
PUBLIC HEALTH RESEARCH

Healthcare inequalities: The United States vs India

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ABSTRACT

Accepted	30 August 2012
Introduction	The relationship between healthcare services and inequalities is more likely when a group that shares a salient identity faces severe inequalities of various kinds. Such inequalities may be catalyzed by economic, social, political or concern cultural status. The objectives of this review are to identify the issues and challenges involve in healthcare inequalities, to compare factors contributes to healthcare inequalities and to purpose suggestions and recommendations for improvement based on issues and challenges between United States and India.
Methods	Comparing annual year healthcare report, documentation of healthcare institutional, Ministry of Health's report and circular, official institutional website, scientific healthcare journals, articles and reports published in 1994 until 2011 regarding healthcare inequalities between United States and India.
Results	Health inequalities in the healthcare system contributed by the different in socioeconomic status and accessibility to the healthcare facility due to high cost of treatment has been common risk 'Catastrophic' factors to the inequalities in both countries. Health financing system and resource allocation that benefit only the upper class social spectrum of the population
Conclusions	Disparities occur due to the imbalance in distribution of wealth, discrimination and change in the world economy. Adapting healthcare system that provides care to all classes of people need improvement as no healthcare system is perfect. This matter must be tackle urgently as it's a matter of national concern.
Keywords	Health inequalities - developed countries - developing countries

INTRODUCTION

World Health Organization's Health Impact Assessment has defined health inequalities as differences in health status or in the distribution of health determinants between different population groups.¹ Inequalities in healthcare are strongly connected to inequalities in other areas of society, such as inequalities in socioeconomic status, living and working conditions.² It is a dilemma with many causes that cannot be tackled by the healthcare sector alone. An integrated approach based on integrated policy is needed. The relationship between healthcare services and inequalities is more likely when a group that shares a salient identity faces severe inequalities of various kinds.² Such inequalities may be catalyzed by economic, social or political or concern cultural status.³

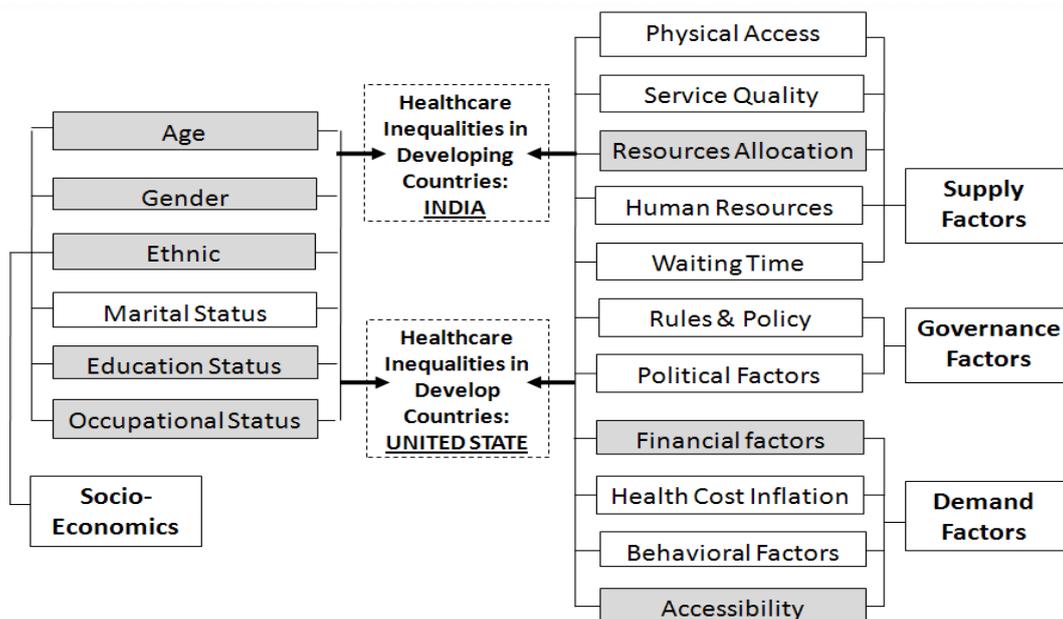
The socioeconomic circumstances of persons and the places where they live and work strongly influence their health.^{4,5} In the United States, as elsewhere, the risk for mortality, morbidity, unhealthy behaviours, reduced access to health care, and poor quality of care increases with decreasing socioeconomic circumstances.^{5,6} This relationship is continuous and graded across a population and cumulative over the life course.^{5,6} Educational attainment and family or household incomes are two indicators used commonly to assess the influence of socioeconomic circumstances on health.⁷ Education is a strong determinant of future employment and income. In the majority of persons, educational attainment reflects material and other resources of family of origin and the knowledge and skills attained by young adulthood. Therefore, it captures both the long-term influence of early life circumstances and the influence of adult circumstances on adult health. Income is the indicator that most directly measures material resources. Income can influence health by its direct effect on living standards (Access to better quality food and housing, leisure-time activities, and health-care services).⁷

