



# Comparative Analysis of the Impact of illness on the patterns of Employment and Borrowing with Special Reference to Urban and Rural Karnataka

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## ABSTRACT

India has come a long way from being called the 'land of snake-charmers' to one of the fastest developing countries of the SAARC region. Having seen the rise and fall of many a kingdoms and being ruled by many, India has soaked up the essence of almost every dynasty resulting in a rich cultural milieu which manages to enthrall everybody. Post independence, India witnessed the drafting of the Constitution which pronounced India as a 'Sovereign, Socialist, Secular, Democratic, Republic' and as a newly emerged welfare state. Since then and after 66 years of Independence, India has been growing steadily though not without challenges. To contextualize this article, we can argue that the health care system of India has been facing many challenges in terms of the perspective of being user friendly and distributed equitably, to favor all the sections of the society equally. Widespread loopholes have been noticed in the delivery of the health care system in India. Availing quality health care has now become the prerogative of only the well to do section of the society, leaving the marginalized section of the society at the mercy of governmental setups which are drowned in their own incompetence and corruption therefore failing to provide quality health care to the society. This paper proposes to take a look at these existent inequalities in the delivery of the health care system. In this effort data has been collected from 6 districts of Karnataka, 3 of which are rural districts and 3 of which are urban. Rural and urban districts are operationally understood as 3 districts each having lowest HDI and 3 districts having the highest recorded human development index (HDI) of Karnataka respectively. High human development Index (HDI) is being represented by Bangalore, Udupi and Mangalore consisting of 1136 people interviewed in total, whereas low level of HDI is represented by Raichur, Chamarajnaraga and Gulbarga, with a total of 1327 respondents.

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## Introduction

Health is regarded as a wealth in Indian society. Human resource is being considered as a major corner stone of Indian economy unlike industrialized countries. Welfare of people is understood as a state of wellbeing influenced by various contributing factors, health being one major component. Health care services are designated to protect and promote the health among various sections of society. Burden of communicable and non communicable diseases have been showing a gradual increase in India. Major social determinants of communicable illness are malnutrition, contaminated and unclean drinking water and poor sanitation whereas major social determinants of non communicable illnesses have been seen to be stress, early life events, social exclusion, unhealthy work conditions, unemployment, addiction, illiteracy and lack proper transport in India (Gupta & Kumar, 2007). Urbanization and migration trends accelerate the growth of health care services in urban areas due to the pressure of rising population. (Solomon, Buck, Chaguturu, Ganesh, & Kumarasamy, 2003). To bridge these gaps, the Government of India and the Government of Karnataka have initiated multiple health welfare programs over the years to meet unmet needs of rural areas. However, gaps in the system of health care service are still evident. The result of disproportionate distribution of health care services across societies is lack in overall growth of the society. Keeping the

health inequalities in mind, this study aims at bringing out the disparities between developed urban districts of Karnataka and least developed rural districts of Karnataka in terms of the way in which ill health or illnesses determine the structure of employment or unemployment and the borrowing patterns of various households in the urban and rural districts of Karnataka pertaining to illness to meet the expenditures incurred due to illness.

Rural and urban districts are operationally understood as 3 districts each having lowest HDI and 3 districts having the highest recorded human development index (HDI) of Karnataka respectively.

High human development Index (HDI) is being represented by Bangalore (n = 434, 17.6 %), Udupi (n= 340, 13.8 %) and Mangalore (n= 362, 14.7 %) consisting of 1136 people interviewed in total.

Low level of HDI is represented by Raichur (n= 457, 18.6%), Chamarajnaraga (n= 317, 12.9%) and Gulbarga (n= 553, 22.5 %) with a total of 1327 respondents.

### Critically analyzing India's status with reference to Health Care

There lies no mystery as to the fact that that poor, the socially and economically downtrodden suffer from a greater incidence of ill health than their richer counterparts. This can be attributed to the facts that the downtrodden always are exposed

to unhealthy living conditions like the unavailability of clean and proper source of drinking water, proper sanitation, housing facilities, and two square meals in a day and so on.

A major reason as to why health inequalities exist in developing countries can be said to be the fact that there is a lack of grass-root level work and the facilities that are supposed to be provided by the so called "welfare states", hardly ever reach those nooks and corners which would best reap its benefits. Here the role of a State, in true sense of the term, in reducing the inequalities in health can be debated and understood.

