

Accessibility And Affordability Of Health Services In India: A Critical Study

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ABSTRACT

Considering India's outstanding economic success following the adoption of new economic strategy in the 1990s, the country has made only gradual and unequal progress in enhancing its citizens' health. Large disparities in health infrastructure and access to healthcare remain and have even gotten worse within and among groups, among rural and urban areas, and throughout states. Despite the fact that member nations of the World Health Organization began to support the idea of health care for all as early as 2005, India has yet to accomplish these goals, unlike numerous other low-income nations. The continual issue of meeting the needs of the most marginalised Indian society is one that the country's health care system must continue to grapple with. Recent progress in access to healthcare caused by various initiatives, the states continue to face serious problems with regard to the affordability and accessibility of health-related services for the poor. Inequalities in the cost and accessibility of health treatments by socio - economic level, location, and gender are still present. This is mostly caused by the numerous obstacles that make it difficult to get essential medical care. The present crisis of public health infrastructure in rural regions and other aspects of health services in India are critically examined and evaluated in this perspective.

Keywords: WHO, Accessibility, Affordability, Inequality, Health service, Health Infrastructure.

Introduction:

Health is acknowledged by the World Health Organization as a human right and as one of the key factors in promoting social well-being (Mann, J. (2011)). We are aware of the link between advancing health indicators and economic progress. However, despite a strong economic growth rate of 7% even during the global economic slump, such a tendency has not been seen in India (Golechha, M. 2014). Given that healthier populations live longer, are more productive, and have higher savings rates, health plays a significant role in economic advancement. Due to early deaths and preventable illnesses, India loses more than 6% of its GDP each year (WHO 2013). Both the psychological and financial costs are enormous. India has had rapid economic growth over the past 20 years, but it has performed poorly in terms of health and human development indexes. Comparing South and East Asian nations with comparable income levels and rates of economic growth, the population averages of health status indicators like child health and maternal mortality remain unacceptable high (Gwatkin, D. R, et al 2007).

India exemplifies a contradiction because it has a burgeoning generic medicines sector, which distributes affordable pharmaceuticals to more than 100 nations, a fairly underwhelming healthcare system, and a thriving medical tourism economy in addition to providing healthcare to more than 1.2 billion residents (Golechha, M. 2014). The slowdowns of the Indian health service have included a weak public sector infrastructure that prevents it from providing appropriate and affordable care. These slowdowns have included a lack of drugs, a lack of cutting-edge laboratory facilities and equipment, a severely constrained health workforce, a public health system that is underfunded (less than 1.04% of the GDP), as well as a poor delivery method for healthcare (Gangolli, et al 2005). In 2000, India's healthcare system was placed 112th out of 190 nations in the World Health Organization's global healthcare assessment. Since then, the public and private sectors have worked together, but the results have been inconsistent. In the majority of healthcare-related metrics, India continues to fall behind similar nations. Public health expenditure is extremely low by any measure, even though India's total healthcare spending as a percentage of GDP is equivalent to that of other developing nations with similar per capita income levels (Rajkumar, et al 2008).

Even for the amount spent on healthcare does not keep up with the rising demand. For the vast majority of people, access to affordable health care is a big issue, particularly for tertiary care. Numerous people are forced to pay high out-of-pocket costs for services they obtain from the private sector due to the lack of comprehensive and appropriately supported public health services (Turshen, M. (1999). The still-significant inadequacies in the healthcare infrastructure are made worse by the underutilization of the available resources. The disparity in healthcare provision among states and demographic groups exacerbates the situation. Rural communities receive particularly low services. Only 2% of the qualified doctors in our country work in rural areas, where 70% of the population resides. The number of health care workers is still too low and underused (Willging, C et al 2005).

