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Eliminating Health Discrepancies: Insights through Free market or State control

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Introduction

Healthcare inequality or healthcare disparity refers to the differences in the quality of health and health care across different populations. This may include differences in the prevalence of disease, health outcomes, or access to health care across racial, ethnic, gender, and socioeconomic groups. Differences among populations in the presence of disease and health outcomes are well documented in many areas. In the United States, disparities are well documented in minority populations such as African Americans, Native Americans, Asian Americans, and Latinos, with these groups having higher incidence of chronic diseases, higher mortality, and poorer overall health outcomes. For example, the cancer incidence rate among African Americans is 10% higher than among whites, and adult African Americans and Latinos have approximately twice the risk as whites for developing diabetes. Similarly, disparities in the overall level of health in individuals also exist between differing socioeconomic groups, with lower-status socioeconomic groups generally having poorer health and higher rates of chronic illness including obesity, diabetes, and hypertension. Those in lower socioeconomic status groups receive less consistent primary care, which is positively correlated to overall level of health in the recipient. Similarly, in England, people living in deprived areas were found to receive around 70% less provision relative to need compared with the most affluent areas for both knee and hip replacements.

A lack of health equity is even more evident in the developing world, where the importance of equitable access to healthcare has been cited as crucial to achieving many of the Millennium Development Goals. Wide health disparities exist in developing countries when it comes to access to quality health care, particularly in rural areas.

Indian Scenario

India has a population of more than a billion, with over 70% population living in rural areas. Large disparities in health and access to adequate healthcare exist in the country and current evidence supports the notion that these disparities continue to exist and are a significant social health issue. Healthcare in India features a universal health care system run by the constituent states and territories of India. Primary health care is provided by primary health centres (PHCs) in rural areas. There is a high patient turnout in these health centers where the treatment is provided free of cost. Primary care is focused on immunization, prevention of malnutrition, pregnancy, child birth, postnatal care, and treatment of common diseases. Free services in the centers are being utilized mainly by the poor. Patients who need specialized care or have complicated illnesses are referred to secondary (often located in district and taluk headquarters) and tertiary care hospitals (located in district and state headquarters or those that are teaching hospitals). The lower middle, middle and upper class people avoid these health centers; instead utilize services of private health practitioners.

The vast majority of the country suffers from a poor standard of healthcare infrastructure which has not kept up with the growing economy. Despite having centers of excellence in healthcare delivery, these

facilities are limited and are inadequate in meeting the current healthcare demands. The government health care sector is underfinanced and nearly one million Indians die every year due to inadequate healthcare facilities and 700 million people have no access to specialist care; 80% of specialists live in urban areas.

India faces a huge need gap in terms of availability of number of hospital beds per 1000 population. With a world average of 3.96 hospital beds per 1000 population and around 8-9 hospital beds per 1000 population in developed countries, India stands just a little over 0.7 hospital beds per 1000 population. Poor services at state-run hospitals force many people to visit private medical practitioners. It is estimated that around 10% to 12% of family income needs to be spent on taking care of emergency health care needs and age old problems. The emergency and specialty care is well beyond the reach of an average citizen. Thus, health care today in India is at crossroads.

No provision for oral health services

India is having around 300 dental schools, which makes approximately about one third of the dental school present worldwide. Annually around 20,000 dentists are graduating every year in India. Also roughly 5000 specialists pass out each year. Even with this kind of manpower the nation has no oral health policy. Fresh dental graduates are paid less then Rs 6000 pm, (approx. 120 $ pm) so many of the dental graduates in India are forced to work in places like call centers or to go for a change in profession.

Oral health policy was drafted by Dental Council of India (DCI) way back in 1985. National oral health policy (1985) recommends dentists to be appointed at primary and community health centres . Till present the policy has not be implemented and there is no provision of basic or emergency public oral health services either in urban or rural areas of India. Oral health has not been included in public health politics, a change that could have led to improvement in the differences in health status of urban and rural population. It would have also brought down the dissatisfaction among the dental community by new jobs being created.

Free versus controlled market

A free market is one which has no economic intervention and regulation by the state. Advocates of a free market traditionally consider the term to imply that the means of production is under private, not state control. Free markets contrast sharply with ‘controlled markets or regulated markets’, in which governments directly or indirectly regulate prices, goods, services and labor, which according to free-market theory causes markets to be less efficient. Where government intervention exists, the market is a mixed economy.

A free-market economy is an economy where all markets within it are unregulated by any parties other than those players in the market. In its purest form the government plays a neutral role in its administration and legislation of economic activity neither limiting nor actively promoting it. Such an economy in its most radical form does not exist in developed economies, however efforts made to liberalise an economy attempt to limit the role of government in such a way. Free market existing with the doctrines of Socialism like limited regulation of prices by the government to protect the poor can be an ideal situation for developing countries like India and South East Asian countries to attain growth and prosperity.

It becomes a topic of discussion whether health sector in developing countries should develop a NHS like organization like in UK where free services are available to all irrespective of color, nationality or income; or a free market as in US and many other developed countries.

