions conducive to ill health and diseases (Nayar 2007). Research conducted in the states of Gujarat and Rajasthan concludes that members of the Dalit community are systematically discriminated against whilst accessing health services. (Acharya, 2007). Differentials in the rate of maternal health between Scheduled Caste (SC)/Scheduled Tribe (ST) and other social groups have also been determined (Dasgupta & Thorat, 2009). A study centered around rural Hindu women in Uttar Pradesh highlighted that caste is a significant barrier to maternal healthcare service use among rural women (Saroha, et. al. 2008). A nationwide study conducted on children and women concluded that children from

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Dalit and Adivasi communities faced higher risks of mortality as compared to other children in all states except a few including Assam, Haryana, Himachal Pradesh, and Jammu and Kashmir. Similarly, the study also revealed that the nutritional status of Dalit and Adivasi women and children in India is relatively poor (Barik & Kulkarni, 2004). Data from National Family Health Surveys (NFHS) has also validated the inference that there are intergroup disparities in health outcomes such as infant mortality, maternal mortality, nutritional status and institutional delivery specifically unfavorable to Scheduled Caste and Scheduled Tribe communities. Data from the NFHS also suggests that Dalit and Adivasis children have a higher burden of malnutrition than others. The disparities are the highest in states where caste practices are still prevalent such as Bihar, Madhya Pradesh, Madhya Pradesh and Uttar Pradesh (IIPS, 2006). Social barriers also prevent access of women to healthcare in rural India. There is a lack of abortion services and contraception methods (Planning Commission, 2012).

In a space where the rates of cardiovascular and communicable diseases in India are steadily increasing, the unavailability of quality healthcare has had adverse consequences on the most marginalized communities of India (Kasthuri, 2018). The lack of access to public healthcare drives people to access private hospitals which puts an immense amount of economic burden to even those who have health insurance (Planning Commission, 2012). Healthcare is considered to be essential for human development as it directly impacts the short and long term productivity of individuals. An efficient health care system contributes to economic growth and development (WHO, 2010). Even though the government of India has launched public health initiatives such as National Health Mission, Ayushman Bharat, National Mental Health Program, their impact is restricted to certain spaces and communities and does not trickle down to help the most vulnerable sections of society (Chokshi, et. al., 2016). Even though many developing countries including Uruguay, Latvia, and Senegal have declared health care to be a fundamental human right, it continues to be a commodity in India which is only accessible by the most privileged sections of the country (UCLA, 2013).

CONCLUSION

Several published studies have paper highlighted the discrimination in the delivery of public health services at various levels. This becomes a crucial challenge for policymakers because public health services are the only options available to resource socially and economically oppressed communities for healthcare when it comes to financial affordability. Caste and gender discrimination are very abundant in rural India (George, 2015). The dominance of caregivers from the upper and middle-level caste groups creates and sustains an environment that is favorable for discrimination. Similarities in the social profile of healthcare personnel have been found to be related to higher rates of discrimination. In Bihar, the jobs in public hospitals are

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hegemonized by members of privileged castes which has led to higher intergroup disparities in access to healthcare. On the other hand, states such as Tamil Nadu and Andhra Pradesh, which have lesser intergroup disparities with respect to access to healthcare are characterized by healthcare delivery systems that have higher representation from members of backward castes, especially in rural areas (George, 2015). There is a need to further empirically test the linkages between lower participation of Dalits in healthcare services and their chances to be discriminated against. It is important to consider the sub-castes that exist amongst the Dalit Community since discrimination has a graded nature even within this single social group.

Since prejudices based on caste and gender are strong in Indian society, there should also be adequate legal safeguards to check discrimination. Flagship programs like the National Rural Health Mission, which currently ignores the caste and gender hierarchy that is pervasive in Indian society, must develop a special focus on social inclusion. Sensitivity training of medical practitioners and the cognizance of caste hierarchy also makes the system more conducive to the oppressed. This should also be reflected in resource allocation between rural and urban regions as well as between localities where Dalits and Adivasis reside given there exist inequalities in the distribution of quality health facilities, personnel, and resources between different regions in India. Partnerships with Non-Governmental Organizations that work at the grassroots level in rural India can also enhance the impact of public health initiatives. The present state of public healthcare in India undermines the principles of justice and equality that the Indian constitution stands for, and there is a need to bring about an organic change in the mentality of people and policymakers to make the healthcare system more conducive to the needs of the most oppressed communities in India.

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