To assess the major inequalities in the conditions of healthcare; the World Health Survey (WHS) was conducted by the WHO at a multi-country level, celebrated in 70 countries. Data was collected to throw light on three major areas namely, the degree of health of the citizens, the effectiveness of the public health care system and the intensity to which it reaches out to people, chief ailments of the present population and the amount every household spends on procuring quality health care in times of illness. The expenditure on illness would in turn reflect the pattern of falling ill of household members and in case of illness whether the public health care system is able to provide treatment or do people have to rely on expensive private care.

Though the role of Government is to ensure an overall equality in the health care systems, the levels of corruption and red-tapeism has been enmeshed in the system to such an extent that price is being paid by the general public in terms of poor healthcare conditions, lack of proper infrastructural facilities and sheer negligence on the part of the hospital staff. The way budgeting has been carried out in the five year plans and the way implementation of policies has been done, there is a lack of responsiveness on the part of the Government.

However the position of the male population is still considered to be better when compared to the female population. The screaming gender is evident in the lack of proper maternal healthcare facilities, the high rates of maternal mortality, female feticide; high infant mortality rates still haunt India and openly question the effectiveness of the health policies prevalent in India. The 11<sup>th</sup> Five year plan however talks about bridging the gap and concentrating on the marginalized sections of the society like women, adolescents, children, elderly people and the differently able so that healthcare systems respond to their needs in a much better way.

The irony of the situation however lies in the fact that people in need of quality health care are most certainly the ones who are deprived of it. The growing rates of inflation, rapid urbanization of the rural poor, increasing gap among the rich and the poor and the expensive private healthcare system prevailing in India have created a considerable level of inequality in the process of acquiring quality healthcare. Socio-economic discrepancies also add on to the already existing inequalities in the system of healthcare as the socio-economic background of a person clearly determine the availability of resources and healthcare facilities in India.

The State or the government can be called the greatest service provider and as such the role of the government would be the fair and impartial distribution of all services that the citizens are supposed to be given. The role of the State is therefore critical and can be expressed in multiple channels. According to the World Health Organization and its Regional Office for the South-East Asia, the role of the State in reducing health inequalities is most crucial and can be laid down. The

general motive is always to improve the overall access to the health care services which can be achieved through increasing public expenditure in the health sector and to by allocating infrastructural facilities to the existing system of health care and government expenditure on the health sector must be increased, which presently is only 5.2% of GDP which is not even closer to the international standard and recommendation of expenditure on health care.

Secondly, reallocation of government resources on need basis must be spread out to geographical regions, especially reaching out to the primary health care sector pertaining to the rural and the under-developed regions for better and improved access to health care by all and sundry irrespective of discriminations. Thirdly, monitoring, evaluating and analyzing the indicators of health in all geographical regions and stratifications must be carried out to get an overall view of the pertinent and present health inequalities in various areas.

Fourthly, taking a multi-department approach on the part of the Ministries of Health to ensure inter-sectoral and intra-sectoral participation cutting across various departments of the government is essential to reduce the gap that has been created in the system of health care in reaching out to all sections of the society and not being present for only the well to do. Lastly, the government should also encourage the role of civil society in the process of reducing inequalities in the system of health care as the society should be a place where every section mutually benefits each other and advocates its needs and requirements.

#### **Health Inequalities in Karnataka:**

Karnataka has been a pioneer in setting up the first ever Primary Health Units (PHUs) even before its inception by the central government. But the current scenario of the efficiency of the health care system needs to be discussed further. There exists a gap in the delivery of the health care system between the urban and the rural areas. Though the state is well known for its health care services yet there are certain discrepancies in the delivery of the health care system. Though the urban areas provide good health care facilities, the rural areas are lagging behind. The basic issues in the health care profile of Karnataka will be discussed in detail in this following section.

