Caste, Discrimination, and Social Exclusion in Public Health Administration: Untold Indian Experiences

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Abstract

Caste, poverty and social exclusion are closely interrelated to health in any prismatic society. Caste and social exclusion have a multidimensional consequence on the social determinants of health and bear an elevated threat of various diseases among the margins. Also this issue has a likelihood of being excluded from the quality health care services. The issue of social exclusion and public health has received wide attention in India in the era of globalization. It is argued that poverty leads to poor health, and poor health is also one of the major factors for social exclusion and poverty. In a prismatic society like India, the caste plays a predominant role in causing social exclusion and thereby various types of health inequalities. Some socially excluded groups are living in extremely poor conditions in rural parts even today. In India SC (Scheduled Castes), ST (Scheduled Tribes), OBC (Other Backward Castes), and minority (Muslims, Christians, etc.) groups are considered as socially excluded groups and have been deprived of good health status for various reasons. This current study has been conducted in South Karnataka-India on selected socially excluded groups to obtain their opinion and experiences through the use of a questionnaire.

The conclusion is that caste and social exclusion are vital factors accounting for the fact that certain sectors of society even today cannot access quality public health care services in India.

Keywords: Health, caste, discrimination, social exclusion, poverty

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วรรณะ การเลือกปฏิบัติ และการกีดกันทางสังคมในการจัดการสาธารณสุข: ประสบการณ์ที่ถูกปิดบังในประเทศอินเดีย

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บทคัดย่อ

การแบ่งชั้นวรรณะ ความยากจน และการกีดกันทางสังคมมีความสัมพันธ์อย่างใกล้ชิดกับสุขภาพของประชาชนในทุกการเปลี่ยนผ่านของสังคม วรรณะและการกีดกันทางสังคมส่งผลต่อการตัดสินเรื่องสุขภาพตามมาในหลายมิติ ท่ามกลางช่องว่างทางสังคม ประเด็นนี้ทำให้โรคภัยต่าง ๆ ทวีความเลวร้ายมากยิ่งขึ้น นอกจากนี้ ประเด็นดังกล่าวยังมีแนวโน้มอย่างมากต่อการแบ่งแยกคุณภาพการบริการสาธารณสุข ซึ่งเป็นผลพวงจากโลกาภิวัฒน์ในรูปแบบเฉพาะของอินเดีย ในสังคมเปลี่ยนผ่าน เช่น อินเดีย การแบ่งชั้นวรรณะเป็นต้นเหตุสำคัญของการกีดกันทางสังคมและความไม่เท่าเทียมเกี่ยวกับสุขภาพของประชาชนจนถึงปัจจุบัน กลุ่มทางสังคมที่ถูกแบ่งแยกบางกลุ่มอาศัยอยู่ในสภาพที่เลวร้ายในภาคชนบท แม้ในปัจจุบัน ในอินเดียนั้น จัณฑาล กลุ่มชนเผ่าที่ถูกบัญญัติวรรณะชั้นต่ำอื่น ๆ และชนกลุ่มน้อย เช่น มุสลิม คริสเตียน เป็นต้น ต่างถูกมองเป็นว่าส่วนเกินของสังคม และไม่ได้รับบริการด้านสุขอนามัยที่ดีด้วยหลากหลายเหตุผล การศึกษาครั้งนี้ศึกษาจากรัฐกรณาฏกะตอนใต้ (South Karnataka) ของประเทศอินเดีย มีการเก็บรวบรวมข้อมูลโดยใช้คำถามแบบมีโครงสร้างกับกลุ่มทางสังคมที่ถูกละเลย เพื่อสอบถามความคิดเห็นและประสบการณ์จริง และสรุปได้ว่า การแบ่งชั้นวรรณะและการกีดกันทางสังคมเป็นปัจจัยสำคัญที่ทำให้บางภาคส่วนของสังคมในปัจจุบันไม่สามารถเข้าถึงการบริการสาธารณะสุขที่มีคุณภาพในประเทศอินเดีย

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Background

India is extremely multiracial, multilingual, multicultural and mainly a caste based prismatic society. Ethnical or caste based social exclusion is commonly found and persistent in Indian society, especially in rural regions. Poverty, socioeconomics, politics and other issues are obviously connected to caste and cultural-lingual character. Poverty and social exclusion in India have roots in India's historical divisions between castes and tribes. Many socio-culturally entrenched old age systems have brought health inequality among margins. Poverty creates inequality and prevents these groups from getting quality healthcare in the country.

