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Inequities in access to health services in India

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Abstract
India's health system faces the ongoing challenge of responding to the needs of the most disadvantaged members of Indian society. Growing socio-economic inequalities in India due to the absence of Universal Health Coverage (UHC) and an important determinant of socioeconomic inequities is caste. For the five-year period before the 2019-21 NFHS (National Family Health Survey), The under-five mortality rate was 42 deaths per 1,000 live births. This indicates that one in 24 children in India die before their fifth birthday. More than four fifths (83%) of these deaths occur during infancy. As on 31st March, 2021, there are 156101 and 1718 Sub Centres (SCs), 25140 and 5439 Primary Health Centres (PHCs) and 5481 and 470 Community Health Centres (CHCs) respectively which are functioning in rural and urban areas of the country. In this paper, we identify the factors that are affecting the equity in access to Health services and four key areas that require the urgent attention.

Keywords: India, health, challenges, inequality, services, rural, urban

Introduction

Growing socio-economic inequalities in India are disproportionately affecting health outcomes of marginalised groups due to the absence of Universal Health Coverage (UHC) and an important determinant of socioeconomic inequities is caste. There are four categories of caste: Schedule castes (SCs), Schedule tribes (STs), Other Backward Classes (OBCs), and others. Data shows that 65.7 percent of the households belonging to the General Category have access to improved, non-shared sanitation facilities while only 25.9 percent Scheduled Tribes (ST) households have improved, non-shared sanitation facilities. 12.6 percent more children are stunted in Scheduled Castes (SC) households than those in households belonging to the general category.

For the five-year period before the 2019-21 NFHS (National Family Health Survey), the neonatal mortality rate (The probability of dying within the first month of life) was 25 deaths per 1,000 live births. This means that one in 40 live births died during the neonatal period. The infant mortality rate (The probability of dying between birth and the first birthday) was 35 deaths per 1,000 live births. The under-five mortality rate was 42 deaths per 1,000 live births. This indicates that one in 24 children in India die before their fifth birthday. More than four fifths (83%) of these deaths occur during infancy. (NFHS-5)

The under-five mortality rate is higher in rural areas than in urban areas (46 deaths per 1,000 live births versus 32 deaths per 1,000 live births). The under-five mortality rate is highest in Uttar Pradesh (60 deaths per 1,000 live births) and lowest in Kerala and Puducherry (5 and 4 deaths per 1,000 live births, respectively). The under-five mortality rate for scheduled tribes (50 deaths per 1,000 live births), scheduled castes (49 deaths per 1,000 live births), and other backward classes (41 deaths per 1,000 live births) are considerably higher than for those who are not from scheduled castes, scheduled tribes, or other backward classes (33 deaths per 1,000 live births). The under-five mortality rate also declines with increasing household wealth. The under-five mortality rate declined from 59 deaths per 1,000 live births in the lowest wealth quintile to 20 deaths per 1,000 live births in the highest wealth quintile. (NFHS-5)

The perinatal mortality rate -Perinatal deaths comprise stillbirths (pregnancy loss that occurs after seven months of gestation) and early neonatal deaths (deaths of live births within the first seven days of life). The perinatal mortality rate is higher in rural areas than in urban areas (34 deaths per 1,000 pregnancies versus 25 deaths per 1,000 pregnancies). The rate is highest in Uttar Pradesh (44 deaths per 1,000 pregnancies), followed by Bihar (43 deaths per 1,000 pregnancies), and is lowest in Goa (2 deaths per 1,000 pregnancies). (NFHS-5).

Features of Health Service Provisioning

The Public Health Service institutions are Sub-centres (SCs) and Primary Health Care (PHCs) are the primary level; Community health centres (CHCs) and Hospitals at the Secondary level and Teaching hospitals at the Tertiary level.