Sholapurkar, Mouli and Gopal (1983) who studied 1331 currently married women in the reproductive age group of 15-49 years and 1299 husbands of currently married women in the reproductive age group of 15-49 years in rural areas of Karnataka revealed that about 69 percent of the former and about 70 percent of the latter utilized health and family welfare services available in Government institutions. They have further identified that family welfare is another area where facilities are available but are underutilized. In identifying the people who do not utilize the health and family welfare services, it may be noted that there are people both in rural and urban areas who do not utilize or utilize only rarely the health and family welfare services. A study conducted in sample villages and taluka head quarter towns in another district of Karnataka by Devi (1986), revealed that utilization of health and family welfare services available from government institution varied according to the literacy level, occupation and income of the heads of households.

In Karnataka, mothers and children are vulnerable to health inequality due to various socio economic reasons. The literacy rate among women is lower than the men. The women lack awareness in general and also they are not keen on keeping good health. Health is always neglected especially that of a woman.

Basit et al (2012) reported about under nutrition status of children in Udupi taluk of Karnataka state. Even though Udupi district reported a high level of human development index (HDI), under nutrition continued due to various factors. The study was aimed at understanding some of the risk factors for under-nutrition in a region with favorable maternal and child health indicators. The study was carried out among children aged one to five years attending the pediatric outpatient department in six rural health care centers in Udupi taluk of Karnataka in Southern India. A total of 162 children were included in the study, of which 56 were cases. A semi-structured questionnaire was used to interview the caregivers of the children and the nutritional status. Childhood illness, short birth interval and consumption of diluted milk were some of the significant contributory factors noted among the population.

Kodkany et al (2004) narrate maternal mortality rates in India are estimated at 560/100,000 live births and postpartum hemorrhage accounts for 35-56% of these deaths. U.S.-Indian collaborative randomized, placebo-controlled, clinical trial conducted in four Primary Health Center areas of Belgaum District, Karnataka, India. They found significant reduction in maternal mortality. This project served as a model applicable to rural settings throughout the developing world for improving delivery practices and reducing maternal mortality and morbidity through supplying essential medicines.

George (2007) explored issues of rural women with obstetric complications accessed health providers in Koppal, the poorest district in the state of Karnataka, south India. Weak information systems, discontinuity in care, unsupported health workers, haphazard referral systems and distorted accountability mechanisms were identified as critical service delivery problems.

For example, maternal deaths were under-reported and not reviewed, antenatal care and institutional delivery were not linked to post-partum or emergency obstetric care, and health workers use inappropriate injections but don't treat anemia or sepsis. Families wasted valuable time and resources accessing health care providers but fail to get effective care, and blame was laid on lower-level health workers and women for not accessing institutional delivery. Author recommended critical managerial changes in service delivery.

Adamson et al (2012) conducted a population-based survey among 16 randomly selected rural villages in rural Mysore District in Karnataka, India between August and September 2008. All households in selected villages were enumerated and women with children 6 years of age or younger underwent an interviewer-administered questionnaire on antenatal care and institutional delivery. Institutional deliveries in rural areas of Mysore District increased from 51% to 70% between 2002 and 2008. While increasing numbers of women were accessing antenatal care and delivering in hospitals, large disparities were found in uptake of these services among different castes. Mothers belonging to general castes were almost twice as likely to have an institutional birth as compared to scheduled castes and tribes. Mothers belonging to other backward caste or general castes had 1.8 times higher odds (95% CI 1.21, 2.89) of having an institutional delivery as compared to scheduled castes and tribes. In multivariable analysis, which adjusted for inter- and intra-village variance, Below Poverty Line status, caste, and receiving antenatal care were all associated with institutional delivery. Strategies for overcoming these barriers may include sensitization of healthcare workers, targeted health education

and outreach, and culturally appropriate community-level interventions.

Skariyachan et al (2012) argued urbanization and industrialization increased the risk of pollution in Bangalore, India. The disposal of sewage into natural water bodies became a serious issue. Byramangala reservoir is one such habitat enormously polluted in South India. Many pathogenic bacteria were characterized and most of them were found to be multidrug resistant. Present study revealed that Byramangala tank has become a cesspool of multidrug-resistant "superbugs" and will be major health concern in South Bangalore, India. The study one of studies highlighted impact of pollution and health risks.

