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Socioeconomic Disparity in Access to Mental Health Care in India

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Abstract: Mental health disparity exists in India despite many policy investments globally and within India. This review examines the paradox: despite many policy-level investments, the socio-economic disparity still exists and is widening. A narrative literature review studying the relationship between socio-economic disparity and mental health in India, analysing all other barriers and policy responses. The review examined the paradox despite the National and District Mental Health programmes, and still, the treatment gap remains 84%, where the poorest population living in rural areas are the real sufferers. There are multiple barriers to access- financial barriers, structural barriers, and social and cultural barriers. It is suggested that Programmatic solutions cannot alone address the structural issues and increasing disparity. Policy-making should not be just for the marginalised community, but should be done by making them participate. A grassroots-centred approach focusing on redistributing power and resources to the marginalised community should be in practise.

Keywords: *Socio-economic Disparity, Mental health care access, Policy investments, Treatment gap, Barriers.*

1. Introduction

“Superfluous wealth can buy superfluities only”; these are the words of an American philosopher, Henry David Thoreau. This highlights the paradox that people with higher incomes tend to increase their spending on unwanted things or things of less use. This might affect the availability of resources to those who need them. The term "social disparity" or ‘social inequality’ has been discussed since the times of Aristotle and Plato. The canonical triumvirate, described as the three main components, ‘class’, ‘status’, and ‘party’ (power), prevails over others. Powerful people are often privileged with these three dimensions, whereas

Vol. 4, Issue 7 July 2026 ISSN: 2584-0142

the powerless people are rarely so. Moreover, under the influence of rich people (Berreman, 2015). Where the debate keeps going on: can money buy you happiness? But in today's world, the question should be reframed as: Can money buy you Mental Health care?

Financial instability does hinder the overall mental health of the people; epidemiological studies show that several cases were assigned and ruled out to understand the in-depth knowledge of different aspects where socio-economic disparity was seen (Megh Rajani et al., 2023). Interestingly, the concept of the '*Inverse care paradox by* Tudor Hart (1971 says that "the availability of good medical care tends to vary inversely with the need for it in the population served. The inverse care law operates more completely where medical care is more exposed to market forces." (Tudor Hart, 1971). In a paper by Nambiar and Mander (2017), the issue is a moral failure that requires urgent redress. Writing that the excluded population gets the least support and bears the real burden, demanding help from states (Nambiar & Mander, 2017).

Looking into the Indian mental health morbidity and the actual sufferers in an empirical context, the National Mental Health Survey (NMHS) was conducted by the National Institute of Mental Health and Neurosciences (NIMHANS) in the year 2015- 16. The survey resulted in the weighted lifetime prevalence for any mental health disorder being 13.67%, whereas the current prevalence was 10.56%; the treatment gap for overall mental health prevalence was reported to be 84.5%. Moreover, the most affected group targeted was the lower strata with lower incomes and a greater burden. (Gautham et al., 2020).

The prevalence of mental health has been rising for many years. The current survey shows that there is a rise of increasing cases of mental health disorders. 15% of the general population suffers from some kind of mental health disorder (*A Comprehensive Analysis of Mental Health Problems in India and the Role of Mental Asylums*, n.d.)

The lower-income families often feel the real struggle of getting access to their own mental health needs. Rural mental health services, health infrastructure, and other medical care services are still affected, despite regular initiatives and reforms by NHRM and other social bodies (Kumar, 2011). Nevertheless, looking into the reports that 72% of Indian people live in rural areas, still, 25% of availability is there for all the healthcare facilities in the residing areas (Gururaj et al., 2005).

Socioeconomic Status prevails all over, including many factors such as – low education, less income, husband's torture, not just women, but also socio-economic status is a hurdle in getting access for mental healthcare services and getting a victim of common mental disorders (CMD) as reported by Rahul Sidhaye and Vikram Patel out of out of 5703 women 609 reported

Vol. 4, Issue 7 July 2026 ISSN: 2584-0142

to have CMD (Shidhaye & Patel, 2010). A book titled '*Equity, Social Determinants and Public Health Programmes'* states that a review of literature finds a very convincing nature of how socio-economic status affects mental health and its access, claiming that depression affects people disproportionately from lower socio-economic backgrounds, and the discrepancy is higher in countries where there is a higher income gap (Blas et al., 2010).