The significance of good health cannot be minimized and it has been considered as one of the significant components of human capital. Good health is an indication of strong mind. Due to its vital importance, health economics is attracting researchers and policy makers more speedily in current decades. It is well said in the theory of human capital that people should invest themselves in terms of education, health and skill development programs. If the quality of human capital is not good, physical capital and natural resources cannot be utilized properly and growth can neither be sustainable nor be qualitative (Mohapatra et al., 2008).

The issue of margins' health has drawn increasing attention both at the national and international level today. Criticism has been focused on poor health infrastructure and health inequalities and its impact on physical, mental, social, moral and spiritual health of excluded groups. Since 1990, the World Health Organization (WHO) has emphasized improving the health status of the margins across the developing countries and stressing promotion of public health administrations. Also some health scientists are focusing on how communities evaluate the risk associated with health discrimination on future generations and the socio-cultural barriers in getting modern medical healthcare facilities and how to overcome this issue (Kesterton et al., 2010).

What Is Social Exclusion?

This term is being used in different countries in different ways, including:

In India:

> *"Social exclusion is the denial of the basic welfare rights which provide citizens positive freedom to participate in the social and economic and political life and which thereby render meaningful their fundamental negative freedoms."* (Gore & Figueiredo, 1997: 17-18)

In Thailand:

> *"Social exclusion is a process through which citizenship rights on which livelihood and living standards depend are not recognized and respected. This involves relationships between people, in which rights are challenged and defended through negotiations and conflict."* (Gore & Figueiredo, 1997: 17-18)

Issues of exclusion and discrimination assume particular significance in the Indian context. In India, the list of social groups experiencing some form of inequality or social exclusion is immense, although possibly most frequently mentioned, and most numerous, are the *Dalits or Untouchables* (Constitutionally declared as Scheduled Castes/SC) and *Adivasis*/Natives (Constitutionally declared as Scheduled Tribes/ST), Other Backward Castes (OBCs) and Minorities (Muslims, Christians etc.) who together make up about more than sixty-eight percent of the total population of India and are facing severe exclusion and discrimination in various sectors including health. Scheduled Castes and Scheduled Tribes are the major excluded sections in Indian society. "Scheduled Castes" is a term given to the section which have usually occupied the lowest status in Indian society, and the Hindu religion provides the religious and ideological basis for an "untouchable" group outside

the caste system and inferior to all other castes (web based). Scheduled Tribes/ST are also at the lowest status in Indian society. They mostly live in the forests of remote parts of the country. Backward Castes (OBC) is a combined word used to categorize castes that are socially and educationally deprived in India. However, the total number of STs are very small when compared to all other groups. Despite widespread economic growth and prosperity in current times, these communities have traditionally been deserted and left out of the process of development, including health. Their exclusion can be witnessed in a lack of access (or unequal access) to various institutions, to public services (education, healthcare, etc.), to public places, including temples, and to many income-earning assets, particularly land. Their socioeconomic status is very distressing, and they are denied quality public healthcare services (Kulkarni & Baraik, 2003).