Officially, Indian policymakers have always been concerned with the reduction of poverty and inequality. However, between the first five year plan after independence in 1947 and the turn of the century, Indian economic policy making went through a sea of change. After independence

and for a period of about forty years, India followed a development strategy based on central planning. One of the reasons for adopting an interventionist economic policy was the apprehension that total reliance on the market mechanism would result in excessive consumption by upper-income groups, along with relative underinvestment in sectors essential to the development of the economy.⁸ Policymakers in India adopted a middle path, in which "there was a tolerance towards income inequality, provided it was not excessive and could be seen to result in a higher rate of growth than would be possible otherwise".⁸ The macroeconomic sensitivity to inflation as fallout from growth reflected government concerns regarding the redistributive effects of inflation, which typically affected workers, peasants and unorganized sectors more. From the mid-1980s, the Indian government gradually adopted market-oriented economic reform policies. In the early phase, these were associated with an expansionist fiscal strategy that involved additional fiscal allocations to the rural areas, and thus counterbalanced the redistributive effects of the early liberalization. The pace of policy change accelerated during the early 1990s, when the explicit adoption of neo-liberal reform programs marked the beginning of a period of intensive economic liberalization and changed attitudes towards state intervention in the economy.⁹ The focus of economic policies during this period shifted away from state intervention for more equitable distribution towards liberalization, privatization and globalization. It should be noted that the Indian experience with such policies over this period was more limited, gradual and nuanced than in many other developing countries, with correspondingly different economic effects.⁹

The objectives of this review are to identify the relevant issues and challenges involve in healthcare inequalities, to compare factors contributes to healthcare inequalities between United States and India and to purpose suggestions and recommendations for improvement based on issues and challenges between United States and India.

Figure 1 Research Framework for the Healthcare Inequalities reviews in United States and India



METHODOLOGY

This purpose of this review is to compare the inequalities factors in healthcare system between United States (develop country) and India (developing country). The scope of this study has focus on socio-economic (such as age, gender, ethnic, education status and occupational status), supply (resources allocation) and demand (financial and accessibility) factors. The information was collected by comparing annual year healthcare report, documentation of healthcare institutional, Ministry of Health’s report and circular, official institutional website, scientific healthcare journals, articles and reports published in 1987 until 2011 regarding healthcare inequalities between United States and India.

RESULTS

United States and India Healthcare Systems

The United States offers the highest quality of care in the world, for most but not all individual patients. Approximately 15% of Americans have no private health insurance and therefore have limited access to the best care and services.¹⁰ The lack of insurance for so many citizens is a national problem that thus far has eluded a comprehensive solution. Furthermore, on a number of health measures pertaining to the population as a whole (Such as life expectancy and infant mortality), the United States lags behind other developed nations.¹⁰

Healthcare is one of India’s largest sectors, in terms of revenue and employment, and the sector is expanding rapidly. During the 1990s, Indian healthcare grew at a compound annual rate

of 16%. Today the total value of the sector is more than \$34 billion. This translates to \$34 per capita, or roughly 6% of GDP. By 2012, India’s healthcare sector is projected to grow to nearly \$40 billion. The private sector accounts for more than 80% of total healthcare spending in India.¹¹ Unless there is a decline in the combined federal and state government deficit, which currently stands at roughly 9%, the opportunity for significantly higher public health spending will be limited.¹¹