Despite all this inequality and mental health services, there is still an inadequacy in accessing the services for mental health care. Still, there is an 84% treatment gap, where the true sufferers are the people already dealing with other specific social inequalities (NMHS, 2016). A person's mental well-being depends on all other social, physical, and economic factors operating at different levels of life. The ones in the middle also suffer from this inequality, as stated in an article, moreover claiming that the greater the inequality, the higher the inequality is in risk (Allen et al., 2014).

There have been many mental health interventions and programmes being initiated; still, the treatment gap widens. Few studies are exploring why inequality persists in mental health access, even after so many mental health programmes are running throughout. This study aims to critically evaluate why socio-economic disparities persist, particularly the structural and financial mechanisms that sustain them, despite policy-level interventions.

2. Literature Review

The cost and quality of living clearly indicate the possibility of survival, demonstrating a marker of social ranking. The Titanic accident, one of the worst marine disasters, reported that among women aboard passengers only 3% of first-class passengers lost their lives, compared to 16% of them in second-class, and 45% of those in third class (Carroll & Smith, 1997). Mental health status has been similar to this pattern, where the social distribution of psychiatric morbidity is inversely related to socioeconomic status and mental illness (Dohrenwend & Dohrenwend, 1969). All components other than just socioeconomic status are dependent and related to a higher risk of depression; low composite SES, income, and educational qualification are significantly related to a higher risk of depression, as discussed in a meta-analysis by Jespersen et al.(2025). Socio-economic measure is not just a singular term but a composite term consisting of income, education, and employment. In the meta-analysis, there has been a significant relationship between lower SES (its components) and depression. Having higher education would eventually lead to attaining higher employment rates and

Vol. 4, Issue 7 July 2026 ISSN: 2584-0142

income, whereas higher income would lead to attaining a higher level of education as well (Jespersen et al., 2025).

A critical distinction is examined from this research, claiming a crucial finding: there is no significant difference between the depression rates and the economic level of the country; results show that the low-income countries have no impact on the depression rates of the individuals, suggesting that absolute national income does not define depression rates in the country (Jespersen et al., 2025). The ones with the lowest incomes are 1.5- 3% more likely to suffer from stress than the ones who are rich (Ridley et al., 2020). The income spread overall in any country does not directly reflect the depression rates of the individual, claiming that the investment made by the providers does not actually meet the exact needs of the disadvantaged. The Lancet Commission on Global Mental Health urged scaling up services, claiming a global call to address mental health inequity- particularly in low and middle-income countries where access remains compromised (Patel et al., 2018). Despite the inclusion of SDGs, the disadvantaged population in lower-income settings remains deprived. Decades of research and progress in different policy-making have not made any proportionate changes in access for the most deprived population; the Lancet Commission itself acknowledges this paradox (Patel et al., 2018).

This pattern is visible in India as well; the National Mental Health Survey (NHMS) conducted in 2016 reported that the treatment gap- the gap between who receives care and who actually needs it is high, standing at 84.5%, with the lowest socioeconomic groups being the real sufferers. The survey was conducted to address the prevalence rate of mental health disorders morbidity. Social demographics in India reported that nearly 150 million people suffer from one or another mental health disorder; the lifetime prevalence of mental health disorders of any mental morbidity came out to be 13.7%, whereas the current prevalence rate of mental morbidity came out to be 10.4% in the survey. Mainly, men were more likely to be in this category among lower-income households and less-educated individuals. The facts demonstrate that the individual income level- not the national wealth- determines an individual's access to these services. (Gautham et al., 2020).

There can be many barriers to accessing mental health services other than just individual income sources; however, the government has been taking many initiatives for mental health accessibility. However, utilisation has been very low due to several factors, such as lack of awareness and misinformation, reluctance to approach health professionals, the absence of multidisciplinary teams in private hospitals, and limited involvement in the government sector. There have been several interconnected barriers at multiple levels- at the

