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The Neglected Middle-Class and Social Justice in Health

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Abstract

With the rise of income inequality, the matter of social justice has also gained the momentum in past few decades. Social justice ensures equal distribution and access to public resources among individuals. However, socioeconomic inequality along with the biased government policy has raised a serious concern over the ethos of social justice in access to public resources including healthcare. The paper analyses the issue of social justice in health in India and one of the poorest states – Bihar. India is a democratic country with a strong democratic structure and constitutional provisions, but still, there is a high socioeconomic inequality. Therefore, it is interesting to study social justice in healthcare access in India. National Sample Survey (NSS) data on health – 71st and 75th rounds are used for the study. Social justice in health is analysed by focusing the healthcare access to the middle-income class. The result shows that inequality in healthcare access across income-class in prevailed in both India and Bihar, but the issue of social justice in health is a serious concern in Bihar only. Biased healthcare policy and inadequate public health protection schemes are some of the major reasons for the poor social justice in healthcare access in Bihar.

Keywords: Social Justice, Healthcare Access, Middle-Income Class, Health Inequality, Healthcare Policy

Introduction

The complete definition of health is still debated due to its multi-dimensional facets and measurements. However, better health status can be expected by ensuring greater healthcare access. Many of the past empirical studies have emphasized equitable healthcare access, so the marginalized section of the population may improve their health status. The 'right to health' under Article 21 of our constitution provides the political spirit to legislate various health-related policies and programs to bring the marginalized into the mainstream of healthcare access. Hence, on the pillar of social justice and rights, several National health policies are formulated. One of the most comprehensive financial protection schemes – 'Ayushman Bharat Yojana' under the PMJAY is also intended to make healthcare access easy and affordable to the marginalized. Since health is a state subject, the state governments including Bihar have their own health-related schemes. For example, Bihar is currently running the 'Ayushman Bharat Bihar', similar to the centre-level scheme.

Hence, if we look at the period of the past 75 years, almost all the health policies and programs are formulated by considering the poor and SC-ST groups as the major beneficiaries. Those policies and programs gave positive results too. However, in the past decade, the cases of non-access to healthcare are significantly increased among the middle-income class. Their cases of mental illness are also increased many folds. The NSS 75th round report on health and NFHS 5 report confirms it. So, again inequitable healthcare access is getting increased, although in another way. Our understanding of social justice in health needs fresh thoughts and introspection.

Income Distribution in India

The income distribution in India is quite uneven. few of the major reports reveal the status of income inequality in India. As per the latest report of Oxfam (2022), 77% of the total national wealth is held by only the top 10% of the population. In 2017, 73% of the total wealth generation went to only 1% of the richest, while 670 million of people (around half of the population) who represent the poorest class, saw only a 1% increase in their wealth. The World Inequality Database (WDI) report (2021) categorizes India as a country with 'extreme' income equality. The top 10% earns 20 times more than the bottom 50%. The State of Inequality in India report (2022) says that around 5-7% of the national income is held by only 0.1% of the richest people. The top 1% holds 6.82% of the total income whereas, the top 10% holds 32.52% of the total income. In contrast, the bottom 50% holds only 22% of the total income. As per the Periodic Labour Force Survey (2019-20), around 90% of wage earners have a monthly salary of less than Rs. 25,000. The National Family Health Survey report (2019-21) finds that rural area has a comparatively higher poor population. Around 54% of the rural population belongs to the poorest and poor group (bottom

two wealth quintiles), while only 10.4% of the urban population is found to be poor. Additionally, 74% of the urban population belongs to the richest and rich groups (top two wealth quintiles). Income inequality is also highly observed across the states. Bihar, Jharkhand, and Assam are the top three states with the highest population in the poorest and poor group (bottom two wealth quintiles), while Kerala, Delhi and Goa have the least population in the same groups. the report highlights the North-South divide in India where Southern states are performing better than the Northern states in dealing with income inequality.

Defining the Middle-Income Class

There is no specific definition of the middle-income class. Rather, different approaches have been used by the authors, policymakers and institutions to define the different income brackets for the poor, middle-income and rich classes. A few of the approaches used by eminent organisations and institutions are discussed here.

