HEALTH SELLS, BUT WHO'S BUYING?

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ABSTRACT

In a health system where - by design - people are expected to pay at the point of service delivery for their own health, it is no surprise if disease and ill-health unfairly accumulate among the poor and disadvantaged. In this commentary, drawing from a book chapter summarising research on health inequities in India,[1] I summarise evidence on how widespread socio-economic inequality in health - among other things - is selectively and unfairly worsening health of some people, more than others. Amidst this bleak scenario of widespread health inequities, the Government of India's ambitious scheme, Ayushman Bharat scheme, appears to be an important step towards addressing inequities in access to healthcare. Through its focus on primary health care on one hand and its commitment to address rising hospitalisation expenses through insurance mechanism on the other hand, the scheme is likely to be an important step towards mitigating healthcare inequities. I conclude this short note by critically examining the implications of some of the features of Ayushman Bharat in addressing unfair disadvantages faced by the poorest and most marginalised communities in accessing primary health care and hospitalisation services.

I. INTRODUCTION

Health, unfortunately, has not been explicitly held up as a right in our Constitution. However, the Constitution guarantees right to life[2] and courts have broadly interpreted right to life as being contingent upon securing appropriate healthcare.[3] Further, the Constitution's Directive Principles oblige the State to ensure social and economic justice, particularly Article 47, which obliges the State to improve nutrition, standard of living and public health.[4] Indeed, public health advocates and courts have broadly conceptualised right to health and healthcare in India

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[1] *Health Inequities in India: A Synthesis of Recent Evidence*, (Ravindran, T.K. Sundari & R. Gaitonde, 1st ed., 2018).

Extract from publisher text: "This timely contribution to the global literature on health inequities approaches the subject through a synthesis and analysis of relevant published literature on India. Amongst the BRICS countries, India ranks the lowest in the gender-gap index and has the highest poverty rate, and there is clear evidence that socio-economic inequalities have increased in India in the twenty-first century. These have direct impact on the health conditions of its people; however, there has been relatively little concerted research attention on health inequities in India. This volume fills the gap by synthesizing research evidence since the year 2000 on the topic. This is perhaps the first volume on this topic of such scope and breadth."

[2] Art. 21, Constitution of India.

[3] PUCL v. Union of India, (2009) 16 SCC 149.

[4] K. Mathiharan, *The Fundamental Right to Health Care,* 11(4) Indian Journal of Medical Ethics ,123 (2016), available at https://ijme.in/articles/the-fundamental-right-to-health-care/, last seen on 12/06/2020.

as being secured indirectly through aforementioned Articles of the Constitution, various health policy documents, policy pronouncements, and India's international legal commitments and treaties.[5] For instance, the National Health Policy 2017 identifies equity as an organizing principle for our health system. One of the ways to achieve better health status for our population is timely and appropriate curative services in times of illness, in addition to health education, preventive care, health promotion and rehabilitation services. These pillars of primary health care have been upheld as the foundational building blocks of a health system.[6] Indeed, the large country-wide network of government primary health centres (**"**PHC**"**) in India are structured as per the overall principles of primary health care laid down in the WHO's Alma Ata Declaration.

Several rounds of national, demographic and health surveys[7] by the Government have shown that access and utilisation of healthcare is consistently patterned along socio-economic characteristics of households.[8] For instance, in reproductive and child health services, there has been decades of technical and financial investment for improving access and coverage. Yet, all four rounds of the National Family Health Survey (**"**NFHS**"**) show that the coverage for family planning, maternal & neonatal health, immunisation and treatment of sick children among the poorest households is half of that among the wealthiest in almost 20 states.[9] Access and coverage of various curative and preventive healthcare services has maintained a stark and stagnant difference between the rich and the poor despite these services being offered free (mostly) within a wide network of primary health centres.

For more serious healthcare requirements (which are rarer than the more often sought primary health care conditions), the rising treatment costs in the private sector render these inaccessible to a large population. In a health system where healthcare must be purchased from the open market, those who cannot afford it are most likely to be deprived of timely and appropriate healthcare. A 2011 analysis of nationwide data by William Joe and colleagues showed that the rising income levels from economic

[5] R. Duggal, *Health and development in India: moving towards the right to health* in *Advancing the Human Right to Health* (J.M**.** Zuniga, S.P. Marks, & L.O. Gostin, 1st ed., 2013).

