



# NIAS Discussions

NATIONAL INSTITUTE OF ADVANCED STUDIES (NIAS)

Indian Institute of Science Campus, Bengaluru, 560012

## Health Inequalities The Indian Context

Report of the NIAS Wednesday Discussion held on 04 January 2017

*The speaker, Dr. Abha S Rao is a social scientist with a background in psychology, human development, family studies, and medical anthropology. Prior to this, she managed a large rural health intervention and explored the social factors that affect the implementation of health programs, including the role of rural community members and lay health workers, and the impact of administrative, societal, historical, and political local concerns. Her experience in the non-academic world has been in the area of intimate partner violence, as an advocate for victims/survivors.*

In the decades since independence, India has made significant gains in health indicators such as life expectancy, severe malnutrition, maternal and infant mortality rates, and in the eradication of key diseases. These gains, however, have not been distributed equitably, and considerable disparities exist along intersecting social and demographic characteristics: gender, caste, tribal status, socio-economic status, rural/urban residence, and region. Furthermore, these gains appear to have stalled: even as economic conditions have improved, nutritional outcomes, maternal mortality rates, and the prevalence of anemia have not. Of even more concern, this leveling has occurred

short of global health standards. What can explain this leveling of health outcomes, and how are they related to the persistence of health inequalities?

Much of the research in this area has focused on the economic model, or the relationship between income and health. It has been noted that this relationship is strong only for the very poor; after the poor overcome poverty, the relationship gets weaker and levels off. The stalled nutritional outcomes noted above may be explained by the increasing availability of options at this point of inflection, and the individual economic choice to make non-nutritional investments. This suggests





that as incomes further improve, individuals will no longer need to make such choices, possibly leading to a second point of inflection at which health outcomes further improve. It also implies that as *all* incomes improve, or income inequalities are reduced, it will ultimately lead to a decline in health inequalities.

However, the relationship between income inequalities and health inequalities is similar to that between income and health: it only matters for the very poor. Once the poor overcome poverty, the relationship weakens (i.e., even if the rich get richer, it has little impact on the health of those who are poorer). It has been suggested that it is not income and individual economic motivations, but social, cultural, and political inequalities, in addition to economic inequalities, that are associated with health outcomes and inequalities. These inequalities can be experienced in terms of structural or socio-cultural limitations.

Wide inequalities exist with respect to structural or health service factors such as the availability of public health facilities that are functioning, appropriately supplied with equipment and medicines, and staffed by trained personnel who provide quality care, and the accessibility of such facilities in terms of roads and transportation. Inequalities have also resulted from weak health sector regulations that have allowed private healthcare providers to offer care in very limited contexts.

### About NIAS Wednesday Discussions...

The NIAS faculty meets every Wednesday morning for academic discussions on various topics. As envisioned by Raja Rammanna, the Founder Director of NIAS, and pursued by his successors, the Wednesday meetings present the ongoing research, work-in-progress, and new/innovative ideas from the research studies of the faculty and the young researchers.

This Forum provides an excellent space to present one's work and also receive feedback and comments. Besides NIAS faculty and doctoral scholars others from outside the Institute also take part in these discussions.

Prof. Sangeetha Menon  
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coordinates these meetings.

Socio-cultural factors such as inequalities in education have contributed to the inadequate understanding and treatment of illness, which can influence behaviors such as health-care seeking and medical adherence, and inequalities in status may discourage disadvantaged individuals and communities from accessing care. Such inequalities, which disproportionately affect individuals who are women, poor, low-caste or tribal, rural, and live in certain parts of the country, can have a significant impact on health inequalities.

It is possible that an increase in income may lower structural inequalities (e.g., by allowing one to move to an area with better health facilities) and socio-cultural inequalities (e.g., by increasing autonomy for women or the low-caste), providing another pathway through which an increase in income will ultimately lead to improved health outcomes and reduced health inequalities. However, economic, structural, and socio-cultural factors interact in complex ways. At an individual level, for instance, a tribal guided by community beliefs may seek care from a local village healer rather than nearby public health facilities, or a woman who observes purdah, even if she were wealthy and educated, may not have the freedom to independently seek healthcare. At a community or national level, the interaction



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of these factors can produce health outcomes or maintain inequalities. This complexity is illustrated below with respect to anemia and maternal mortality.

India carries the largest global burden of anemia. In children, it can lead to cognitive impairment and delays in psychomotor development; for women, the consequences are severe: it is associated with poor pregnancy outcomes and is a leading cause of maternal mortality. India has had a national anemia control program since 1970, which involves the distribution of iron folic acid supplementation and the provision of education and nutrition counseling to vulnerable populations, but the program has not been effective in reducing the prevalence of anemia.

Fieldwork in Chamarajnagar district in south Karnataka suggests that economic reasons (inability to afford foods rich in iron), structural reasons (poor implementation of the anemia control program, unsatisfactory health worker conditions, access to private practitioners), socio-cultural reasons (religiously-proscribed diets, lack of knowledge about anemia and its seriousness), and an interplay of the above factors (inhibition of anemia program implementation due to caste and education inequalities between the health worker and villagers) have all contributed to the continued severity of the anemia problem.





The maternal mortality rate (MMR) has also leveled off in India, and has done so short of the targets set by the Millennium Development Goals. Tamilnadu is one of only three states in the country that has achieved this target, primarily through substantial financial investment in public health measures (increasing accessibility to health facilities, training health workers) and incentives to mothers (for receiving antenatal care, delivering in an institution, immunizing the baby). However, Tamilnadu's MMR is still higher than peer regions (such as Sri Lanka), and in a third of the districts in the state, the rate has actually increased over



the last decade. Rates of malnutrition and anemia remain high in the state, and these are highly related to gender, caste, and poverty. Further economic growth is unlikely to improve Tamilnadu's MMR unless it is invested in addressing the roots of social and cultural inequality.

The issues raised above – the leveling of health outcomes short of global standards, and the interplay of economic, structural, and socio-cultural inequalities that may lead to those diminished outcomes and contribute to health inequalities – lead to an unsettling concern: Is it possible for individuals to develop (knowingly or unknowingly) a limited conceptualization of health based on what is likely or possible, given the constraints of such inequalities, rather than what is desired? If so, this can result in the maintenance of the above trends. Emphasizing economic development or tackling economic inequality without promoting a broader yet more inclusive development can slow down or even stall the pace of India's healthy growth.