Achary (2010:34) writes,

> *"As an attribute of individuals, caste-based discrimination focuses directly on the health status of SCs and disadvantages they experience. Discrimination in access to health care service can thus, be understood through three basic forms-· a) Complete exclusion or complete denial of health care services, b) Partial denial or selected exclusion of health care services."*

Data from the 2005-2006 National Family Health Survey (NFHS-3) repors the caste differentials with respect to health status in India. This regular survey stresses the reduced or low access to quality maternal and child healthcare among the SCs and STs. Accordingly, infant and under-five mortality among the SCs and the STs are quite high. The prevalence of anemia is also very high among the lower castes. Also it is quite apparent that the level of ante-natal and post-natal care is very low among these margins. Furthermore, it is found that institutional deliveries and essential vaccination coverage among these excluded groups are also very low. In addition, it shows a low level of contraceptive usage among the excluded groups (Jacob, 2009). The NFHS-2 (1995-96) had similar results.

Table 1. Poverty Incidence by Socio-Religious Groups and Household Types in India (2004-2005)

Religions	Rural				Urban				
	Social Groups	SENA	AL	OL	SEA	SE	RW/SE	CL	OTH
Hindu	ST	39.03	61.92	46.24	46.39	49.84	15.93	71.15	17.16
	SC	33.91	49.07	35.08	27.41	47.36	24.35	65.67	28.07
	OBC	21.73	43.70	29.30	21.31	30.99	16.87	54.57	18.60
	OTH	9.53	31.21	14.81	11.00	11.72	7.33	37.00	7.60
Muslim	ST	1.84	62.88	-	26.67	25.76	0.35	83.75	9.59
	SC	45.65	62.34	-	46.38	46.51	46.31	39.86	63.13
	OBC	30.42	49.72	28.86	26.78	46.88	32.99	57.67	40.20
	OTH	26.39	42.56	32.18	19.77	37.41	33.34	62.05	25.90
Christian	ST	12.42	35.10	32.90	23.00	17.37	5.98	40.30	7.70
	SC	40.54	26.31	42.63	52.00	28.68	10.86	64.70	6.35
	OBC	5.02	32.23	9.27	10.83	11.70	5.17	39.88	12.00
	OTH	-	21.67	5.49	3.32	8.74	3.57	20.06	5.24
Sikh	ST	-	-	-	-	-	-	-	-
	SC	3.31	11.66	7.53	-	18.28	16.53	50.98	1.08
	OBC	3.89	13.09	15.29	-	6.20	7.10	7.25	9.95
	OTH	-	17.69	0.26	-	1.07	2.85	22.11	0.10
Buddhist	ST	5.40	2.26	27.24	8.65	0.94	0.30	-	0.79
	SC	28.14	57.66	50.05	20.95	36.91	11.97	55.10	20.97
	OBC	57.70	-	-	-	-	-	-	-
	OTH	-	-	27.07	2.96	56.14	90.10	-	-
All	ST	36.33	60.81	45.29	42.98	42.03	13.57	69.70	14.96
	SC	32.87	47.84	33.76	27.27	46.01	23.28	64.59	27.26
	OBC	23.02	43.70	28.45	21.42	34.37	17.84	54.59	22.20
	OTH	15.51	35.27	19.71	11.98	17.57	11.00	48.44	10.51

Source: Estimated from National Sample Survey Organization, (NSSO) 61st Round.

Note: SENA = Self-employed in Non-agriculture
AL = Agricultural Labour
SEA = Self-employed in Agriculture
SE = Self Employed
RW/SE = Regular Wage and Salary Earners
CL = Contract Labors
OTH = Others

Table 2. Different Types of Mortality over the Five Years Prior to the Survey

Excluded groups	Neonatal mortality	Post neonatal mortality	Infant mortality	Percent of Under Five deaths (Urban)	Percent of Under Five deaths (Rural)
SC	35.0	15.8	50.7	28.1	24.6
ST	29.0	14.9	43.8	23.0	13.9
OBC	26.4	15.8	42.2	35.1	38.6
Minorities	21.6	13.9	35.5	33.0	21.9

Source: National Family Health Survey (NFHS), 2005.

Table 3. HIV Prevalence Rate (15-49 Age Group) by Social Group

Excluded groups	Percentage of HIV positive (Women)	Percentage of HIV positive (Men)	Total percentage
SC	0.23	0.34	0.28
ST	0.12	0.36	0.25
OBC	0.24	0.34	0.30
Minorities	0.06	0.21	0.13

Source: National Family Health Survey, 2005-06.