The Organisation of Economic Cooperation and Development (OECD) considers people as poor who are living on less than US $2 per day while those whose daily earnings are in the range of US $10 to US $100 per day fall in the middle-income class. The People Research on India's Consumer Economy (PRICE) defines the middle-income class household with an annual income of Rs. 3 lakhs to Rs. 30 lakhs. National Council for Applied Economic Research (NCAER) defines the middle-income class as people who earn between Rs. 2 lakhs to Rs. 10 lakhs a year. Pew Research Centre finds that the middle-income class earns between US $10.01 to $20 daily. Hence, the middle-income class is defined differently by different organizations and institutions according to their own understanding and context of income distribution. In our study, we follow the income classification as suggested by the NFHS report i.e., the bottom two income quintiles as the poorest and the poor; the top two income quintiles as the richest and the rich; and the third quintile is the middle-income class.

In this paper, we try to explore healthcare access across income-class in general and identify the major barriers to healthcare for the middle-income class in particular. The study is conducted in both India and Bihar. The Longitudinal Ageing Study in India (LASI) data under the NFHS 5 is used for the study. The socio-economic determinants, contributing to healthcare access are also analysed and then, figure out their role in non-access to healthcare for the middle-income class. The effectiveness of health schemes is also analysed and tried to determine, whether the scheme itself has a significant contribution to social injustice in health for the middle class or the other neglected factors are responsible too. According to the findings of the study, appropriate suggestions are made to make health policies and programs more equitable and effective.

Data and Methods

The "National Sample Survey (NSS) data on consumption: Health" for the period 2014-15 (71st round) and 2017-18 (75th round) are used here. The data is available on both inpatients and outpatients, although, in this paper, only outpatient data is used. The sample sizes of the 71st round data are 37,282 and 924 for India and Bihar respectively and for 75th round data, the sample sizes are 43,240 and 731 for India and Bihar respectively.

To test the association between the non-access to health and socioeconomic determinants, a logistic regression model is used here which is as follows:

Yi (Non-access to healthcare) $= \alpha + \beta_1$ (sector) $+ \beta_2$ (household size) $+ \beta_3$ (Religion) $+ \beta_4$ (Social group) $+ \beta_5$ (Gender) $+ \beta_6$ (Age) $+ \beta_7$ (Education level) $+ \beta_8$ (Income) $+ \beta_9$ (Whether illness is chronic) $+ \beta_{10}$ (Whether med service free) $+ €_i$

The dependent variable – 'non-access to healthcare' is a dichotomous variable with the outcome – yes or no. All independent variables are categorical variables with either two or more than two responses. All the analysis is conducted in SPSS ver. 20.

Results and Analysis

Table 1 shows the proportion of non-access to healthcare by household members in India and Bihar for years 2014-15 and 2017-18.

Table 1: Trends in unmet need for health care among the ailed person, 2014-15 & 2017-18

		Non-access to healthcare (%)			
		All India		Bihar	
		2014-15	2017-18	2014-15	2017-18
Sector	Rural	17.7	13.8	37.6	38.2
	Urban	11.1	8.1	41.3	30.2
Household Size	0-5	15.1	11.3	44.9	39.4
	6-10	16.2	12.9	32.3	35.9
	11-15	10.8	8.3	4.2	24.7
	16 and above	6.3	6.0	18.1	22.6
Gender	Men	15.5	12.0	33.8	38.3
	Women	15.1	11.5	41.8	36.0
Age	0-14	18.4	15.9	50.6	42.1
	15-29	19.6	16.1	42.2	26.4
	30-44	18.4	13.8	27.5	36
	45-59	12.5	9.2	31.5	31.3
	60 and above	10.7	8.1	30.2	44.7

Social group	SC & ST	20.3	14.9	41.9	44.3
	OBC	14.2	12	37.3	36.8
	Others	13.0	9.1	36.3	22.9
Income level	Poor	21.6	16.4	45.2	40.4
	Middle-income	15.5	10.8	35.5	40.1
	Rich	9.7	7.5	21.7	10.7
Education level	Illiterate	16.6	13.5	31.4	36.8
	Primary & Middle	16.1	12.2	54.3	51.4
	Sec & High. Sec	10.6	8.3	32.6	11
	Grad and above	12.5	6.4	17	19.5
Religion	Hinduism	15.7	12.3	40.6	36.8
	Islam	14.6	10	21.3	39.5
	Others	12.4	8.6		
Total		**15.3**	**11.7**	**38.0**	**37.2**