Healthcare Inequalities

The inequalities in United States healthcare exacerbate the already severe socioeconomic inequalities and injustices in the country. In higher-wage firms 67.0% of workers are covered by their own employer, compared to 47.0% of workers in lower-wage firms. While the overall United States life expectancy rate is 77 years, the rate for blacks is about 72 years with black males at a third-world level of 68 years. While high blood pressure, heart disease, and diabetes are rampant among the poor and working class, there are few programs to improve the income related lifestyle. The United States has one of the highest infant mortality rates in the Organization for Economic Co-operation and Development Countries (OECD).¹²

In United States, over \$250 billion is spent annually on drugs, realizing a 15.7% profit for the drug industry, as a percentage of its revenues.¹³ From the pharmaceuticals’ point of view, public health is the opposite of wealth. The private insurance system has begun to sponsor programs to promote healthier eating habits, exercise, and so forth, to limit their expenses for costly procedures

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and hospitalizations. However, insurers and individuals spend huge sums on medications that are palliatives which promise high profits for pharmaceutical companies. These drugs, like cholesterol lowering statins, often underperform lifestyle changes.

In 2007, the population of the children in India has recorded that about 43.5% are fully immunized and 79.1% of children from 6 months to 5 years of age are anaemic.⁵ Besides that, 56.1% ever married women aged 15-49 are anemic and 2/3 of the India's population has been denied their access to receive the essential drugs. The previous study conducted also has shown that the Infant Mortality Rate is 58/1,000 live births and Maternal Mortality Rate is 301/10,000 for the country.¹⁴

Financial System Inequalities

About 47 million Americans which are 16.0% have no health insurance at all, 20 million are underinsured, and 108 million have no dental insurance. Families that have insurance via an employment-based health plan contribute an average of \$3,281 a year. The employee share of health insurance premiums rose from 14.0% in 1992 to 22.1% in 2005, not including the higher deductibles or co-pays paid by employees that also have occurred over this same time period. Health insurance costs have been increasing three times as fast as wages. However, the ratio of private industry employer spending on healthcare, including insurance, to profits has been cut in half between 1986 and 2005.¹⁵

Healthcare spending is currently 16.0% of the gross domestic product. It is projected to rise to 25.0% by 2030.¹³ In 2003, the United States spent \$5,635 per person on health, more than twice the average within the OECD Countries, an association of developed capitalist countries. This was around ten times more than the lowest-spending countries within the OECD Countries, Mexico and Turkey. These costs have doubled in the past seven years, and now the annual premium that a health insurer charges an employer for a health plan covering a family of four averages \$12,106.00.¹²

However, over the past forty years, adjusting for inflation, corporate profits per worker have doubled while workers' wages are lower. Not only do workers contribute \$3,281 of the annual family premium, but they also shoulder the costs of deductibles and out of pocket expenses, which are also rising.¹⁶ Premiums for family coverage have increased 78.0% since 2001, while wages have risen 19.0% and the cost of living has climbed 17.0%. In 2006 was the tenth straight year that medical cost growth outpaced wage growth. In 2005 the annual premiums for family coverage eclipsed the gross earnings for a full-time, minimum-wage worker \$10,712. The reality is that

costs have been shifted more and more onto workers.¹⁶

The difference across the economic class spectrum in India and by gender in the untreated illness has significantly increased according to the Centre for Health Equity, India. The study conducted in India has recorded that about 80.0% healthcare expenditure born by patients and their families as out-of-pocket payment (fee for service/treatment and drugs).¹⁷ The healthcare financing system in India shows that only 15.0% is publicly financed, 4.0% from social insurance, 1.0% by private insurance, 80.0% is out of pocket spending (85.0% goes in private sector). These can be interpreted that only 15.0% of the population is in organized sector and has some sort of social security and 85.0% is left to the mercy of the market (moral hazard, adverse selection, supplier induced demand) and because of the small percentage of budget allocated for health (0.9% of GDP) and the budget allocated over the last decade has been stagnant.^{18,19}

Social Economic Inequalities

Income of the black American was 80.0% of the white American and black women earns 84.0% of the white American women.²⁰ This disparity in income has led to the out of pocket payment from medical bill in the group of worker that can't afford the family insurance package, later they will be burdened by this medical bills. This medical bill has made few of the workers that suffer catastrophic illness such as cancer to bankruptcy.²¹

The less fortunate must make sure they are healthy if not they will suffer because there is no healthcare for them if they get sick. Especially children without parents, they are not covered at all by the insurance.²⁰ Women without health insurance are likely not going for screening test for breast and cervical cancer. They will come for the screening when the symptoms started showing. This in turn will cause late detection and give poor prognosis in term of cure.²²