Table 4. Percentage of Children Under Age Five Years Classified as Malnourished According to Three Anthropometric Indices of Nutritional Status by Social Group

Indices	Weight –for-Age		
	Percentage below - 3SD	Percentage below - 2SD	Percentage below + 2SD
SC	18.5	47.9	0.3
ST	24.9	54.5	0.4
OBC	15.7	43.2	0.3
Minorities	15.6	41.8	0.4

Source: National Family Health Survey, 2005-07.

SD: standard deviations

Mean anthropometric distribution of studied children (according to weight against age, height against age and weight against height) has revealed that thirty-two percent (average) of SC children are between -3SD to -2SD and thirty-nine percent (average) of ST children are between -3SD to -2SD. In the case of OBC children, twenty-nine percent are in a group of between -3SD to -2SD. Also, in the case of minorities, twenty-eight percent of children are in a group of between -3SD to -2SD. All of these facts prove children from the disadvantaged groups are more vulnerable to malnutrition problems.

Table 5. Households Who Do Not Get Safe Drinking Water Throughout Year (Per One Thousand)

Household Social Group	Rural	Urban	Rural+Urban
ST	237	157	228
SC	131	107	126
OBC	120	87	111
Others	130	80	108
All	138	89	124

Source: NSSO Housing Conditions & Amenities in India, 2008-09.

This table quite clearly shows a lack of accessibility to drinking water for disadvantaged groups. In the case of those who reside in rural areas, two hundred and thirty-seven of the ST population and one hundred and thirty-one of the SC population (per thousand) are not getting safe drinking water throughout the year. Also it is quite clear that in urban areas one hundred and fifty-seven of the ST population and one hundred and seven of the ST population (per thousand) are not getting safe drinking water throughout the year. For the OBC, one hundred and twenty rural-based populations and eighty-seven urban-based populations are not getting safe drinking water throughout the year. It proves that these sections of the society are deprived from receiving safe drinking water due to the caste system.

It is well known that poverty and social exclusion are significant socioeconomic variables in the health status of any social group in India. Historically, Scheduled Caste and Scheduled Tribes, Backward Castes and certain minorities are considered as socially marginal groups and these groups are living under unfavorable conditions and poverty for the past few centuries. The current health status (as depicted) and usage patterns of such disadvantaged groups is an obvious indication of their deprivation and social exclusion. There is undoubtedly a close connection between poverty and health (Nayar, 2007).

Methodology

The current study is undertaken among the selected members of the social excluded groups. This study was conducted in low profile areas of Mysore and Hassan districts (South Karnataka-India) among eighty-seven community members from Scheduled Caste (Dalits), Scheduled Tribes (Natives) OBC (Other Backward Castes) and Minorities (Muslims, Christians, etc.) from various sections of society. These members were randomly selected and structured questionnaires were administered.

Tools for Data Collection

1. Survey
2. Interview
3. Content Analysis

Other Data Resources

Apart from the members of the socially excluded groups, the sample also covered people associated with the various health programs such as state and district health program officers, block-level health providers, health educators, government officials, NGO members, etc.

Table 6. Respondent Characteristics

Variables	Frequency (N=87)	Percentage
Age		
Just above 20	23	26.44
22-25	21	24.14
26-30	43	49.42
Educational Level		
Primary education	51	58.62
High school	23	26.44
College	10	11.49
Illiterates	3	3.45
Annual Income (in Rs.)		
50,000-75,000	23	26.44
Above 1,00,000	11	12.64
Below 25000	53	60.92
Social Group		
SC	31	35.63
ST	9	10.34
OBC	20	22.99
Minorities	27	31.04
Domicile		
Local	62	71.27
Inter district	15	17.24
Inter state	10	11.49
Occupation		
Government sector	12	13.79
Private sector	14	16.10
Informal sector	51	58.62
Other	10	11.49

Table 7. What Are the Different Health Issues among Socially Excluded Groups?