Vol. 4, Issue 7 July 2026 ISSN: 2584-0142

community level, many view mental health problems as manifestations of social stress or spiritual stress, rather than addressing these issues as medical conditions that require interventions. Looking into the structural barriers, such as not having a qualified team or mental health professionals in private institutions, and a lack of involvement in the government sector. Moreover, issues such as poor-quality services, long waiting hours, and all these barriers are proven to be a disadvantage, especially for people in lower socio-economic areas (Lakshmana et al., 2022). The rural-urban divide in mental health care delivery is exacerbated by several barriers and loopholes in the system, especially for those in the affected sector is with lower socio-economic status, as stated in a review of barriers to effective implementation of mental health policies in India; the five major challenges that were explored include the insufficient financial allocation for mental health programmes, which lead to limit the availability of services secondly, shortage of mental health professionals especially in the rural areas, poor integration of mental health services into the primary healthcare system and lastly the lack of bureaucratic inefficiencies among the mental health services; the affected group are people residing in rural areas such challenges increase the gap and diversifies urban-rural divide in mental health care services in India (Yadav, 2025).

The rural-urban divide represents one of the most significant structural barriers to mental health care in India. The rural population faces different challenges, such as inadequate investment in rural mental health infrastructure, a distinct help-seeking system that affects the help-seeking behaviour, and low availability of mental health professionals (Gupta, 2024). Moreover, there are only 0.29 psychiatrists per 100,000 population; this gap is further widened by the poor motivation of mental health professionals to work in rural areas Gupta, 2024) despite the government pf India's expansion of the District Mental health programme over 20 years now, still the treatment gap in rural areas lies in 70-90%, meaning the majority of people who need metal health care services remains untreated, these findings suggests that the policy level initiatives are inadequate untill the structural causes and the underlying factors in resource distribution are not addressed at the grass-root level (Gupta, 2024).

The literature reflects the relationship between socioeconomic status and mental health outcomes; also, substantial evidence exists claiming that there are certain barriers to accessing mental health services, especially in the rural regions of the country. Still, a critical gap remains unexplored; despite many policy interventions and different mental health programmes, the mental health divide remains the same, and in some divisions it widens. Few studies have also examined the deeper level, structural mechanisms that keep alive these inequalities even when there are timely initiatives taken by the government. This paradox highlights the failure of

Vol. 4, Issue 7 July 2026 ISSN: 2584-0142

policy and programmes in reducing the gap in access to mental health care, especially for the lower groups of society, pointing to the need for critical examination of how mental health services, policies, and programmes are designed and implemented at the grassroots level. This present review aims to highlight the same issue and what remains to be understood about this disconnect of policy -level investment and ground-level access equity.

3. Results

3.1 *Socio-economic status and Mental Health link*

There is a well- established relationship between socio-economic status and mental health care services. The individual's income is the primary determinant of mental health concerns, rather than the nation's income (Jespersen et al. 2024; Ridley et al.,2020, Patel et al., 2018). These findings reflect on an important concern about why national- level investment policies alone cannot guarantee equitable access to the lower-income groups. The national level investments cannot always guarantee the eradication of the real problem or the root cause of these issues.

3.2 *India's Mental Health burden and treatment gap*

India, despite having a diverse population, still suffers from the problems of the treatment gap. The lifetime prevalence of people suffering from mental health concerns is 13.7%, whereas the treatment gap, the ratio of people needing care but not receiving it, is 84.5%. People with lower socioeconomic status are seen to bear the greatest burden. The availability of psychiatrists is just 0.29 psychiatrists per 100,000 people. Despite numerous district and national mental health programmes, the gap remains at 70-80% (Gautham et al., 2020; Gupta, 2024). This explains how, at the individual level, poverty plays a greater role as a barrier to mental health care and access.

3.3 *Different interrelated barriers to Mental Health Access*

Diverse interrelated barriers to Mental Health Access, at different levels: financial burden, structural barriers, and, importantly, at the community level, misconceptions about mental illnesses as a spiritual or religious issue rather than a medical problem (Lakshmana et al.,2022). Especially rural areas are the real sufferers of this inequity, bearing all the financial, structural, and emotional burdens. Moreover, the unwillingness of mental health professionals to work within rural settings because of the limited availability of resources is another barrier (Gupta, 2024).

Vol. 4, Issue 7 July 2026 ISSN: 2584-0142

4. Discussion

The central finding of this review paper is a paradox- despite years of investment into policy interventions and expansion of national and district mental health programmes, and many other programmes of awareness about mental health care, the socioeconomic divide and gap in access to these services have widened for the lowest income groups in India. Access has become difficult for those who are in real need. There is an increase in the treatment gap- the availability of mental health services to those who are in need. This paradox eventually suggests that not just investments alone are sufficient to address this problematic gap of access to mental healthcare services.