There is a significant drop in cases of non-access to healthcare over two periods on the national level. In 2014-15, the case of non-healthcare is 15.3% which drops to 11.7% in 2017-18 on all India level. In Bihar, the cases of non-access to healthcare are quite high at 38% and 37.2% in 2014-15 and 2017-18 respectively, indicating a marginal fall of only 0.8% over these two periods in Bihar. The result shows the health system of Bihar is not much responsive to the need of ailing people.

If we observe the trend of non-access to healthcare across socio-economic variables like Income, Age, Education, religion etc., the trend has declined significantly in India, but the trend has a mix of results in Bihar.

In India, the cases of non-access to healthcare in rural area has fallen by 3.9% points, while a fall of 3.0% points is observed in urban areas. The rural-urban gap in non-access to healthcare has also reduced from 6.6% to 5.7% over periods. In Bihar, the trend of inequality in healthcare access is not impressive. In rural areas, the cases of non-access to healthcare increase by 0.8% points while in urban areas, it increases by 11.1% points. The rural-urban gap in non-access to healthcare has widened from 3.7% to 8.0% points over periods.

In India, the case of non-access to healthcare is lower in large household sizes. Further, a downward trend of non-access is observed for all sizes of households, and a large fall is observed among the lower size of households (3.8% in 0-5 and 3.3% in 6-10). The gap in healthcare access across sizes of households is also reduced over periods. In Bihar, the cases of non-access to healthcare are higher than the nation's average across all sizes of households. Further, only small size households show improvement in reducing the cases of non-access (5.5% in 0-5), while the household size of 11-15 shows the highest increment of 20.5% points.

In India, there were 15.5% of men and 15.1% of women didn't have access to healthcare in 2014-15 but their percentages fall to 12.0% and 11.5% respectively in 2017-18. Thus, improvement in access to healthcare is observed in both men and women, although such improvement is higher (0.5%) among women. Further, the gender gap in healthcare access is although small, but not narrowed over periods on all India level. In Bihar, there were 33.8% of men and 41.8% of women who didn't have access to healthcare in 2014-15 but the proportion of men increased to 38.3% and, of women decreased to 36.0% in 2017-18. Hence, the situation of women has significantly improved (2.3%) but the men's condition has deteriorated (3.5%) over time with access to healthcare. It results in the narrowing of the gender gap, although not at a satisfactory level of healthcare access.

In India, household members from all age groups have shown improvement in healthcare access. The highest fall of 4.6% points in cases of non-access to healthcare is observed in the age group of 30-44 years followed by 15-29 years (3.5%). However, low percentage drops in non-access to healthcare among children (2.5%) and old age people (2.6%) are unsatisfactory. In Bihar, a significant fall of 15.8% points in cases of non-access to healthcare is observed among the age group of 15-29 years, followed by age group of 0-14 years (8.5%). The old age group (60 and above) reports an increase of 14.5% points in cases of non-access which is a matter of concern, followed by working-age people of age 30-44 years (8.5%).

In India, cases of non-access to healthcare fall across all social groups. SC-ST group observes the highest fall of 5.4% points, followed by others (3.9%) and OBC (2.2%). The gap between SC-ST and others has also reduced but increased between OBC and others with non-access to healthcare. In the case of Bihar, a significant fall of 13.4% points in cases of non-access to healthcare is observed among the others while OBC observes a marginal increase of 0.5% points while SC-ST reports an increase of 2.4% points.

