SOCIO-ECONOMIC INEQUALITIES IN ACCESS TO MATERNAL HEALTH CARE IN INDIA: CHALLENGES FOR POLICY

Prof. Rama V. Baru
Centre of Social Medicine and Community Health
Jawaharlal Nehru University
New Delhi
Overview

- This paper provides a brief overview of socio-economic inequalities in access to maternal health services in India
- It explains why these inequalities persist
- It argues that commercialisation of health services is a determinant of accentuating inequities and contributing to poverty
The acceleration of economic growth since 1981 has not translated adequately into a sustained improvement in India’s human development outcomes [GDP growth: 1950-80 = 3.5; 1980-2000= 5.5; 2000-2011= 8.0 approx]

MMR and Under five mortality are unacceptably high and the decline has been slow. This is a cause for concern for both national and global policy (Subramanian et al :2006).

India offers a complex picture of multiple inequalities. There are regional, subregional, social and economic dimensions of inequality along multiple axes of class, caste, gender and religion

Broadly, these inequalities get reflected in health outcomes and access to health services

The available macro data sets enable us to examine these relationships and the patterns

However these data sets do not lend themselves to an analysis of intersectionality between these various inequalities (Iyer et al : 2007)

A few micro studies have analysed the relationship between inequalities, commercialisation and access (Jeffery et al :2007; 2008; 2010)
Inequalities in Under-Five Mortality in India, 2006


**Full Immunisation Rate**, Inequalities in utilisation of preventive care

Socio-economic inequalities and access to delivery services

Delivery in health facility across wealth index

Commonly cited reasons for inequities

- Supply side factors like weak public provisioning; poor quality of services

- Demand side factors- lack of knowledge; cultural beliefs; poverty; lack of purchasing power
Determinants of inequities in access

- Health service determinants and socio-economic determinants. Both these intersect and are responsible for the persistence of inequities.

- Commercialisation of health services has been a key factor perpetuating inequities in access.
Defining commercialisation

Commercialisation includes processes like marketisation, commoditisation, privatisation and liberalisation.

“the provision of health care services through market relationships to those able to pay; investment in, and production of those services, and of inputs to them, for cash income or profit, including private contracting and supply to publicly financed health care; and health care finance derived from individual payments and private insurance”

(Mackintosh & Koivusalo: 2005, p.3)
Attitude to public and private sectors is sharply divided between the academic view of privatisation and the approach of policymakers.

Need to ‘unbundle’ the complexity of commercialisation of health service systems—private and public.
Commercialisation and embodying inequality: Evidence from India

- Historical roots of commercialisation of Indian public sector in provisioning and drugs

- Formal and informal payments in public services during post-independence period

- Growth and diversification of ‘for profit’ health services since 1970s

- India has a large, differentiated ‘for profit’ sector
  
  *Muraleedharan: 1999; Nandraj and Duggal: 1997; Baru: 1998*

- Formal and informal providers
  
  *Narayana: 2006; Singh: 2010*
- Institutional arrangements replicate the social hierarchy \[(Baru:1998)\]

- Differences in qualification of providers, scale of operation and quality of care

- Lack of regulation

- Complex inter relationships between public sector doctors and paramedical personnel with private institutions \[(Baru:1998)\]
- Health sector reforms accelerated commercialisation—public and private (Qadeer et al: 2002)

- High out of pocket private spending (Bonu et al: 2007)

- Adverse consequences for access; cost and quality of care in public and private sectors 

- Cause for households going into poverty and also a defining aspect of being poor – i.e. those who are poorest cannot afford access to care 
  (Hart: 2000; Garg & Karan: 2005; Bonu et al 2007)
Rise in cost of care, high out of pocket expenditure, rising burden on households leading to differential levels of impoverishment of households across income quintiles for maternal health services

(Skordis-Worrall :2011; Pathak et al:2010)

- Significant poor-non poor gap in access to maternal health services (Pathak et al:2010)

- Reasons for these trends are attributed to growth of ‘for profit’ services and a deficient public sector
Consequences of commercialisation for maternal health services

- Informal payments for antenatal, delivery and postnatal services to the public sector form a significant percentage of expenditure on maternal health services (Sharma et al: 2005; Pathak et al: 2010; Skordis-Worrall: 2011)


- Shortage of supply of drugs through public institutions force women into purchasing from the free market
The contracting out of ultrasound facilities by public sector and referral from public to private sectors adds to out of pocket expenditure (NFHS 3: 2007; Jeffery & Jeffery: 2010)

Back and forth linkages between public and private sector; between formal and informal sector for maternal health services. (Unisa: 1999; Narayana:2006; Singh:2009; Jeffery & Jeffery: 2010)

Paying for care has therefore become entrenched in public and private sectors. This has resulted in the blurring of the roles of public and private sectors (Baru & Nundy:2008)

Rising commercialisation has altered the behaviour of public institutions and personnel. Normative values of public institutions have been gradually eroded (Baru:2005)
**Summing Up**

- Complex interaction between socio-economic inequalities and health services
- Commercialisation as a driver of inequities in access
- Health services planning and regulation must be in tandem to address inequities caused by commercialisation
- Recognising the limits of health services in addressing inequalities in access
- Addressing structural inequalities beyond health services
- Need for intersectoral coordination and greater convergence between health services and strategy for poverty reduction
Selected References

- Jeffery, P and Jeffery, R (2010) “ Only when the boat has started sinking: A maternal death in rural north India” Social Science and Medicine. November. 71(10), pp.1711-1718


Care and Skilled Birth Attendance in India, 1992–2006. PLOS open access journal