Bhojani et al. (2012) considered the burden of chronic conditions is on the rise in India, necessitating long-term support from healthcare services. Healthcare, in India, is primarily financed through out-of-pocket payments by households. Considering scarce evidence available from India, our study investigates whether and how out-of-pocket payments for outpatient care affect individuals with chronic conditions. A large census covering 9299 households was conducted in Bangalore, India. Of these, 3202 households that reported presence of chronic condition were further analyzed. Data was collected using a structured household-level questionnaire. The response rate for the census was 98.5%. Overall, 69.6% (95%CI=68.0-71.2) of households made out-of-pocket payments for outpatient care spending a median of 3.2% (95%CI=3.0-3.4) of their total income. Overall, 16% (95%CI=14.8-17.3) of households suffered financial catastrophe by spending more than 10% of household income on outpatient care. Occurrence and intensity of financial catastrophe were inequitably high among poor. Low household income, use of referral hospitals as place for consultation, and small household size were associated with a greater likelihood of incurring financial catastrophe. The out-of-pocket spending on chronic conditions doubled the number of people living below the poverty line in one month, with further deepening of their poverty. In order to cope, households borrowed money (4.2% instances), and sold or mortgaged their assets (0.4% instances). This study provided evidence from India that the out-of-pocket payment for chronic conditions, even for outpatient care, pushes people into poverty. Findings suggested that improving availability of affordable medications and diagnostics for chronic conditions, as well as strengthening the gate keeping function of the primary care services are important measures to enhance financial protection for urban poor.

Bellad et al. (2012) Consanguinity is widely observed in Indian culture and in the study attempted to determine whether consanguinity adversely influenced pregnancy outcome in South India, where consanguinity was a common means of family property retention. Data were collected from a prospective cohort of 647 consenting women, consecutively registered for antenatal care between 14 and 18 weeks gestation, in Belgaum district, Karnataka in 2005. Three-generation pedigree charts were drawn for consanguineous participants. Overall, 24.1% of 601 women with singleton births and outcome data were consanguineous. Non-consanguineous couples had fewer stillbirths (2.6 vs 6.9%  $P=0.017$ ; adjusted  $P=0.050$ ), miscarriages (1.8 vs 4.1%,  $P=0.097$ ; adjusted  $P=0.052$ ) and lower incidence of birth weight <2500 g (21.8 vs 29.5%,  $P=0.071$ , adjusted  $P=0.044$ ). Gestation <37 weeks was 6.2% in both the groups. Adjusted for consanguinity and other potential confounders, age <20 years was protective of stillbirth ( $P=0.01$ ), pregnancy loss ( $P=0.023$ ) and preterm birth ( $P=0.013$ ), whereas

smoking (P=0.015) and poverty (P=0.003) were associated with higher rates of low birth weight.

#### Objectives of the study:

- To understand the borrowing patterns of households and the means of financing treatment of sickness in the top three and bottom three districts based on HDI in Karnataka
- To understand employment status of individuals of select households in the top three and bottom three districts based on HDI in Karnataka
- To understand the impact of sickness on employment of individuals of select households in the top three and bottom three districts based on HDI in Karnataka
- To understand health inequalities in Karnataka, comparing households in the top three districts in the Human Development Index with that of the bottom three districts.

Comparison between top three districts and bottom three districts in the Human Development Index of Karnataka help to identify disparity in the various factors associated with health.

#### Sample selection and Methodology

**Table 1. Cross Tabulation of Impact of Sickness on Individuals Employment and the number of days worked in last month and HDI**

			No. of days worked in the last month			Total
			1 - 7	8 - 21	More than 21	
HDI	High	Count	5	83	350	438
		% within HDI	1.1%	18.9%	79.9%	100%
		% within No. of days worked in the last month	50.0%	26.3%	55.9%	46.1%
		% of Total	.5%	8.7%	36.8%	46.1%
	Low	Count	5	232	276	513
		% within HDI	1.0%	45.2%	53.8%	100%
		% within No. of days worked in the last month	50.0%	73.7%	44.1%	53.9%
		% of Total	.5%	24.4%	29.0%	53.9%
Total	Count	10	315	626	951	
	% within HDI	1.1%	33.1%	65.8%	100%	
	% within No. of days worked in the last month	100%	100%	100%	100%	
	% of Total	1.1%	33.1%	65.8%	100%	

As per the Table no. 1, out of 438 people from high HDI districts, 5 (1.1%) worked for 1-7 days, 83 of them (18.9%) for 8-21 days and majority of them (n=350, 79.9%) worked for more than 21 days in a month. Out of 513 people from low HDI districts, 5 (1 %) worked for 1-7 days, 232 of them (45.2%) for 8-21 days and majority of them (n=276, 53.8%) worked for more than 21 days in a month. Number of working days was less among low HDI people (only 53.8% of them worked more than 21 days in a month) compared to high HDI people (79.9% of them worked more than 21 days in a month).