The political and public health leadership in India has spearheaded creative initiatives, turned the best ones into policy, and made significant contributions to improving health outcomes. Over 157 thousand people have been employed in the health industry since the National Rural Health Mission was established in 2005. Between 2000 and 2012, the infant mortality rate (IMR) decreased from 68 to 42 per 1000 live births. More than 120 to 130 million women have given birth in government facilities thanks to the Janani Suraksha Yojana, and each year, more than 600,000 newborn babies are cared for in neonatal care nurseries at district hospitals (Golechha, M. 2015). The nation has been free of polio for decades. Although exciting, this is insufficient. More than 40 million people experience poverty and incur enormous debts to get healthcare each year, with the majority living in rural areas. In India, non-communicable diseases and injuries are to blame for 52% of fatalities. It is anticipated that non-communicable illness mortality will rise. As a result, drastic reforms are required in Indian healthcare (WHO 2000).

Article 38 of the Indian Constitution imposes a state's obligation to secure a social order for the promotion of the welfare of the people, but this cannot be done without public health. It implies that human welfare is impossible without public health. Article 39(e), which relates to workers' rights to health protection (Khandekar 2012). Article 41 gave the State a mandate to provide public aid, primarily to the sick and disabled. By providing maternity benefits, Article 42 provides for the protection of the mother's and infant's health. The Directive Principle of State Policy under Article 47 of India states that it is the state's principal responsibility to advance public health, secure justice, improve working conditions for people, extend

benefits for sickness, old age, disability, and maternity, as well as other related matters (Srinivas, P. 2013).

A qualitative approach on the efficient use of healthcare services offered by Primary Health Centre and Sub-Center in rural Tamil Nadu, India, was carried out in **2016 by Rushender Rajan, Balaji Ramraj, et al.** By using the simple random sample procedure, 3220 households were chosen. Utilizing a systematic interview schedule, data was gathered. The results showed that the majority of respondents were aware of primary health centre (PHC) health care services, and that primary level services (PHC and Sub-centres) are more frequently used for precautionary and promotional care than for acute ailment diagnosis, intrapartum care, family welfare benefits, and special inquiry assistance.

In **2015, K N Prasad, V Suchi**, and others did a cross-sectional study on how the rural Pondicherry population used the health amenities at the Primary Health Center. 300 families were chosen using a straightforward random selection method. Data was collected via a questionnaire and an interview. The results imply that the majority of participants used PHC services.

A cross-sectional study on the perception and use of primary healthcare services in a semi-urban community in South-Western Nigeria was carried out in the year **2021 by B.E. Egbewale and O.O. Odu.** By using a multistage sample procedure, 395 adults were chosen. Data were gathered through an interview with a semi-structured, previously tested questionnaire. The findings indicate that the majority (71.1%) of respondents knew that a PHC facility was present within their health districts and that 44.1% of respondents had ever used a PHC facility within those districts.

Health Determinants

A variety of elements interact to influence the health of people and communities. People's situations and environments determine whether they are healthy or not. Our surroundings, where we live, our genetics, our money and educational attainment, as well as our relationships with friends and family, all have a significant impact on our health to a huge extent. The availability, accessibility, and affordability of fundamental health services are made possible through healthcare finance and provisioning systems. The accessibility, availability, and affordability of health care are significant determinants for enhancing health among the many different factors that affect health. However, the primary goal of the

current study is to assess the availability and cost of health care in India and the chosen states, particularly in rural areas.

Objectives of the study

- To Study the Availability of Health Care Facilities in the Rural Communities.
- To Study the Affordability of services of Health Care workers in the rural areas.
- To find out Accessibility of the villagers are about healthcare services and resources.

Data and Methodology:

This article only uses secondary data. The Ministry of Health and Family Welfare of India's Bulletin on Rural Health Statistics 2015, National Health Profile 2015, Population Census 2011 issued by the Registrar General of India, and National Health Accounts India were the four sources used to compile the data for this study. Released by the National Health Accounts Cell of the Indian Ministry of Health and Family Welfare (In collaboration with WHO India Country Office). This paper's analysis is both qualitative and descriptive. The three primary aspects of health services in India—availability, accessibility, and affordability—have been analysed in order to explain the narratives.

Several socioeconomic and health indicators India:

Any state's social and health indicators are used to measure the state's and nation's level of prosperity. The living style and health characteristics that indicate the general state of the population's health are revealed by socioeconomic factors. The health state of individuals can be determined by a variety of markers. Researchers primarily focus on four important health metrics: the infant mortality rate (IMR), total fertility rate, maternal mortality rate (MMR), and death rate (TFR). The health situation with regard to India is shown in Table 1.

