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Research Article

Health Inequity & Indian Health Care System

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ABSTRACT

Maternal and reproductive health is compromised in developing countries due to a lack of infrastructure and resources (Sanneving et al., 2013). The current health care system in India is still uneven and inequitable (Sanneving et al., 2013). A more unified health care delivery system is warranted to ensure maternal and reproductive health care to the population. The commission on Social Determinants of Health (CSDH) has identified five main structural determinants of health inequity in India namely, socio-economic factors, age, education, and gender (Sanneving et al., 2013). The interplay between social determinants in health inequity should be thoroughly understood to formulate better health policies to achieve health equity (Sanneving et al., 2013). Our paper will analyze the socio-cultural causes in the Indian system and will propose recommendations for changes in the current health care delivery system for safe maternal health.

Keywords: Health inequity, Maternal & Reproductive Health, India, Socio-cultural determinants

INTRODUCTION

Maternal health is the focus of Millennium Development Goal -5 (MDG) and to achieve the MDG goal, reproductive health care should be made accessible to the resident population (Sanneving et al., 2013). Universal access to reproductive health care will help to reduce maternal mortality. Maternal health is compromised in developing countries due to a lack of infrastructure and resources (Sanneving et al., 2013). The current health care system in India is still uneven and inequitable (Sanneving et al., 2013). India has significantly changed its national health policy and channelized funds to build a more accessible health care system. A more unified health care delivery system is warranted to ensure maternal and reproductive health care to the population.

Culture, policies, and socio-political issues are key determinants of health inequality (Sanneving et al., 2013). The commission on Social Determinants of Health (CSDH) has identified five main structural determinants of health inequity in India namely, socio-economic factors, age, education, and gender (Sanneving et al., 2013). These factors are all interrelated to each other. They are the key determinants to influence the utility and accessibility to maternal health care. The interplay between social determinants in health inequity should be thoroughly understood to formulate better health policies to achieve health equity (Sanneving et al., 2013). Our paper will analyze the socio-cultural causes in the Indian system and will propose recommendations for changes in the current health care delivery system for safe maternal health.

Socio-Cultural Causes of Health Inequity

Maternal and reproductive health in India is a social phenomenon since the utilization of health care services is influenced by socio-cultural factors. MDGs can be achieved by achieving health equity and to achieve health equity it is important to understand the patterns of health inequity in the society. Health inequity can be rectified by identifying the vulnerable and disadvantageous segments of society (Haghparast-Bidgoli et al ., 2015). The best approach is to understand the interplay of all possible social determinants rather than just identifying a single determinant. The inadequate social arrangement is responsible for the unequal and unfair distribution of health (Haghparast-Bidgoli et al ., 2015). Health inequity has a social origin, unequal distribution (Haghparast-

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Bidgoli et al ., 2015). Analysis of social determinants is essential to identify health inequity (Haghparast-Bidgoli et al ., 2015).

The commission on Social Determinants of Health (CSDH) has developed a framework to analyze social determinants of health inequity (Haghparast-Bidgoli et al ., 2015). This action-oriented framework helps in identifying entry points for corrective action and policymaking to reduce health inequity in the system. The common notion is that health inequity arises from the unequal distribution of funds and resources in society (Haghparast-Bidgoli et al ., 2015). The political factors responsible for health inequity include governance, microeconomic, macroeconomic, socio-cultural factors, and epidemiological parameters (Haghparast-Bidgoli et al ., 2015). Structural determinants generate socio-economic stratification that results in the socio-economic position of the individual. Structural determinants include education, occupation, and income. A better picture of health inequality can be analyzed by understanding the interplay between structural, socioeconomic, and political determinants (Haghparast-Bidgoli et al ., 2015).Intermediary social factors include housing, physical conditions, living conditions, social support, and behavioral factors (Haghparast-Bidgoli et al ., 2015). These determinants should be systematically mapped to maternal health to identify gaps in the current system for corrective actions.