Be it the free market, state controlled market or a National Health Service like organization, each has its pros and cons. Starting NHS like service as in UK in the current scenario will not be feasible for developing countries including India. Reasons being densely populated states and underfinanced health care. Later, if funds do permit then existing primary and community health centers can be reorganized as National Health Service clinics.

A more appropriate action for the Indian health sector in the current situation will be to revamp the primary and community health centers in rural and urban areas. Government participation has to increase in safeguarding the health of its people, be it a NHS like organization or a total state controlled health sector or something in between. Currently a vast majority of the country suffers from a poor standard of healthcare infrastructure which has not kept up with the growing economy. Despite having centers of excellence in healthcare delivery, these facilities are limited and are inadequate in meeting the current healthcare demands. We need to keep in mind about our people, specifically those in rural areas and their living standard and adopt a policy which suits our people better.

Disparities in access to health care

Reasons for disparities in access to health care are many, but can include the following:

Lack of a regular source of care: Without access to a regular source of care, patients have greater difficulty obtaining care, fewer doctor visits, and more difficulty obtaining prescription drugs.

Lack of financial resources: Lack of financial resources is a major barrier to health care access for majority populations. The health care system might also be facing financial restraints from the government and those enrolled in such health insurance plans would face limits on covered services and limited number of health care providers.

Lack of insurance coverage: Without health insurance, patients are more likely to postpone medical care, more likely to go without needed medical care, and more likely to go without prescription medicines. Minority groups usually lack insurance coverage at higher rates than other groups.

Structural barriers: These barriers include poor transportation, inability to schedule appointments quickly or during convenient hours and excessive time spent in the waiting room, all of which affect a person's ability and willingness to obtain needed care.

Scarcity of providers: In inner cities, rural areas, access to medical care can be limited due to the scarcity of primary care practitioners, specialists, and diagnostic facilities.

Health literacy: This is where patients have problems obtaining, processing, and understanding basic health information. For example, patients with a poor understanding of good health may not know when it is necessary to seek care for certain symptoms. The problem can be more pronounced due to socioeconomic and educational factors.

Lack of diversity in the health care workforce: A major reason for disparities in access to care are the cultural differences between health care providers and patients. For example, patient health decisions can be influenced by religious beliefs, mistrust of Western medicine, and familial and hierarchical roles, all of which a health care provider may not be familiar with.

Age: Age can also be a factor in health disparities for a number of reasons. Old patients may face barriers such as impaired mobility or lack of transportation which make accessing health care services challenging for them physically. Also, they may not have the opportunity to access health information which could put older individuals at a disadvantage in terms of accessing valuable information about their health and how to protect it.

Provider discrimination: This is where health care providers either unconsciously or consciously treat certain racial and ethnic patients differently than other patients.

Lack of preventive care: Preventive measures like screening for chronic diseases including cancer should be the focus. This needs creating awareness among the population through mass education, organizing public health programs etc. For example, minorities are not regularly screened for colon cancer and the death rate for colon cancer has increased among African Americans and Hispanic people.

Legal barriers: Access to medical care by low-income groups can be hindered by legal barriers to public insurance programs. For example, in the United States federal law bars states from providing Medicaid coverage to immigrants who have been in the country fewer than five years.

Linguistic barriers: Language differences restrict access to medical care for minorities in the United States who are not English-proficient.

These are some aspects of the health care offices that should be considered; they include the location of the healthcare offices, public transportation availability, clinic hours, the physical environment of the clinic, and the rapport built with the patients. Hiring professional interpreters for speaking and hearing impaired can decrease the communication barriers. Greater representation of minority group and rural population within the health care workforce is essential to reduce the health disparities.

Majority of the Indian population is unable to access high quality healthcare provided by private players as a result of high costs. Many are now looking towards insurance companies for providing alternative financing options so that they too may seek better quality healthcare. The opportunity remains huge for insurance providers entering into the Indian healthcare market since 75% of expenditure on healthcare in India is still being met by out-of-pocket consumers. Even though only 10% of the Indian population today has health insurance coverage, this industry is expected to face tremendous growth over the next few years as a result of several private players that have entered into the market. Health insurance coverage among urban, middle- and upper-class Indians, however, is significantly higher and stands at approximately 50%. Health insurance has a way of increasing accessibility to quality healthcare delivery especially for private healthcare providers for whom high cost remains a barrier. In order to encourage foreign health insurers to enter the Indian market the government has recently proposed to raise the foreign direct investment (FDI) limit in insurance from 26% to 49%. Increasing health insurance penetration and ensuring affordable premium rates are necessary to drive the health insurance market in India.

Conclusion

Health sector in India and many other developing countries is more of a free market, with a public distribution system with subsidized prices being fixed by the government to protect the poor. This idea sharpens the debate between those who believe that the answer to the problems in the health sector lies in much more government involvement through expansion of public programs and those who believe that the free market can and does have much more potential to get health insurance costs down and provide people with greater access to coverage and more choices. Competition is working, but there are threats on the horizon. The leadership in developing countries including India should set a clear agenda involving expanding government health care programs and cutting back the initiatives begun over the past several years to bring more competition and patient choice into private and public programs.

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