As per Table No. 2 mainly people borrowed money from money lenders (31.4%) commercial banks (24.8%) and co-operative banks (16.9%). Borrowing money from all other sources was very less. Another interesting finding up to 50000 people mainly depended on money lenders. Above fifty thousand loans sake mainly people depended on commercial banks.

As Table No – 3, Illness caused more burden of borrowing 9.7% in low HDI group compared to 5.4% in high HDI. Major cause of borrowing in high HDI was for maintenance sake

26.9%, whereas low HDI people borrowed mainly for ceremonies sake (29.7%). Another key difference is observed between high and low HDI is in borrowing percentage of education. High HDI borrowed 18.3% of total borrowing for education purpose, but low HDI borrowed only 1.4% of their total borrowing for education.

#### Findings:

##### Patterns of Illness:

While taking into account the patterns of illness, certain common trends were visible. Common illnesses were found to be occurring frequently among both high HDI group (73.2%) and low HDI Group (82.7%) even though it is more prevalent among people belonging to low HDI districts than among people belonging to high HDI districts. Another significant finding is hypertension and diabetes is another major illness prevalent among people belonging to both high HDI and low HDI districts. Also, more percentage of people from low HDI areas (84.1%) have been admitted to hospital as compared to high HDI areas (73.7%) associated with major illness. This in fact makes it evident that expenditure on illness is quite huge and to meet these needs, people belonging to low HDI areas depended mostly on money lenders to meet treatment expenditure of major illness whereas people belonging to both groups depend to a great extent on friends and relatives financially for meeting expenditures on health.

Talking about expenditures on health, majority of people belonging to high HDI areas have been seen to be spending less than Rs 1000 and majority of people belonging to low HDI areas have been seen to be spending more than Rs 1000 for health related expenditure.

Among low HDI group, 34.8% of people spent more than Rs 5000 and 18.6% of high HDI group spent more than Rs 5000 as treatment expenditure. Another key finding is that 18.5% of people who reported health expenditure from low HDI spent Rs 10001-50000 whereas only 8.8% people from high HDI have spent the same amount.

##### Patterns of Employment and Borrowing:

There is a good deal of relation among the patterns of employment, borrowing and the patterns of illness. Usually due to illness, people have to borrow heavily for meeting the expenditures that they have to pay for getting health care. The other aspect is that due to illness, the patterns of employment also change as people become unemployed due to illness.

People belonging to high HDI areas are employed equally in all sectors whether primary, secondary or tertiary, but among people belonging to low HDI area, 45.6% people are employed in agriculture sector. The reason behind this is that in urban areas, all sectors of employment are developed and therefore the opportunities for jobs are also present. In rural areas people still rely on agriculture for livelihood. Only 23.6% of people belonging to high HDI areas are employed in agriculture sector. Security Guard jobs (60.5 %) are seen to be more among high HDI people and tailoring job (76.4%) and Painting job (68.5%) are more in low HDI people. People from high HDI area were more regular in employment than people from low HDI area (81.6% and 59.9%), which can in fact tell us that people belonging to areas not developed much are more prone to illness due to the inequalities in health present between urban and rural areas. People belonging to high HDI regions had taken relatively higher amount of loans (22.9 %: Rs 50000-100000, 18.8%: more than Rs 100000) compared to people belonging to low HDI regions (12.8 %: 50000-100000 Rs, 14.2%: more than Rs 100000).