The Indian population living below the poverty line is 37 % of the total population (Haghparast-Bidgoli et al ., 2015). The government of India spends 5% of GDP on health (Haghparast-Bidgoli et al ., 2015). Indian health care system is not dominated by private insurance companies hence the out of pocket payment for health care is highest in India. Lack of insurance system imposes a large financial burden on the citizens. The health financing system has been identified as an important cause of health inequity in India (Haghparast-Bidgoli et al ., 2015).

Gender also influences the maternal health of Indian women. Only 55 % of Indian women are literate and their health care decisions are taken by men (Haghparast-Bidgoli et al ., 2015). Indian women access health care services with the permission of their men. Lack of literacy and health care awareness is also responsible for health inequity in society (Haghparast-Bidgoli et al ., 2015). Women's autonomy in making health care decisions is important to ensure reproductive health in this segment of society (Haghparast-Bidgoli et al ., 2015). Gender norms also influence the decisions related to contraceptive use and sterilization procedures.

Age is also a responsible factor for health inequity. The adolescent population has inequitable access to reproductive health due to social taboos and stigmas (Haghparast-Bidgoli et al ., 2015). Pre-marital sexual relationships are discouraged in Indian society (Banerjee et al., 2017). Hence, unmarried adolescent girls have low use of condoms, and inaccessibility to abortion care. Child marriage also has a significant impact on maternal health. Early marriage is associated with high fertility, multiple pregnancies, and poor obstetric outcomes (Banerjee et al., 2017). Teenage pregnancy is associated with fetal complications due to preterm births and stillbirths. Banerjee et al (2017) analyzed the socio-economic profile of women seeking abortion services in public health facilities across this state and out of pocket cost accessing abortion services. The study recommended that improved availability of safe abortion services at the primary level in Madhya Pradesh (India) will help to meet the need of safe abortion services among poor, which eventually will help to reduce the maternal mortality and morbidity due to unsafe abortion (Banerjee et al., 2017).

Collective analysis of the socio-cultural determinants of health inequity in Indian society helps to strategize convergent actions to address health inequity. These convergent actions will converge around a unified theme to improve maternal and reproductive health (Nambiar et al., 2015).

Recommendations and Policy Changes

Current health policy analysis and synthesis, global research on maternal and reproductive health, changes in social processes affecting health equity, and reforms in socio-political structure will help to transform the current Indian health care system to a more homogenous system with equal health care rights to all individuals of the society (Nambiar et al., 2015). The health task force should promote evidence-based applications in the current system for better health outcomes. The administrators should empower research managers with strategies to actively implement policies to achieve MGD goals. Federal and state-level agendas should be generated. Funds should be allocated based on priorities to address the issue of health inequity. The collaboration of health services and allied services should be encouraged to broaden the health care coverage to all segments of society. Workshops should be organized with presentations for stakeholders to bridge the gap between policies and actions. Cyclic evaluation of strategies and outcomes should be done periodically for continuous quality improvement. Information sharing at all levels, cooperation, coordination, and integration will help to build an intersectoral action plan for deliverable outcomes (Nambiar et al., 2015). Constructive engagement between global health researchers and policymakers is essential to address health inequity based on social determinants of health (Nambiar et al., 2015). The convergence approach will help to transform the current lateralized system to a more unified health care model ensuring health for all (Nambiar et al., 2015). A collaborative approach between government representatives, health care workers, and social workers are warranted to heed the global call to address health inequity (Nambiar et al., 2015).

CONCLUSION

Socio-cultural factors are responsible for health inequity in India. The Indian government is working on a new health care model to remove health inequity and improve maternal and reproductive health. But the progress made in achieving the objective of MGD is uneven and inequitable. The collective picture of socio-economic and structural determinants will help to improve accessibility to maternal health. Proposed interventions will help to target maternal mortality and morbidity, and resolve health inequity in the current Indian health care system. Constructive engagement between policymakers and public health researchers is required for the

active implementation of the proposed plan of action (Nambiar et al., 2015). More research is warranted to explore new strategies to reach out to the most vulnerable and marginalized population of Indian society.

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