Table 1: India's socioeconomic and health indicators

Indicators	India
Population (in crores in 2011)	121
Female-to-male ratio (females per 1,000 males)	943
Per capita state domestic product (Rs)	39904
Literacy rate (%) (Male/Female)	74.04 (82/65)
Life expectancy at birth (years)	67.9
Infant mortality rate(1000)	39
Under-five mortality rate(per 1000 in 2015)	29
Maternal mortality rate(100000)	167
Total fertility rate(1000)	2.3
Death rate (1000)	7

Source: Ministry of Health and Family Welfare GOI, National Health Profile 2015, Central Bureau of Health Intelligence, Directorate General of Health Services, and Census 2011 GOI.

Accessibility of Health Services:

In order to obtain the best health outcomes, individuals must have timely access to personal health services. There are 3 distinct steps needed:

- (1) Entrance into the medical system.
- (2) Finding a healthcare facility where the required services are offered.
- (3) Choosing a medical professional the patient can trust and communicate with.

In the case of India, state-of-the-art medical care that is accessible and affordable is luring medical tourists from the developed world. In India, the medical tourism industry is expanding. By 2015, the medical tourism market in India is projected to increase at a 30% annual pace, reaching revenues of Rs. 9,500 crore. By 2012, it is predicted that medical travel to India will be worth up to \$2 billion annually. The Indian government is actively seeking out patients from outside. However, it is a sad irony that the underprivileged in India lack access to basic medical treatment. Like most developing nations, India sees millions of deaths from illnesses that may be prevented.

India has a doctor to population ratio of 1:1600, or six doctors for every 10,000 people, with a population of 1.21 billion (Sundararaman & Gupta 2010). India's physician to population ratio was placed 98th out of 144 nations, well below the average of 1:1000 for all countries (WHO 2006). In comparison to the global average of 2.9 beds per 1000 people, each government hospital in India serves an estimated 61,000 patients and has a bed for every 1833 patients. Both a lack of human resources—specialist doctors with postgraduate medical degrees in these particular fields—and the physical incapacity of the health infrastructure to deliver fundamental medical care and all-inclusive emergency services—are to blame. The availability of health services and their acceptability are the two key factors that affect accessibility to health services.

The Sub-Centre (SC), Primary Health Center (PHC), and Community Health Center (CHC) are the three pillars of India's three-tiered rural health-care infrastructure. These health centres were established based on population norms of 5000 per Sub-Centre, 30.000 per Primary Health Center, and 120.000 per Community Health Center in Plain Areas, and 3000 per Sub-Centre, 20.000 per Primary Health Center, and 80.000 per Community Health Center in Hilly/Tribal/Desert Areas. Additionally, there will be four PHCs and six Sub-Centers per PHC (GOI, 2011). A requirement for the general development of the entire system is the expansion of these healthcare facilities, particularly the expansion of the Sub-Centres. The primary point of interaction between the community and the primary healthcare system is the subcenter, which is the most remote location. Sub-Centres are expected to offer services related to maternal and child health, family welfare, nutrition, immunisation, diarrhoea control, and control of communicable diseases programmes. They are staffed by one auxiliary nurse midwife (ANM)/female health worker and one male health worker (and one additional second ANM under NRHM).

The PHC serves as the local community's primary point of contact with the medical officer. A PHC that contains 4 to 6 patient beds and is staffed by medical officers, paramedics, and other staff serves as a referral unit for 6 Sub-Centres. PHCs are designed to offer the rural people comprehensive curative and preventive healthcare. CHC constitutes the third layer of India's rural healthcare system. A CHC that serves as the referral centre for four PHCs and offers obstetric treatment and specialist consultations is staffed by four medical specialists (a surgeon, physician, gynaecologist, and paediatrician) and 21 paramedical and other employees. It contains one operating room, an X-ray room, a labour room, and laboratory facilities in

addition to its 30 indoor beds. As far as population coverage standards are involved, all three types of health centres have not yet met the current population standards for the entire nation.