Table 2. Cross Tabulation of Amount Borrowed (Rs) and Borrowing Source

			Borrowing –Source										Total	
			Commercial banks	Co-op Banks	Govt	NBFIs	Insurance companies	Employer	Land lord	Money lender	Friends and relatives	Chit Funds		Others
Amount Borrowed(Rs)	Less than 5000	Count	1	1	1	0	0	1	1	8	0	0	1	14
		% within Amount Borrowed(Rs)	7.1%	7.1%	7.1%	.0%	.0%	7.1%	7.1%	57.1%	.0%	.0%	7.1%	100%
		% within Borrowing - source	1.7%	2.4%	20.0%	.0%	.0%	12.5%	5.9%	10.5%	.0%	.0%	12.5%	5.8%
		% of Total	.4%	.4%	.4%	.0%	.0%	.4%	.4%	3.3%	.0%	.0%	.4%	5.8%
	5000 - 15000	Count	6	3	0	2	0	1	3	7	2	1	2	27
		% within Amount Borrowed(Rs)	22.2%	11.1%	.0%	7.4%	.0%	3.7%	11.1%	25.9%	7.4%	3.7%	7.4%	100%
		% within Borrowing - source	10.0%	7.3%	.0%	66.7%	.0%	12.5%	17.6%	9.2%	14.3%	14.3%	25.0%	11.2%
		% of Total	2.5%	1.2%	.0%	.8%	.0%	.4%	1.2%	2.9%	.8%	.4%	.8%	11.2%
	15000 - 50000	Count	24	25	0	0	1	4	10	40	10	3	5	122
		% within Amount Borrowed(Rs)	19.7%	20.5%	.0%	.0%	.8%	3.3%	8.2%	32.8%	8.2%	2.5%	4.1%	100%
		% within Borrowing - source	40.0%	61.0%	.0%	.0%	33.3%	50.0%	58.8%	52.6%	71.4%	42.9%	62.5%	50.4%
		% of Total	9.9%	10.3%	.0%	.0%	.4%	1.7%	4.1%	16.5%	4.1%	1.2%	2.1%	50.4%
50000 - 100000	Count	14	7	3	0	0	1	3	10	0	2	0	40	
	% within Amount Borrowed(Rs)	35.0%	17.5%	7.5%	.0%	.0%	2.5%	7.5%	25.0%	.0%	5.0%	.0%	100%	
	% within Borrowing - source	23.3%	17.1%	60.0%	.0%	.0%	12.5%	17.6%	13.2%	.0%	28.6%	.0%	16.5%	
	% of Total	5.8%	2.9%	1.2%	.0%	.0%	.4%	1.2%	4.1%	.0%	.8%	.0%	16.5%	
More than 100000	Count	15	5	1	1	2	1	0	11	2	1	0	39	
	% within Amount Borrowed(Rs)	38.5%	12.8%	2.6%	2.6%	5.1%	2.6%	.0%	28.2%	5.1%	2.6%	.0%	100%	
	% within Borrowing - source	25.0%	12.2%	20.0%	33.3%	66.7%	12.5%	.0%	14.5%	14.3%	14.3%	.0%	16.1%	
	% of Total	6.2%	2.1%	.4%	.4%	.8%	.4%	.0%	4.5%	.8%	.4%	.0%	16.1%	
Total	Count	60	41	5	3	3	8	17	76	14	7	8	242	
	% within Amount Borrowed(Rs)	24.8%	16.9%	2.1%	1.2%	1.2%	3.3%	7.0%	31.4%	5.8%	2.9%	3.3%	100%	
	% within Borrowing - source	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	% of Total	24.8%	16.9%	2.1%	1.2%	1.2%	3.3%	7.0%	31.4%	5.8%	2.9%	3.3%	100%	

Table 3. Cross Tabulation of Borrowing Patterns, Purposes for which it is Spent and HDI

			Borrowing - Purpose - Maintenance							Total	
			Mainten ance	Illness	Education	Ceremoni es	Purchase of Land/Building	Purchase of consumer durable	Investme nts		Others
H D I	High	Count	25	5	17	14	17	1	11	3	93
		% within HDI	26.9%	5.4%	18.3%	15.1%	18.3%	1.1%	11.8%	3.2%	100%
		% within Borrowing - purpose maintenance	49.0%	26.3%	89.5%	24.6%	43.6%	20.0%	36.7%	16.7%	39.1%
		% of Total	10.5%	2.1%	7.1%	5.9%	7.1%	.4%	4.6%	1.3%	39.1%
	Low	Count	26	14	2	43	22	4	19	15	145
		% within HDI	17.9%	9.7%	1.4%	29.7%	15.2%	2.8%	13.1%	10.3%	100%
		% within Borrowing - purpose maintenance	51.0%	73.7%	10.5%	75.4%	56.4%	80.0%	63.3%	83.3%	60.9%
		% of Total	10.9%	5.9%	.8%	18.1%	9.2%	1.7%	8.0%	6.3%	60.9%
Total	Count	51	19	19	57	39	5	30	18	238	
	% within HDI	21.4%	8.0%	8.0%	23.9%	16.4%	2.1%	12.6%	7.6%	100%	
	% within Borrowing - purpose maintenance	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	% of Total	21.4%	8.0%	8.0%	23.9%	16.4%	2.1%	12.6%	7.6%	100%	