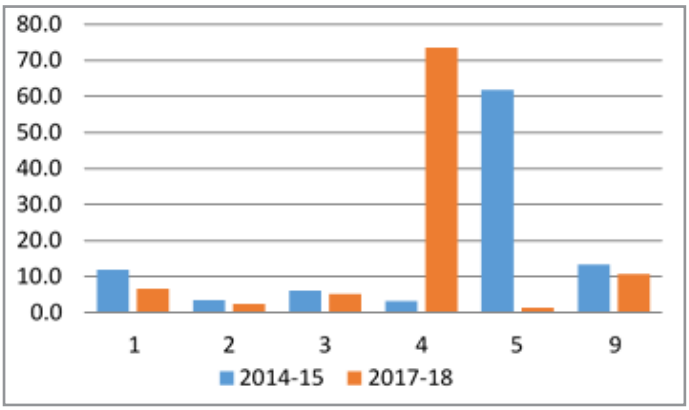
In India, cases of non-access to healthcare have fallen across all income classes, and such fall is more significant among the poor (4.7%) and middle-income-class (4.3%). The gap in cases of non-access between the poor and rich has also fallen by 3.0% points, and among the middle-income and rich by 2.5% points over periods. In Bihar, cases of non-access to healthcare among the poor and rich have reduced by 4.8% and 11% points respectively, while the middle-income class shows an increment of 5.4% points. Further, the gap in cases of non-access between the poor and rich has increased by 6.2% points and between the middle-income and rich by 15.6% points over periods. Therefore,

the condition of the middle-income class in healthcare access is more distressing than others.

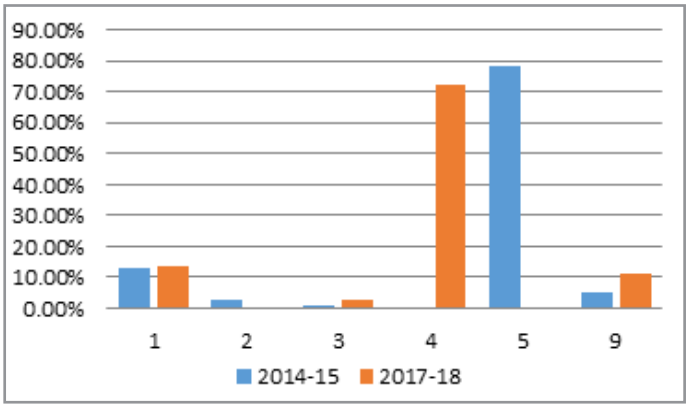
In India, the cases of non-access to healthcare have fallen across all education levels over periods. However, such fall is highest at 4.1% points among the people of higher education, followed by Primary & Middle (4.0%) and illiterate (3.1%). In Bihar, the cases of non-access to healthcare have significantly fallen by 21.6% points among people with Secondary & Higher Secondary education, followed by Primary & Middle (2.9%). Illiterate has reported the increment in cases by 5.4%, followed by Graduation & above (2.5%).

In India, cases of non-access to healthcare have fallen among all religions, but such fall of 4.6% points is highest among Muslims followed by Others (3.8%) and Hindus (3.4%). Further, the gap in cases of non-access to healthcare between Hindus and Muslims has widened by 1.2% points. In Bihar, only two religions – Hindu and Muslim are observed because the observations among other religions are very few and hence, excluded from analysis. The case of non-access to healthcare among Hindus has fallen by 3.8% and among Muslims, increased by 18.2% points and thus, reducing the Hindu-Muslim gap in non-access to healthcare

Graph 1 and 2 shows the major reasons for non-access to healthcare in India



Graph 1: Major reasons of non-access to healthcare (%): India



Graph 2: Major reasons of non-access to healthcare (%): Bihar

Reasons	Code
no medical facility available in the neighbourhood	1
facility too expensive	2
cannot afford to wait long due to domestic/economic engagement	3
ailment not considered serious enough	4
familial/religious belief	5
Others	9

In India, 'familial/religious beliefs' are the major reason for non-access to healthcare in 2014-15 where 61.9% of household members have confirmed it, followed by 'Other reasons' (13.4%) and 'lack of medical facilities nearby' (11.9%). In 2017-18, the 'ailment not considered serious enough' becomes the major reason for non-access that contributes to 73.5% of cases, followed by 'Others reasons' (10.8%) and 'familial/religious beliefs' (6.7%). In Bihar, around 78.2% of household respondents confirm "family and religious beliefs" as a major reason for non-access to healthcare in 2014-15, followed by 'lack of medical facilities nearby' (13.1%) and 'Other reasons' (5.2%). In 2017-18, the 'ailment not considered serious enough' becomes the major reason for non-access that contributes to 72.1% of cases, followed by 'lack of medical facilities nearby' (13.4%) and 'Others reasons' (11.1%).