Response	Frequency	Percentage
Increasing infant, child and maternal mortality	12	13.79
Severe anemic issues	11	12.64
Different types of communicable diseases	7	8.05
More lifestyle disorders (caused because of poverty)	31	35.63
Different types reproductive health issues/HIV	17	19.54
Health issues caused because of their unique socio-cultural background	9	10.35
Total	**87**	**100.00**

Table 8. Why Is Health Inequality More Prevalent among Socially Excluded Groups?

Response	Frequency	Percentage
Social isolation and social alienation	32	36.78
Cultural and linguistic barriers	12	13.79
Poor social healthcare protections	13	14.94
Low healthcare delivery for the socially excluded	21	24.14
Poor health programs and policies	9	10.35
Total	**87**	**100.00**

Table 9. How Is Caste-Based Politics Responsible for Poor Health Outcomes?

Response	Frequency	Percentage
Castes lead to social exclusion and unfair economic arrangements	23	26.44
Caste-based distribution of power, income, goods and services	12	13.80
Caste is inextricably linked and is a proxy for socio-economic status	31	35.62
Lower castes populations are restricted from clean water, sanitation, nutrition, housing, education, health	6	6.90
Discrimination at health institutions	11	12.64
Caste-based politics is more common	4	4.60
Total	**87**	**100.00**

Table 10. How Is Social Exclusion Responsible for Poor Health Outcomes at Public/Private Hospitals?

Response	Frequency	Percentage
Negligence of the hospital staff because of caste issues	12	13.80
Indifferent treatment because of caste issues when compared to others	31	35.62
Denying quality health service, citing various unwanted reasons	21	24.14
Lack of information from the service agency	11	12.64
Abuse, intentional delay, carelessness, etc.	12	13.80
Total	**87**	**100.00**

Table 11. How Are Government Health Policies Responsible for Poor Health Outcomes for the Margins?

Response	Frequency	Percentage
Isolation or remoteness, including poor health infrastructure and poorer access to health markets and services	21	24.14
Service delivery is not being customized to undertake the "differentials" that marginal populations face	32	36.78
Decreasing Government budget for healthcare sector	12	13.79
Vulnerable groups are more exposed to adverse living conditions leading to health inequities	18	20.69
Low transparency and responsibility of health financing for the marginal population	4	4.60
Total	**87**	**100.00**

Table 12. What Would You Suggest to Combat Public Health Discrimination?

Response	Frequency	Percentage
Societal mind set should change	33	37.93
Living standards of the margins must be improved	22	25.29
More policy reform and budget required for rural health infrastructure	3	3.46
Social determinants to healthcare must be emphasized in health polices	10	11.49
Representation of various castes and classes in the government health institutions is a must	9	10.34
Active role of NGOs and civil society is required	10	11.49
Total	**87**	**100.00**

Discussion

The structural determinants of daily life contribute to the social determinants of health and fuel the inequities in healthcare among caste groups. Viewing health in general as an individual or medical issue, reducing population health to a biomedical perspective, and suggesting individual medical interventions, reflect a poor understanding of issues. Social interventions should form the core of all health and prevention programs, as individual medical interventions have little impact on population indices that require population interventions.

The socioeconomic profile of respondents shows that the mean age of the respondents was 25.1 years old. Of the caste groups, thirty-seven percent were SCs, STs ten percent, OBC twenty-three percent and the Minorities were thirty-one percent. Next, three percent of the respondents had no formal education and fifty-eight percent had studied up to a primary level and high school level (twenty-six percent). The majority (sixty percent) of the respondents are in an income group of below Rs. 25000/pm. Regarding occupation, thirteen percent are in the government sector, one hundred and sixty-five are in the private sector and fifty-eight percent are in the informal sector. Around seventy-one percent were the local respondents.