As on 31st March, 2021, there are 156101 and 1718 Sub Centres (SCs), 25140 and 5439 Primary Health Centres (PHCs) and 5481 and 470 Community Health Centres (CHCs) respectively which are functioning in rural and urban areas of the country. (https://main.mohfw.gov.in/documents/reports)

Sub Centres (SCs)

- At national level, there is an increase of 10075 numbers of SCs from the year 2005.
- The significant increase in SCs has been observed in the States of Rajasthan (3019), Gujarat (1888), Madhya Pradesh (1315) and Chhattisgarh (1297).
- There are a total of 1718 Sub Centres in the urban areas as on 31st March 2021.
- There are a total of 26351 Sub Centres in the tribal areas as on 31st March 2021. (https://main.mohfw.gov.in/documents/reports)

Primary Health Centres (PHCs)

- At national level, there is an increase of 1904 PHCs in 2021 with comparison to the year 2005. The increase in PHCs from year 2005 has been observed in the States of Jammu & Kashmir (557), Karnataka (460), Rajasthan (417), Gujarat (407) and Assam (338).
- There is a total of 5439 PHCs in the urban areas as on 31st March 2021.
- There is a total of 3966 PHCs in the tribal areas as on 31st March 2021. (https://main.mohfw.gov.in/documents/reports)

Community Health Centres (CHCs)

- At national level, there is increase of 2135 number of CHCs from the year 2005. The increase in CHCs from year 2005 has been observed in the States of Uttar Pradesh (367), Tamil Nadu (350), Rajasthan (263), West Bengal (253) and Bihar (205).
- There is a total of 470 CHCs in the urban areas as on 31st March 2021.
- There is a total of 975 CHCs in the tribal areas as on 31st March 2021. (https://main.mohfw.gov.in/documents/reports)

Changes on the Manpower position (Rural Areas)

- The number of ANMs at Sub Centres and PHCs has increased from 133194 in 2005 to 214820 in 2021 which amounts to an increase of about 61.3%. As on 31st March, 2021 the overall shortfall (which excludes the existing surplus in some of the States) in the posts of HW(F) / ANM is 2.9% of the total requirement as per the norm of one HW(F) / ANM per Sub Centre and PHC.
- A total of 1224 Sub Divisional/Sub District Hospital and 764 District Hospitals (DHs) are functioning as on 31st March, 2021 throughout the country. There are 15274 & 26929 doctors and 42073 & 90435 paramedical staffs are available at SDH and DH respectively. (https://main.mohfw.gov.in/documents/reports)

Changes on the Manpower position (Urban Areas)

- 20937 Health Worker (Female)/ANM is in-positioned at PHCs. There is 20.6% posts vacant and shortfall of 30.8% of HW (F)/ANM at PHC, out of the total requirement at all India level.
- There are 6809 Allopathic Doctors, 4561 Pharmacists, 4161 Laboratory Technicians and 8058 Nursing Staff are available at PHCs. (https://main.mohfw.gov.in/documents/reports)

Factors Affecting Equity in Access to Health Services

There are five key health service factors that affect equity in access to health services.

1. **Insufficient Investment in Public Sector** – The low public investment in health services over the last six decades has been a significant cause for the poor functioning and utilization of public services. The per capita expenditure on health is low compared with other countries with the same level of income and the government expenditure is even lower.
2. **Unregulated commercialization and risking cost**- Unregulated commercialization of provisioning has an adverse impact on the quality and the cost of health care.
3. **Health sector reforms**- Today, India ranks below most other nearby countries in life expectancy, maternal mortality, and infant mortality. Health care reforms started around 2005 through programs aimed at strengthening rural health services and providing partial financial protection for health care to vulnerable families.
4. **Variable quality of care in public and private sectors**- The quality of health services is dependent on the factors related to accessibility to services, presence of adequate drugs, supplies, staff, and facility amenities. Study shows that the people are not satisfied with the public services and highlight the lack of infrastructure and rude behavior of the personnel as main reason for not using public services.
5. **Lack of accountability in public and private sectors**- The lack of accountability of the public sector is well known, the private sector is not any different. A few cases were registered with the consumer court was given for the medical negligence in the private sector.
6. **Barriers for marginalized populations**- The evidence shows that the poor and those who are socially marginalized get the least access to healthcare services.

Conclusion

In order to address the problem of inequities in health services in India, we identify four key areas that require the urgent attention. First, The need arises for enhanced public investment on the number of programmes that are focusing on poor and socially marginalized group of people. Second, the regulation of the public and private sector is required in provisioning. Third, new and innovative system of monitoring performance and evaluative progress towards health outcome. Fourth, Health security in India needs to become an urgent national and political priority. Rapid improvements in health are needed not only to accelerate Indian economic growth, they are also fundamental to India gaining recognition as a distinguished middle- income country with improved standard of living and reduced level of human deprivation.

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