[6] *Health for all: An alternative strategy,* available at https://hetv.org/pdf/frch-alternative.pdf, last seen on 12/06/2020.

[7] See *Home*, National Family Health Survey India (NFHS), available at http://rchiips.org/nfhs/index.shtml.

[8] M. Asaria, S. Mazumdar& S. Chowdhury et al*, Socioeconomic inequality in life expectancy in India,* 4(3) BMJ Global Health (2019), available at https://gh.bmj.com/content/4/3/e001445, last seen on 12/06/2020; Y. Balarajan, S. Selvaraj., & S.V. Subramanian, *Health care and equity in India,* 377(9764) The Lancet 505, 515 (2011), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3093249/, last seen on 12/06/2020.

[9] Dr. N. S. Prashanth, *Health Inequities in India: A Synthesis of Recent Evidence* (Ravindran, T.K. Sundari & R. Gaitonde, 1st ed., 2018).

progress was accompanied by, or even in some instances escalated, health inequalities; while higher incomes and wealth can make health and healthcare accessible for some, it also aggravates the situation of those who are unable to – for reasons often related to underlying social inequalities and access to resources – achieve economic improvements, thus entangling economic position and healthcare into a vicious feedback loop where one aggravates the other.[10]

II. RESEARCH ON SOCIO-ECONOMIC INEQUITIES

Most of our knowledge of inequities in health by socio-economic position are from NFHS surveys. Researchers have shown that there are avoidable differences in healthcare outcomes and access to health care for a variety of conditions. Indicators related to child survival, maternal mortality and morbidity, child nutrition and anaemia in women, as well as indicators related to utilisation of maternal and child health services (antenatal and postnatal care, skilled birth attendance and child immunisation) are all worse off among India's poor, although the degree to which they are worse off varies from one state to another.[11] A 2010 study on inequalities among women in Uttar Pradesh, Maharashtra and Tamil Nadu using data for three time points from 1992–93 to 2005–06 showed that increments in utilisation of antenatal care and institutional delivery were mainly noted among non-poor mothers, and the poor mothers benefited least from government sponsored maternal health care services and schemes.[12]

In addition to unequal coverage, there are also differences in the quality of services provided. Studies have looked into quality and content of advice received; they have found that healthcare advice concentrated disproportionately among the rich. In one of the few studies of its kind, a health worker examined four North Indian states (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) and reported higher visits to better

[10] W. Joe, U. S. Mishra, & K. Navaneetham, *Inequalities in childhood malnutrition in India: Some evidence on group disparities,* 10(3) Journal of Human Development and Capabilities (2009), available at https://www.tandfonline.com/doi/abs/10.1080/19452820903048886, last seen on 12/06/2020.

[11] Ibid; Supra 9; P. K. Pathak, A. Singh, & S. V. Subramanian, *Economic inequalities in maternal health care: Prenatal care and skilled birth attendance in India*, *1992 - 2006,* 5(10) PLoS One (2010), available at https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0013593, last seen on 12/06/2020.

[12] P. K. Pathak, A. Singh, & S. V. Subramanian, *Economic inequalities in maternal health care: Prenatal care and skilled birth attendance in India*, *1992-2006,* 5(10) PLoS One (2010), available at https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0013593, last seen on 12/06/2020.

off rather than poorer households.[13] In this study, higher social and economic status was associated with increased chances of receiving specific components including blood pressure measurement, a blood test and urine testing. In a 2012 study, which examined the rich–poor gaps in seven types of advice given to pregnant and newly delivered women, it was found that the rich–poor ratios were consistently in favour of the richer households.[14]

III. FINANCING HEALTHCARE THROUGH DEBTS

In addition to the social costs of being poor, living in a system that requires payments for healthcare at the point of service delivery, more so during periods of high vulnerability due to illness episode, impoverishes households. Poor households often cope with this by postponing care-seeking. The illness becomes unbearably severe (and hence even more expensive) or they end up debt-financing healthcare costs, further impoverishing them. Several studies show that the household effects of healthcare-related impoverishment affect the entire household and possibly has inter-generational effects.[15] One in four of the world's stunted children live in India and given the inter-generational nature of disadvantage, this can only translate into an overall poorer and a more *unfair* future, if not corrected now.[16]

IV. LIFECYCLE OF DISADVANTAGE

Hereditary transmission of various illnesses has been well documented. However, the clustering of socio-economic disadvantage within certain

[13] S. Pallikadavath, M. Foss, & R. W. Stones, *Antenatal care: Provision and inequality in rural north India,* 59(6) Social Science and Medicine 1147, 1158 (2004), available at https://www.sciencedirect.com/science/article/abs/pii/S0277953604000139?via%3Dihub, last seen on 12/06/2020.

