

## **SOCIOECONOMIC DISPARITIES IN HEALTH CONSUMPTION: UNCOVERING BARRIERS AND PATHWAYS TO EQUITABLE ACCESS**

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### **ABSTRACT**

Understanding decision-making in health consumption promises several crucial insights into India's healthcare landscape. By analyzing the influence of socioeconomic status on healthcare choices, policymakers and researchers can develop tailored interventions and strategies to bridge the gaps in access and improve health outcomes for marginalized populations. This paper investigates the relationship between income levels, education, occupation, and access to healthcare services among diverse populations in India. By reviewing existing literature and case studies of low-income communities, this study aims to uncover patterns, barriers, and pathways to equitable access. Through an in-depth understanding of the complex interplay between economic factors and health decisions, this research underscores the urgency for targeted interventions and policies that address health through evidence-based interventions. Lastly, it argues for the relevance of such findings in promoting equitable access and improving the well-being of India's population.

### **Introduction**

India, a nation of remarkable diversity, has long aspired to achieve Universal Health Coverage (UHC) for its vast population. While commendable efforts have been made in recent decades, the country's overall progress toward UHC has been gradual, with numerous challenges that are yet to be addressed. This includes a fragmented healthcare system, inadequate public health infrastructure, insufficient government spending, high out-of-pocket expenditure, implementation challenges in health schemes, and a lack of focus on preventive healthcare, among several others (Chawla, 2023; Ghia & Rambhad, 2023).

Moreover, India's health inequalities have long played out on social and economic axes—specifically caste, income, and gender. This means they disproportionately affect marginalized communities, which exacerbates their vulnerability to various health challenges. Recent data

further underscores the extent of this disparity. Most significant among them is a report by Oxfam India (2021), which notes that despite an increase in life expectancy, the rich, on average at least, live seven and a half years longer than the poor. Similarly, a woman from the general category lives 15 years longer than a Dalit woman.

Additionally, it was observed that the infant mortality rate (IMR) is not equal across social groups either. Dalits, Adivasis, and OBCs are reported to have higher IMR compared to those from the general category (Oxfam India, 2021). In fact, the IMR of Adivasi groups is estimated to be 40 percent higher than that of people from the general category and 10 percent higher than the national average. Making matters worse, marginalized communities are also disproportionately burdened by out-of-pocket expenditure when they access healthcare. According to past estimates, six crore people are pushed into poverty every year due to healthcare expenditure alone (Kurian, 2015, p. 5). To address these fundamental inequalities UHC needs to be supported by a strong public health sector. But in order to achieve this in an effective manner, it is vital to first understand the healthcare choices made by marginalized communities.

In India, healthcare decision-making is intricately intertwined with the socioeconomic status of individuals and communities. Socioeconomic status—which encompasses factors such as income levels, educational attainment, and occupation—significantly influences healthcare choices and access to medical services. Analyzing these behavioral aspects of India's healthcare consumption promises crucial insights that can inform policy decisions, lead to effective resource allocation and targeted interventions, and improve overall health in vulnerable regions.

Hence, this paper will examine the factors affecting the choice of healthcare provider in low-income settings. By exploring decision-making in these households, this paper will ultimately attempt to shed light on how socioeconomic status (SES), particularly factors like income levels, education, and occupation, influences healthcare choices, and highlight its relevance in the broader healthcare paradigm.

## **Background**

India's health system embodies a dualistic structure, comprising both a public sector as well as a flourishing private sector. The public health sector in India caters primarily to the healthcare needs of economically vulnerable communities. Despite efforts to improve accessibility and affordability, the public sector still grapples with issues like limited financing, insufficient infrastructure, and shortages of healthcare professionals, which ultimately affect individuals from lower socioeconomic strata at a disproportionate rate (Gupta, 2020).

On the other hand, the private health sector in India offers advanced medical technologies and specialized healthcare services. However, it predominantly serves the affluent segments of society. Over the years, an emphasis on quality and convenience has allowed the private sector to expand significantly and cater to multiple income subgroups. However, the high costs and geographic interests associated with private healthcare mean that it is still a premium healthcare service that is unaffordable for the majority of the population.