Today excluded groups are facing different types of health issues. Various data have shown that some of the excluded groups are facing more neonatal, post-neonatal infant death issues. It is also found that the death rate of children under five is greater among these groups (Table 2). The National Family Health Survey reports also show that the HIV prevalence rate is also higher among a few excluded groups. Malnutrition issues are also more common among these groups (Table 4). Additionally, certain types of communicable diseases and physical handicap issues are more common because of poor quality lifestyles. Administrations are not taking much care to overcome these issues.

Health status in India mainly depends on social status. Caste factors are significant in Indian society, especially in rural areas of the country. Because of caste issues, certain social excluded groups have been socially disconnected even in the health administration. This leads to low level social activity and required social support and social networks to get health information. However, these two aspects are linked to health issues in few studies. Even today, various caste groups like SC/ST have been deprived from getting some social support, social integration, because of resources dominated by the higher caste population.

Culture and language also play a key role in achieving good health status in many rural parts of the country. However, understanding culture and language of the most of the excluded sections is largely overlooked in the country's health policies and administrations mostly ignore it. Cultural norms of any excluded groups play a key role in having healthcare behavior and healthcare seeking behavior and should be a part of any healthcare policy. It has been found that excluded groups are impoverished and because of this they have to spend more from their pocket. Catastrophic health expenditures are also largely ignored in the health economics of the country. This also leads marginal populations to bear greater financial burden on families. The government has implemented various free and low cost health insurance schemes for poor people. However, because of poverty and the social exclusion faced by these groups, they still receive low quality healthcare.

Caste plays a predominant role in accessing quality health care. Caste factors invariably lead to social exclusion and give rise to low-level economic arrangements. Because of caste factors, the labor market will not allow marginal populations to use the resources. Distribution of goods, power and income, also depends on caste factors in rural India. Excluded groups cannot effectively access required income and goods because of social exclusion. Furthermore, low-level sanitation, housing, safe drinking water, also leads to poor health status among the excluded groups. Public administrations also severely discriminate against these groups because of caste. Even government officers adopt discriminative practices, excluding groups in providing quality health services. Excluded groups are more prone towards exploitation in different types of public health institutions (Ram et. al., 1998). In the study, various government officials indirectly and unofficially agreed about this sort of caste-based discrimination in various public hospitals.

This study has found that government hospital staffs are discriminating against people from the Excluded Groups during registrations, checkups, treatments, and when providing medicines. Patients from excluded groups are denied quality pre- and post-natal healthcare in rural parts of the country. Sometimes, government health workers will not visit excluded groups' homes because of caste factors. Even doctors avoid touching SC/ST children. Abuse, carelessness and intentional delay are more common among government health institutions towards patients from the excluded groups. It is reported government health policies are mainly responsible for the poor public health outcomes. Moreover, there are some widespread problems faced by the beneficiaries belonging to the SC communities only. It is reported that SC/ST women are severely being discriminated and humiliated in the name of caste, even in many cash assistance health related programs. It is one of the main reasons for the low access to this health service by the margins at various government hospitals. Today, many rural regions do not have any government funded health infrastructure and qualified doctors where large sections of the margins are residing (Kulkarni & Baraik, 2003). Also conditions of the hospitals providing Indian system of medicines situated in low profile areas

are even more pitiable with old age service delivery channels. This has created havoc among the margins. Also, the government's budget does not currently give enough funds for all health sectors in India. Because of these factors, the death rate among the margins, even from the various curable diseases, is rising.

Conclusion

The key blockade to mainstreaming healthcare and scaling up successful interventions is caste inequality based on socio-cultural issues, especially in rural regions. The methodical favoritism and nepotism by the higher caste and the mistreatment of the lower caste populations based on culture, tradition and religion, needs to be avoided at all costs if interventions are to be effective. Omnipresent and overriding associations between caste and culture which have key effects on health outcomes of the margins must be overcome even in public policy matters. The Public Health Administration should be very sensitive of this issue. Failure to recognize this relationship and the refusal to tackle these issues results in poorer health standards for the marginal people in the country. In India customs, norms, culture, and tradition continue to promote inequality in every walk of life.

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