[14] A. Singh, S.S. Padmadas, U. S. Mishra, S. Pallikadavath, F. A. Johnson, & Z. Matthews, *Socio-economic inequalities in the use of postnatal care in India,* 7(5) PLoS One, (2012), available at https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0037037, last seen on 12/06/2020.

[15] U. Bhojani, B. Thriveni, R. Devadasan *et al.*, *Out-of-pocket healthcare payments on chronic conditions impoverish urban poor in Bangalore, India*, 12(1) BMC Public Health (2012), available at https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-990, last seen on 12/06/2020; T.L. Cheng, S.B. Johnson, E. Goodman, *Breaking the Intergenerational Cycle of Disadvantage: The Three Generation Approach*, 137(6) Pediatrics (2016), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4894258/, last seen on 12/06/2020; OECD and WHO Report on Poverty and Health, available at https://www.who.int/tobacco/research/economics/publications/oecd_dac_pov_health.pdf, last seen on 12/06/2020.

[16] J. Khan, S.K. Mohanty, *Spatial heterogeneity and correlates of child malnutrition in districts of India,* 18(1) BMC public health (2018), available at https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-5873-z, last seen on 12/06/2020.

castes, communities and population groups has its origins with social, economic and political structures. If children born into poor households are more likely to be stunted and underweight, they in turn enter adulthood carrying the burden of these disadvantages.[17] Indeed, early childhood under-nutrition translating into poor educational attainment has been well documented in public health research,[18] with various emerging evidence pointing towards both epigenetic and biomedical pathways conspiring with adverse social conditions creating intergenerational disadvantages.[19] Aside from the social justice and unfairness angle, the economic impact in terms of loss of schooling and economic productivity losses of such early childhood deprivation has been estimated to be approximately 40 billion dollars, just in India.[20]

V. PURCHASING PRIVATE CARE

Public health research on socio-economic inequities in health overwhelmingly report that healthcare financing in India is regressive. While healthcare seeking in the private sector is widespread, it is not the case for all services.[21] Wherever primary health care services have provided a high-quality service that is accessed by a wider strata of population, as is the case with immunisation for example, the potential effects of economic inequalities may have been mitigated by the universally subsidising effect of public programmes aimed at reducing

[17] A. Dharmalingam, K. Navaneetham & C.S. Krishnakumar, *Nutritional status of mothers and low birth weight in India,* 14(2) Maternal and child health journal 290, 298 (2010), available at https://link.springer.com/article/10.1007/s10995-009-0451-8, last seen on 12/06/2020.

[18] Y. Acharya, N. Luke, M.F. Haro, W. Rose, P.S. Russell, A.M. Oommen, S. Minz, *Nutritional status, cognitive achievement, and educational attainment of children aged 8-11 in rural South India,* 14(10) PLoS One, (2019), available at https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223001, last seen on 12/06/2020; H. Alderman, J. Hoddinott, B. Kinsey, *Long term consequences of early childhood malnutrition,* 58(3) Oxford economic papers 450, 474 (2006).

[19] J. Galler, D.G. Rabinowitz, *The intergenerational effects of early adversity*, 128 Progress in molecular biology and translational science 177, (2014).

[20] *Food for thought,* Save The Children, available at https://www.savethechildren.org/content/dam/global/reports/education-and-child-protection/food-for-thought.pdf, last seen on 12/06/2020.