This divide has received great interest in the country's socioeconomic scholarship, which believes an interdisciplinary approach is needed to understand healthcare inequalities in the country (Bhan et al., 2016; Selvaraj & Karan, 2009; Subramanian et al., 2008). Because of this, healthcare consumption is also seen as a multifaceted process in India, influenced by various SES variables. This paper will consider three such variables: income, education, and occupation.

All three SES variables play a pivotal role in shaping individuals' access to and utilization of healthcare services. Income serves as a significant determinant of healthcare consumption, as individuals with higher income levels often have greater financial resources to afford quality healthcare services. This enables them to seek timely medical interventions, undergo diagnostic procedures, and access specialized treatments, leading to improved health outcomes. In contrast, individuals with lower income levels may face barriers to accessing healthcare, leading to delayed treatment, compromised health outcomes, and an increased risk of preventable diseases.

Educational attainment is another key SES variable that influences healthcare consumption patterns. Individuals with higher education levels tend to exhibit better health literacy, enabling them to make informed decisions regarding preventative healthcare measures, disease management, and treatment options. In contrast, limited education can lead to misconceptions about health-related information, delays in seeking appropriate medical care, and a reluctance to adopt preventative health behaviors, contributing to disparities in health outcomes among individuals with lower educational attainment.

Thirdly, occupational status also plays a crucial role in determining access to healthcare services. Mainly because individuals in certain occupations may have better access to employer-sponsored health insurance and workplace healthcare facilities. Professionals with stable employment are more likely to receive comprehensive health coverage and timely medical interventions, leading to better healthcare outcomes and a reduced financial burden compared to individuals in lower-paying or informal occupations.

The complex interplay between income, education, and occupation reinforces the multifaceted nature of healthcare consumption disparities rooted in India. These disparities further intersect

with factors such as gender, caste, and geographical location, creating unique challenges and barriers to healthcare access for marginalized populations.

From the 1980s onward, the public availability of survey data marked a crucial turning point in research on health inequalities in India (Bhan et al., 2016). This is credited to two main undertakings—the availability of data from three rounds of the National Family Health Survey and the release of the National Sample Surveys (NSS) on household consumption. By analyzing some of the recent studies and literature in this space, this paper will delve into the complex relationship between socioeconomic status and healthcare decision-making in India, highlighting how SES shapes health consumption patterns and choices.

### **Discussion**

Socioeconomic disparities are widely known to dominate India's two health sectors — public and private. Previous scholarship has illustrated the extent of this divide through the use of SES variables. After analyzing the variation in health outcomes within India, Balarajan et al. (2011) report that as far back as 2004–05, the national immunization coverage for children of mothers with no education stood at a staggeringly low 26%, while the national average and coverage for children of mothers with more than 5 years of education during the same period was 44% and 64% respectively. Secondly, even though in-hospital deliveries had risen in the following 2005–06 period, women in the richest quintile were six times more likely to do so than women in the poorest quintile (Balarajan et al., 2011).

Public sector facilities, available at little or no cost, can, theoretically speaking, improve these statistics. However, after looking at health consumption data, it can be argued that policy making should move away from the assumption that the public sector alone is the preferred point of access among marginalized groups. Especially since the opposite seems to play out in many settings.

Despite the financial incentive, in India's urban slums, where large swathes of low-income households are located, there doesn't appear to be any particular preference for public healthcare providers. In a study exploring the choice of provider among people living in the urban slums of Ahmedabad, Černauskas et al. (2018) note that while some preferred public providers, this pattern was by no means uniform. In fact, many individuals, they report, had a preference for private providers despite the higher price tag.

One reason behind this might be that “appropriateness of care” emerged within the sample group as the most valuable attribute while seeking care (Černauskas et al., 2018). This refers to the technical aspects of healthcare like “doctor's skills, knowledge, and appropriate use of care and medicines”— which were highly valued among participants. Coupled with the fact that low-

income households in India often perceive that private healthcare providers offer superior quality services compared to public facilities, it explains why there is a notable reluctance to visit public hospitals in India (Reddy, 2015).