Totally 244 participants shared details of loans 148 of them from low HDI districts and 96 of them from high HDI districts. The reason behind this can be understood on terms of the disparities in standard of living between the urban and the rural areas. The urban areas have a higher standard of living as compared to the rural areas and therefore the expenditures are exorbitant especially the expenditures on health care. This results in high borrowings in urban areas as compared to rural areas. While majority of borrowers from low HDI borrowed money from private lenders and majority of people from high HDI borrowed from government or semi government institutes. Significantly high percentage of borrowers from low HDI (38.8%) borrowed from money lenders, whereas 19.8% of borrowers from high HDI depended on money lenders. Illness caused more burden of borrowing 9.7% in low HDI group compared to 5.4% in high HDI.

#### Conclusion:

In order to conclude we can say that though the percentage of money borrowed for the sake of illness is low, the amount is considerably high. The cost of health care in urban areas is twice as much as in rural areas but the quality of available health care is better in urban areas as compared to the rural areas. The rural areas have less access to health care facilities and the available facilities are not up to the mark or well equipped to cater to the needs of people. Another reason for lower borrowings for illness in areas with low level of HDI is also the lack of awareness among people and their negligence towards health.

The whole borrowing-illness-unemployment scenario creates a vicious circle which hits people belonging to areas with low Human Development Index much more profoundly than people belonging to areas which have recorded high Human Development Index. Opportunities are less in rural areas, pattern of employment is irregular and when illness strikes, people are not able to work therefore resulting in loss of pay and increased debts to meet the expenditures of treatment. Since the structure of employment is also irregular, there is no guarantee that once they recover they are soaked back into employment. This leads to further indebtedness and the vicious circle continues. The urban situation is similar but the advantage is that opportunities are better. Cost of health care is high and cost of living as well. Therefore in case of illness and borrowing, both urban and rural areas suffer alike. In order to bridge these gaps the aim must be on improving infrastructure and aiming at achieving high levels of Human Development Index so that there is overall growth and development.

Employment status, literacy level, health infrastructure, financial availability of health professionals and health awareness have been identified as target indicators to change for leading population from poor health care services to high quality health care services. Neglect towards nutrition and immunization needs of under developed or rural population would increase health care cost of nation, which is primarily responsible for health care. As popularly believed only healthy citizens would be able to contribute to development needs of country. Significant portion of budgetary allocation is essential to build health infrastructure in the society.

Karnataka has been noted among international community through its rapid growth in the area of technological revolution and urbanization rate. This potential state steadily contributes to national economic growth and industrialization. Cultural and geographical diversity have been observed in the state as a boon to learn how to tackle various social needs in a harmonious environment. But huge health inequality would lead to greater

resentment among population, as noted in multiple nations in this decade. Presence of trained professional social workers in the state is a good indicator to bridge gap in the area of health services. Mere buildings or few policies on paper might not change grass root realities of health. Active participatory model of health policies and implementations are essential to change neglected attitudes towards health needs of marginalized sections of societies. Investment in the area of health should not be considered as a financial burden.

The study findings offer an empirical background to plan tailor made programs for people from low human develop index. Only such programs would decrease infant mortality rate, malnutrition, maternity mortality rate, birth rate, disability adjusted life years and prevalence of both communicable and non communicable illnesses. Involvement of various stake holders in planning level is important to formulate need based interventions to settle health inequality. In those committees must be formulated under the professional leadership of trained social workers who work to promote health among vulnerable populations. Holistic development is the solution to ensure equity in health services, than just constructing physical infrastructure. Social work interventions will play key role in future to eradicate health inequality.

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