[21] J. W. Skordis, N. Pace, U. Bapat, S. Das, N.S. More, W. Joshi, A.M. Brannstrom & D. Osrin, *Maternal and neonatal health expenditure in Mumbai slums (India): A cross sectional study,* 11(1) BMC Public Health, 150 (2011), available at https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11-150, last seen on 12/06/2020;B. Kanjilal, M. Mukherjee, S. Singh, S. Mondal, D. Barman, & A. Mandal, *Health, equity and poverty exploring the links in West Bengal, India,* Future Health Systems Innovations for Equity, Research Monograph, Indian Series, (2007), available at https://www.academia.edu/25733292/Health_Equity_and_Poverty_Exploring_the_Links_in_West_Bengal_India, last seen on 12/06/2020.

mortality among children, especially the various national programmes focusing on child health.[22]

However, increased dependence on private sector for secondary and tertiary care, and increased out-of-pocket payments for care in public sector, have resulted in worse-off healthcare outcomes among the poor and socio-economically disadvantaged. The policy response in most states has been the institution of state-managed insurance schemes for the poor by purchasing secondary and tertiary care for select conditions from the private sector. Several researchers caution about the effectiveness of such schemes targeting the poor that seek to identify the *true* poor using improperly distributed identity cards (even smart cards).[23]

As expected, many research articles report on how "...non-poor, urban households have benefitted disproportionately from economic progress as well as health interventions meant for the poor and marginalised households".[24] Hence, national schemes, such as the recently announced National Health Protection Scheme *Ayushman Bharat*, which selectively cover secondary and tertiary care mostly in private hospitals, while no doubt expanding access to services, do not address the root cause of the deepening socio-economic inequity in health: the unfair distribution of good quality primary health care and the inherent rich-poor divide in the quality and quantity of healthcare being provided.

VI. TRANSLATING ECONOMIC GROWTH INTO HEALTH

Inequities in health by socio-economic position have persisted during the period of rapid economic growth (1992–93 to 2010) and despite the introduction of numerous schemes specifically to improve maternal and child survival.[25] Various research studies show that the healthcare access and health status gap between rural and urban areas and that between the

[22] S. Chalasani, *Understanding wealth-based inequalities in child health in India: A decomposition approach,* 75(12) Social Science and Medicine 2160, (2012), available at https://www.sciencedirect.com/science/article/abs/pii/S0277953612006168, last seen on 12/06/2020.

[23] H. Thakur, *Study of Awareness, Enrollment, and Utilization of Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme) in Maharashtra, India,* 3(282) Frontiers in public health, (2016), available at https://www.frontiersin.org/journals/public-health/sections/public-health-education-and-promotion#editorial-board, last seen on 12/06/2020; R. Dasgupta, S. Nandi, K. Kanungo, M. Nundy, G. Murugan & R. Neog, *What the good doctor said: a critical examination of design issues of the RSBY through provider perspectives in Chhattisgarh, India,* 43(2) Social Change 227, (2013), available at https://journals.sagepub.com/doi/abs/10.1177/0049085713493043, last seen on 12/06/2020; B. Criel, et al., *Towards equitable coverage and more inclusive social protection in health,* 32 Studies in Health Services Organisation and Policies (2014).

[24] Supra 8, Y. Balarajan, S. Selvaraj, & S.V. Subramanian, *Health care and equity in India,* 377(9764) The Lancet 505, (2011), available at https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61894-6/fulltext, last seen on 12/06/2020.

[25] Ibid.

poor and the non-poor have widened since 1992–93 in many states.[24] Some studies have reported that wealth inequalities in child immunisation were more pronounced in the Southern states (considered better-off in terms of health) than in the empowered action group states (considered worse-off in terms of health).[26] In fact, states with higher average survival and coverage indicators have shown a trend of widening inequalities.[27] It is very likely that schemes and services tend to be benefitting population groups in a selective manner, and hence unless there is specific push for addressing equity in design and delivery of programmes, the gaps will continue to widen. Ambitious nationwide health reforms, such as the one envisioned under *Ayushman Bharat,* will fail to address the inequitable distribution of healthcare access unless they embrace the underlying drivers, and hence, incorporate design features that do things differently for different regions, contexts, populations and other axes. Current design aims for a rather centralised health authority that oversees design for strategic purchasing of services from secondary and tertiary care, and an ambitious nationwide template for implementing reforms in primary health care through the establishment of health and wellness centres.