Table 2: Association between unmet needs and socioeconomic determinants: 2017-18

	India		Bihar	
	Odd ratio	Sig.	Odd ratio	Sig.
Sector (Ref: urban)	.919	0.04**	1.101	.658
Household size (Ref: 0-5)		0.00***		.808
5 - 10	.778	.353	.886	.922
11 - 15	.887	.654	.785	.843

16 and above	.989	.969	1.129	.922
Gender (Ref: men)	1.080	0.03**	1.046	.811
Age (Ref: 0-14)		0.00***		.397
15 - 29 years	.825	0.00***	.598	0.09*
30 - 44 years	1.176	0.02**	.757	.455
45 - 59 years	1.246	0.00***	.537	.108
60 and above	1.013	.810	.606	.172
Social group (Ref: others0		0.00***		0.02**
SC-ST	.984	.710	.943	.830
OBC	1.207	0.00***	1.862	0.01**
Income Quintile (Ref: Quintile 1)		0.00***		.158
Quintile 2	2.093	0.00***	1.135	.755
Quintile 3	1.760	0.000***	2.054	0.06*
Quintile 4	1.408	0.000***	1.699	.133
Quintile 5	1.163	0.03**	1.567	.180
Education level (Ref: Illiterate)		0.01**		0.05*
Primary & Middle	1.119	.176	1.289	.638
Sec & High. Sec	1.042	.606	2.103	.160
Graduation & above	.915	.278	1.148	.800
Religion (Ref: others)		0.00***		
Hindu	1.354	0.00***	1.382	.221
Muslims	1.160	0.00***		
Chronic illness (Ref: yes)	.268	0.00***	.155	0.00***
Medical service free (Ref: yes)	.640	0.00***	.503	.015**
Constant	.124	0.00***	.297	.359

*****p < 0.01; **p < 0.05; *p < 0.10**

In India, almost all the socioeconomic variables are significant except household size. it means the socioeconomic variables such as sector, gender, age, education, social group, income class, and religion are significantly associated with cases of unmet needs. However, in Bihar, the age group of 15 – 29 years, social group, and income quintile 3 are significantly associated with unmet needs. Apart from socioeconomic variables, the other two factors – 'absence of chronic illness' and 'medical services not free' are also significantly associated with unmet needs in both India and Bihar.

In the context of the middle-income class and social justice, we can observe that there is a great injustice in the middle-income class in access to healthcare in Bihar. On all India levels, all income quintiles are significantly associated with unmet needs, and as we move from lower to higher income quintiles, the odd ratio of non-access to healthcare gradually decreases. So, individuals in 2nd quintile are 2.09 times more likely to have non-access to healthcare in comparison to 1st quintile, while individuals at 5th quintile are only 1.16 times more likely to have non-access to healthcare. Hence, there is a uniformity in healthcare access across income classes and our finding on all levels confirms the previous studies where it is commonly argued that healthcare access improves with income [1, 2]. However, in Bihar, such an argument doesn't validate. The likelihood of non-access to healthcare among individuals at 3rd quintile, also called the middle-income class group is higher than individuals at 2nd quintile (likelihood, 2.05 > 1.13). It means, the situation of the middle-income class is more worrisome than the poor in healthcare access and hence, a social injustice in healthcare access arises in Bihar.

Discussion

Income class is one of the major determinants of healthcare access [3]. There is a positive correlation between them. The higher the income, the higher would be the healthcare access and vice versa [4, 5]. The positive association between income level and healthcare access is stronger in the region where there is a lack of public health infrastructure. Inadequate public health services and manpower lead to the shifting of the household to the private healthcare system and when people are compelled to avail the services of private healthcare, it is common to observe that people from higher income levels would have higher healthcare access and the poor will be deprived of most of the essential healthcare services. In any case, if the poor also move to the private healthcare system, the high out-of-the-pocket expenditure (OOPE) will lead to further push them into the vicious cycle of poverty and destitution.