Medical Services Affordability:

Affordability is best described as a gauge of a person's or something's capacity to pay for a good or a service. It states if an individual or group can buy something with their available funds without making undesirable or unreasonable concessions. Similar to this, health care affordability refers to a person's or an organization's ability to finance or provide for their medical expenses. Therefore, the cost of treatment, households' capacity to cover these expenditures, and its effects on household life all play a role in how affordable health care are (Gilson et al 2007). OOP (Out of Pocket) expenditures make up a disproportionately big share of all healthcare spending in India. Direct payments for consultations, diagnostic tests, medications, and transportation are included in OOP expenses.

OOP expenditures do not account for indirect costs like lost wages as a result of the illness. OOP payments are thought to cover 97% of private expenditures and 80% of all health-related expenses (GOI 2006). The cost of buying medications makes up the majority of OOP expenses. According to estimates from the National Sample Survey (NSS) for 1999–2000, 77% of OOP spending in rural areas and 70% in urban areas is on medications (Sakthivel 2005). The fact that the poorest rural quintile spends 87% of OOP expenditure on medications while the corresponding expenditure for the richest urban quintile is comparably smaller at 65% demonstrates the adverse socio-economic difference in OOP expenditure (Garg and Karan 2005). The higher quintiles of the population are negatively impacted by the high OOP expenditure in the absence of financial risk insurance. After accounting for health expenses resulting from OOP payments, estimates for 2005–06 show that 35 million more persons, or 3.5% of the population, lived below the poverty line (Dreze and Sen 1996). From the estimate provided in 1999–2000, when 3.25%, or 32 million individuals, lived below the poverty line, a minor rising trend was seen (Garg and Karan 2005).

Given the state's federal structure, the individual states that have an impact on the accessibility, acceptability, and availability of services are primarily responsible for funding, providing, and managing health care. This only serves to highlight the range of health spending while fully understanding that per capita estimates are merely averages that obscure imbalances. The structure of how health services are provided is influenced by the spending trends in this area.

Table 2 - Trends in Public Health Spending

Year	Public Expenditure on Health (in Rs crores)	Population (in crores)	GDP (Rs in crores)	Per Capita Expenditure on Health (in Rs)	Public Expenditure on Health as Percentage of GDP (%)
	1	2	3	4	(5) = [(1) I (3)]*100
2009-10	72536	117	6477827	621	1.12
2010-11	83101	118	7784115	701	1.07
2011-12	96221	120	8832012	802	1.09
2012-13	108236	122	9988540	890	1.08
2013-14(RE)	131062	123	11345056	1064	1.16
2014-15(BE)	159492	125	12653762	1280	1.26

Source: Health Sector Financing by Centre and States/UTs in India, National Health Accounts Cell, MOHFW, GOI.

Conclusion:

Even after six decades of planned expansion, India's health-care system is still not up to par. The Government of India's NRHM (2005-2012) programme, which was introduced in 2005, has significantly improved the nation's health-care infrastructure, but progress has been unevenly distributed between regions and interstate, on a broad scale. Many rural and underdeveloped sections of the country have very limited access to healthcare services. In this regard, this work has investigated the existing status of public health infrastructure and health service available in the rural areas of the selected states. After the introduction of NRHM in 2005, researchers discovered that the infrastructure for rural health care in the area has significantly improved, particularly with regard to health centres.

Equally significant, India's rural healthcare industry faces a dearth of qualified medical professionals, including specialists, nurses, and other healthcare professionals. Although many of the positions for different cadres of health workers are sanctioned, they are vacant in virtually all of the states, which leads to underuse of the resources in the current health centres and, ultimately, to closure of those facilities. In rural places, it can be difficult to find public health-care services located within safe physical reach. Therefore, India's rural health care system urgently needs to be strengthened through aggressive measures. In order to define the important areas, a plan must be established while keeping in mind the challenges of enhancing the health care system. The state governments ought to implement more explicit policies to construct new health facilities, particularly Sub-Centres, and to upgrade the current facilities to the next level. Additionally, the current health facilities need to be fully manned with qualified medical professionals and furnished with all necessary amenities.

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