VII. BEYOND HEALTH SERVICES INTO SOCIAL DETERMINANTS

Healthcare access or availability is only one of the determinants of health. The Commission on Social Determinants of Health of the World Health Organisation highlighted the significant role of various social determinants of people's health.[28] The Commission's framework describes the interactions between circumstances of daily life, especially the material circumstances with various other factors including the degree of social cohesion, psychosocial factors, behaviours and biological factors together with the health system, which together shape the distribution of health and well-being. In addition to these, the framework identifies wider societal factors (structural drivers) including policies, socio-economic and political context on one hand as well as deep-rooted power

[26] P. Arokiasamy, K. Jain, S. Goli, & J. Pradhan, *Health inequalities among urban children in India: A comparative assessment of empowered action group (EAG) and south Indian states,* 45(2) Journal of Biosocial Science 167, (2013), available at https://www.cambridge.org/core/journals/journal-of-biosocial-science/article/health-inequalities-among-urban-children-in-india-a-comparative-assessment-of-empowered-action-group-eag-and-south-indian-states/FCC58276BD0A6D1BCEFECA090E13DD3D, last seen on 12/06/2020.

[27] R. P. Pande, & A. S. Yazbeck, *What's in a country average? Wealth, gender, and regional inequalities in immunisation in India*, 57(11) Social Science and Medicine 2075, (2003), available at https://www.sciencedirect.com/science/article/abs/pii/S0277953603000856?via%3Dihub, last seen on 12/06/2020.

[28] *Closing the gap in a generation: Health equity through action on the social determinants of health: Final Report of the Commission on Social Determinants of Health,* World Health Organization, (2008), available at https://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf, last seen on 12/06/2020.

imbalances, rules and norms in society, social position, gender, ethnicity, occupation, income, etc. which interact with the circumstances of daily life in producing the (mal)distribution of health and well-being that we see today.

Increasingly, analysis of failure of specific disease control efforts in the country point out the failures in addressing social determinants. On being asked about why India still has one-third of all new cases of Tuberculosis, leading experts on disease control point out the inadequate efforts to tackle key social determinants such as poverty and malnutrition.[29] Access to quality public spaces and amenities such as clean drinking water, parks and access to transportation are already known to be unfairly distributed in cities. This difference is further aggravated by worse-off access and poor quality of services in urban poor neighbourhoods, be it for maternal and child health services, or for non-communicable diseases or infectious diseases such as Tuberculosis. Indeed, if cities aspire to be smart, the best way to get there would be by deploying fairer distribution of health, healthcare and good quality public services than through technology or industry alone.

VIII. SOCIO-ECONOMIC INEQUITIES IN HEALTH

The most obvious pathway reported in literature as driving the inequity along socio-economic lines is the over-dependence on an open and unregulated market mechanism for seeking healthcare.[30] In a health system where healthcare must be purchased from the open market, those who cannot afford it are likely to be disadvantaged with respect to health outcomes. Furthermore, healthcare by its very nature does not lend itself to being distributed equally; the fundamental organising principles of a well-functioning market for health are absent due to inherent asymmetries of information and power between the buyer and the consumer. As a result, it is not an accident that we find ourselves in a society where average income may be rising, but the degree of health inequalities is increasing as reported in studies by health economists.[31] Various psychosocial and biomedical evidence too have been presented to show how poverty and discrimination - in addition to themselves acting as barriers to healthcare - can also aggravate ill-health through independent biomedical and psychosocial mechanisms. Indeed,

[29] Supra 8; M. Pai, N. Correa, N. Mistry &, P. Jha, *Reducing global tuberculosis deaths—time for India to step up,* 389(10075) The Lancet 1174, (2017), available at https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30790-0/fulltext, last seen on 12/06/2020.
[30] Supra 10.
[31] Supra 27.

overwhelming evidence from a wide range of studies shows us that people may tolerate inequality, but not unfairness.[32]

While the focus on widening coverage of health services and schemes to target the poor and disadvantaged is important, striving for more universal public services and systems that do not discriminate, and systems that address underlying reasons driving unfair distribution of health can only be brought about by well-funded and strong primary health care. In addition, health programmes and policies that address the drivers of unfair distributions, and shifting service and system priorities towards redressing this unfairness through better design and adaptation of programs are needed, if at all the unfairness in the distribution of health has to be corrected.

[32] C. Starmans, M. Sheskin & P. Bloom, *Why people prefer unequal societies,* 1(4) Nature Human Behaviour, (2017), available at https://www.researchgate.net/publication/315944588_Why_people_prefer_unequal_societies, last seen on 12/06/2020.