The middle-income class in India is characterized by a moderate level of income, education, and social status [6]. They are usually involved in salaried jobs or medium-level businesses.

They have greater responsibility for providing education to their children, fulfilling all the basic needs of the family to lead a respectable life, and being largely involved in social events and festivals. Thus, they usually lead a very balanced life and therefore, they are more conscious towards expenses and savings.

The NSS 75th round data shows that the reason for 'ailment not considered serious enough' is largely given by individuals from the middle-income class. However, the cause of such quoted reason is not given, there are some strong psychological causes. First, the waiting time for consulting doctors in public healthcare is comparatively longer than in private healthcare. Due to the busy time schedule of the job and high engagement in family affairs, the middle-income class has a greater opportunity cost of waiting time than the poor. Therefore, they either prefer to consult private healthcare or simply ignore the illness. Second, due to the heavy burden of household expenses, they don't find a greater incentive to spend money on healthcare services, although treatment and medication are equally important. They ignore the illness until it becomes imperative to consult the doctor. Third, public health insurance is mainly focused on poor households. Public health insurance schemes such as "Rashtriya Swasthya Bima Yojana (RSBY)" is mainly given to underprivileged and poor family and therefore, the middle-income class is deprived of any health protection schemes. The other public health programs are either women-specific (eg: Janani Suraksha Yojana) or specific to a particular social group (eg: Mobile health program for SC-ST group). Therefore, even in the middle-income class, men are more deprived of healthcare than others. According to the Niti Aayog report (2021), around 30% of the population or 38 crore individuals are deprived of public health insurance schemes either due to coverage gaps or overlaps between schemes. Hence, there is a grave concern about social justice for the middle-income class in health and healthcare access especially in Bihar which stands at last on the Niti Aayog Health Index, 2021 [7-10].

Conclusion

The cases of non-access to healthcare have fallen from 2014-15 to 2017-18 in both India and Bihar, although the non-access to healthcare in Bihar is still higher than the national average across most of the socioeconomic determinants. The analysis further suggests that in Bihar, the middle-income is largely deprived of healthcare access than the poor which means, that social justice in healthcare access is highly ignored. High income inequality, poor public health infrastructure, biased health policy, lack of provision of public financial protection schemes for the middle-income class are some of the major reasons. The social construct of the middle-income class is another reason for their non-access to healthcare. Therefore, the health policy and program also need to be pro middle-income class for greater social justice in health and healthcare access.

References

1. Asaria M, Ali S, Doran T (2016) How a universal health system reduces inequalities. lessons from England. J Epidemiol Community Health 70: 637-643
2. Gwatkin D (2009) Reducing health inequalities in developing countries. Oxford textbook of public health. 4th edition. https://www.researchgate.net/publication/251992115_REDUCING_HEALTH_INEQUALITIES_IN_DEVELOPING_COUNTRIES
3. Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E, et al. (2010) Socioeconomic disparities in health in the United States: what the patterns tell us. Am J Public Health 1: 186-196.
4. Lobmayer P, Wilkinson R (2000) Income, Inequality and Mortality in 14 Developed Countries. Sociology of Health & Illness 22: 401-414.
5. Kawachi I, Kennedy BP (1999) Income inequality and health: pathways and mechanisms. Health Serv Res 34: 215-227.
6. Ahalya R, Paul S (2017) Identification and characterization of middle class in India and its comparison with other economic classes. Available at: https://www.isid.ac.in/~epu/acegd2017/papers/AhalyaRamanathan.pdf
7. Health Index (2021) Niti Aayog. https://social.niti.gov.in/hlt-ranking/hlt-state-ranking/NDQ%253D
8. India: extreme inequality in numbers (2022) Oxfam International. https://www.oxfam.org/en/india-extreme-inequality-numbers
9. Kudrati M (2023) What Data Says About How Middle Class is Defined in India. https://www.boomlive.in/explainers/middle-class-india-nirmala-sitharaman-definition-income-meaning-earning-5-lakhs-10-lakhs-20804
10. Niti Aayog (2021) Health Insurance for India's Missing Middle. https://www.niti.gov.in/sites/default/files/2021-11/HealthInsuranceforIndia%E2%80%99sMissingMiddle_01-11-2021_digital%20pub.pdf