More insight can be drawn from a similar study investigating healthcare choices made by slum dwellers in Mumbai. Like in Ahmedabad, Naydenova et al. (2017) also observe that there is no unanimous preference for the public sector among vulnerable groups. Instead, they report that private, or at least a mix of both providers, emerges as the preferred mode at large. They also go a step further and analyze these choices for specific health conditions to report “stark differences” (Naydenova et al., 2017). While private healthcare emerged as the choice for most conditions, it is worth noting here that the public sector plays an important role in maternal health, with 60% of women opting for a public provider and 33% of women reporting accessing a combination of both during their pregnancy. Results like this, when coupled with further evidence, can help policymakers improve public health through targeted interventions that carefully consider behavior patterns and barriers rather than implementing broad, indefinite remedies.

Moreover, another study into healthcare consumption in rural populations shows that SES variables don't just impact individuals but that they might transfer into communities. After studying illnesses that needed primary care across 100 villages in Madhya Pradesh, Das & Mohpal (2016) observed that despite being one of India's poorest rural regions, private providers still dominate the landscape of health. In fact, people often made “complex trade-off” decisions to access quality healthcare, including “distance to a provider and the provider's fees and competence”.

Das & Mohpal (2016) also argue that it is actually the SES of villages, rather than individual households, that impacts provider choice. This is because high and low SES households from richer villages visited equally knowledgeable providers, while poor people in poor villages often received low-quality care. Such approaches to SES variables can prove pivotal in identifying sections that are especially vulnerable and also offer a comprehensive framework for policy matters.

In India, the effectiveness of treatments, personalized care, and better-equipped facilities seem to motivate many low-income households to prioritize private healthcare options. However, the role of the public sector should not be overlooked. As Mahapatro et al. (2021) summarize, “public hospitals whose biggest stakeholder are the poor are yet to be tailored for them”. Especially since the increasing dominance and dependence of the poor on private providers comes with large financial implications.

Understanding consumption data among such groups, as this paper outlines, is vital here. It can not only help policymakers decide what services to integrate, but also shed light on which pain points can be addressed within existing care delivery channels. The heterogeneous nature of provider choice, even among India's poorest, also points to another direction: the scope for public-private synergy in UHC. Due to India's regional diversity, further research is required to individualize this partnership to meet community-based needs.

More crucial, however, is the need for reform within the public sector. Several programs have been implemented in the 21st century in order to improve UHC in India. Yet, these initiatives have not trickled down to the poorest sections of society. Moving forward, decisions that account for healthcare consumption and choices, among other factors, can help ensure that the benefits of policy reach those segments of the population that need them most.

### **Conclusion**

In many ways, the dominance of the private sector further reinforces the socioeconomic disparities prevalent in India's healthcare landscape. However, as findings show, the private sector isn't solely accessed by the elite, but is also the preferred provider for marginalized communities across several health contexts.

The aspiration for comprehensive and satisfactory healthcare experiences often overrides financial constraints, leading to a preference for private providers even at the expense of significant monetary costs. The time-sensitive nature of healthcare needs also compels low-income households to prioritize timely and convenient access to healthcare services. Private providers often offer shorter waiting times, flexible appointment schedules, and a more patient-centered approach, which resonate with the immediate healthcare needs of low-income households. Understanding these motivations can help implement measures to ensure that quality healthcare becomes accessible to all segments of society, irrespective of their SES status.

The findings of this paper also outline the importance of creating financially viable pathways to quality healthcare delivery. Through further investment and support, the public healthcare system can address the inefficiencies and inadequacies that turn low-income groups towards private options. While collaborative efforts between the public and private sectors can provide an effective solution to bridge the gaps in health coverage and promote equitable access, it is also essential to have regulatory control over the latter to ensure quality of care and protect patients.

Analyzing the behavioral side of healthcare consumption can also help scholars and decision-makers effectively allocate resources, carry out targeted interventions, and understand the needs of marginalized communities. By promoting strategic planning and the implementation of evidence-based reform, it can play a key role in ensuring equitable access for all social groups.

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