Programmes do not focus on those who need: - the programmes do not really address the needs of the people who are in real need, the persistent gap lies in the fundamental mismatch between how these programmes are designed and the reality of the people who are below socioeconomic status and in actual need of these mental health services. While these national mental health programmes were designed to address their needs, they failed to target the underlying hidden costs of attaining these services- transportation, lost wages during treatments and the opportunity cost spent on seeking care. These hidden costs lie as an extra burden for the people living below the poverty line (Gautham et al., 2020). These programmes were designed to help poor people by not targeting the real grassroots cause, but with the aim of establishing just the policy-level investments. The real sufferers are still inaccessible to these services.

One explanation for this persistent gap lies in the fundamental difference between programmatic solutions and structural solutions. The programmatic solutions often target the implementation of the programmes or the policy level investments, as seen. Programmatic solutions (NMHP, DMHP) address the visible symptoms- need for more mental health services, whereas the structural solutions lie in how we can redistribute resources, power and decision-making to marginalised communities. India’s solutions or investments have been more programmatic than structural, without targeting the grassroots level. The programmes designed without targeting the structural inequities and the real cause will inevitably fail to address the needs of the poor, eventually increasing the gap, leading to the poor suffering more from such mental health concerns and treatments.

Secondly, rural-urban inequality reflects a more structural disparity that no programme alone can resolve. Rural areas have fewer mental health professionals; there are 0.29 psychiatrists per 100,000 population. The reason behind this number is that they lack motivation to work in the rural areas because of poorly constructed buildings, lack of resources

Vol. 4, Issue 7 July 2026 ISSN: 2584-0142

available and unhygienic settings to work in (Gupta,2024). This is a structural issue which needs to be taken care unless there will be less workforce and the situation can be worse than now. Similarly, community-level stigma about mental health adds to the burden of urban-rural disparity. There are still increasing stigmas even after launching numerous mental health awareness camps. Stigma is rooted deeply in the belief system that campaigns alone cannot resolve these issues (Lakshmana et al., 2022). These structural issues require similar structural solutions for better functioning.

Third, a critical gap exists between intent and implementation. There is a significant mismatch between what is promised to do and what is actually implemented on the ground. The District Mental Health Programme claims to help all the districts and work on all the needs, contradictory to this, there is still a 70-80% of treatment gaps that exist, meaning the majority of people still suffer from a lack of full access to Mental Health services (Gupta, 2024). This gap between promise and how things work in reality reveals deeper problems: stating that these policies are developed and designed at the national level without understanding the real problems of rural people, including the less available transportation resources, lack of community involvement, and staff shortage (Yadav,2025). These policies are good on paper and in theory, but lack in practise.

This review reveals that addressing and solving these socio-economic disparities in mental health access requires moving beyond programmatic solutions, including working on structural solutions. Future research should not just focus on the barriers to access, but also on how the inequality still multiplies despite constant efforts to provide mental health services. Policy makers should realise that these policies and programmes can not just give solutions by investing alone in these programmes; it requires participatory policy design, where these programmes should include designing and implementing mental health services by making the rural community participate in these policy-making programmes that would address the real reasons and the issues people face, rather than just addressing the barriers. Until these programmatic policy designs shift to structural and the policy-making does not shift to participatory, the gap still widens even after investing more.

5. Conclusion

This review examined socio-economic disparities in access to mental health care in India and found a paradox: despite many years of policy investments, funded projects, programmatic expansions, and growing awareness, the treatment gap still exists and is widening, especially for the lowest-income population. The evidence so far suggests that rather

than focusing on the programmatic solutions, structural issues cannot be waved off by adding services through policy implementation. The deeply rooted structural inequalities cannot be solved. This review states some important implications for policymakers in India. Firstly, targeting structural solutions rather than overlooking programmatic solutions for the rural area population. Secondly, implementation matters more than just designing the policies; the practice of those policies is more important than just writing them on paper and making claims. Thirdly, there would be better functioning if the policy investments were made in partnership with low-income communities, but not for them. The paradox of widening inequality despite making many changes and investments can only be resolved when policies are made to acknowledge the structural inequalities and target the root cause, not merely service availability.

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Vol. 4, Issue 7 July 2026 ISSN: 2584-0142

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