India's performance in health and well being underscores this disparity. India is ranked low in terms of overall health status compared to other countries.²³ Population with multiple community level of status social demographic will be charge higher and higher burden shared among poor people.²⁴ About 72.0% of India's population (5,75,936 villages) are inhibited by the rural poor with agriculture as their predominant occupation and they are largely small and marginal farmers, agricultural laborers, artisans and scheduled castes and scheduled tribes.²⁵ A large number of rural people (quarter of a population) are still living below the poverty line and often face the basic problem of survival, jobs, poverty, hunger, shelter, ill-health, disease & being excluded from healthcare services.²⁵ Since poor community is the most

sensitive to health payment charge, at the end their liability to get the healthcare services will deprive.²⁴ India's health and primary education system was ranked 101th out of 131 countries and economies by the World Economic Forum (WEF) in 2007 and 2008.²³ Cutbacks by poor on food and other consumptions resulting increased illnesses and increasing malnutrition.¹⁹

Resource Allocation

The United States private-public healthcare system spends much more on healthcare than any other nation; in fact, annual healthcare spending in United States now exceeds \$1.6 trillion.²⁶ Resource allocation depends on the market and the market is control by the private sectors. In United States, competition exists among provider networks, whether they consist of hospitals or doctors or both, to assemble bargaining power so that they can strike a better deal for themselves, healthcare is treated as a commodity.²¹ The United States has spends more than any other nation nearly \$300 billion a year to administer its healthcare system. Raise in premiums can be certified to healthcare costs driven up by expensive new drugs, many of them heavily advertised to consumers, medical advances including diagnostic tests that require costly new machines.²¹

India's human resources for health challenge present a further hurdle for assuring equity in healthcare. The rural areas in India are served by over a million rural practitioners, many of whom are not formally trained or licensed.²⁷ The most disadvantaged are more likely to receive treatment from less qualified providers. There were poor system, infrastructural & healthcare facilities especially allocated in India's rural areas.²⁷

CONCLUSIONS

United States healthcare system needs to utilize personal medical insurance in order to cover the medical bills. Government also contribute and cover the elderly and children but this medical care is limited to a group of people. The resources allocation such as professional worker such as doctors is driven by the market itself. United States healthcare system use about 16.0% of the GDP and still 47 million Americans are not insured. They only serve only people that can afford to pay the medical bills. This medical insurance also increases every year and it does not care whether the worker can pay the premium or not. Disparity in health can be seen between the ethnic group and socioeconomic classes. People that are wealthy are getting all the care and treatment and the poor will suffer if they get sick. Number of unemployment kept increasing every year and number of uninsured also increase. In developing country where healthcare system depend on out of pocket and health insurance, disparities arise from the

socioeconomic classes. Increase burden of disease among the poor are transparent compare to the wealthy group of people. Accessibility to healthcare is restricted due to distance, transport and high cost of treatment. Anywhere in the world whether developed or developing country some degree of disparities of healthcare does occur. Disparities occur due to the imbalance in distribution of wealth, discrimination and change in the world economy. These are some of the factor that contributes to disparities. Adapting healthcare system that provides care to all classes of people need fine tuning as no healthcare system is perfect. This matter must be tackle urgently as it is a matter of national concern.

Importantly, India's ineffective regulatory mechanisms and legal processes urgently need to be reformed; with effective implementation strategies. The growth of the private sector and pharmaceutical industry has outpaced the capacity of the government and other stakeholders to implement the necessary and appropriate regulatory processes. Incentives, rules, and strategies are needed to engage and persuade the industry to ensure that its obligations and responsibilities to population health and equity are upheld. In this way, an organised civil society might have a role in influencing the political agenda, partly through dissemination of knowledge and improvements in education to generate increased health consciousness and address the factors that affect the demand-side challenge of appropriate health-seeking behaviour—eg, engagement of accredited social health activists as part of the National Rural Health Mission to generate increased awareness within communities of the available services. This programme should be complemented by improved awareness of the right to health and the right to healthcare, with more accountability of the government and other stakeholders to deliver their obligations fairly.

ACKNOWLEDGEMENT

We would like to thanks nursing staffs who involved in this study. This study was supported by a research grant from Songkhla Hospital.

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