ORIGINAL ARTICLE

Access to Public Health Care System: A Study of Primary Health Care in Delhi

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ABSTRACT

Background: The Primary Health Care System plays a critical role in providing basic healthcare and given the skewed quality services, it is imperative that a robust healthcare system is in place. The primary objective of the study is to examine the access to primary health care system in Delhi NCR. **Material & Methods**: A household survey was conducted to identify the weaknesses in the primary healthcare setup, covering 156 households comprising of 800 members across Delhi. A detailed analysis of access to health services was carried out. **Statistical analysis used:** simple graphs and tables **Results**: The average health expenditure is close to one-fourth of income, primarily on medicines. The marginalised sections access government and free primary health centres while 60% of upper middle class access private care. The gender bias is observed in the provision of quality health care. For major ailments, households irrespective of social group, caste or gender, access private health facilities. **Conclusions**: Discrimination on the basis of social grouping is on a limited scale but economic factors play a crucial role in access to quality health care. To mitigate health disparities, benefits through medical cards to the disadvantaged sections including women, poor and Dalits must be offered.

KEYWORDS

Primary Health Care; Household Expenditure; Discrimination

INTRODUCTION

A good primary healthcare system improves efficiency by taking away burden from hospitals which can focus on secondary care involving specialised medical needs of the society. It contributes towards provision of equitable access to basic health care and health outcomes(1). A survey to study these aspects was conducted in Delhi.

Public health is a state subject, though with the internationalisation of many dimensions of health, particularly post COVID-19 pandemic, the role of the central government is increasing with respect to WHO stipulated regulations, monitoring and responses to disease. The revised guidelines of 2022(2) on Indian public health standards according to the National Health Mission have emphasised the importance to be flexible and adaptable to the specific needs of different states. The outbreak of Covid-19 highlighted the formidable challenges that the global healthcare system faced. Despite its issues and shortcomings, public health care system played an important role during the pandemic.

In Delhi, a significant proportion of population seeks outpatient care up to five times annually(3) where these visits are associated with substantial stress and financial burden(4). The expansion of smaller hospitals and primary health centres has been relatively slow, resulting in a higher burden on tertiary public hospitals and on non-transparent private healthcare providers.

MATERIAL & METHODS

This study focuses on the crucial role that the primary health care system plays for people who do not have easy access to private and expensive health care facilities. A sample survey was conducted across 156 households (comprising 800

members) in various areas of Delhi-NCR. The sample included households from Sukhdev Vihar, Okhla, Kardampur, Ghonda, Najafgarh, Burari, Shahdara, Jharoda, Mehrauli, Sultanpur, Patparganj, and Vikaspuri. The Mohalla Clinics were chosen as the initial point of survey as the patients visiting these clinics are primarily not from upper echelons of the society. Also, the clinics were easily located as they were spread across the city. Households visiting these clinics on the survey days were randomly selected, with additional households surveyed from the surrounding areas of the clinics, between September and November 2024.

By including both clinic visitors and nearby residents, the survey captured a diverse range of perspectives, ensuring the data collected was comprehensive and representative of the broader population. A detailed, structured questionnaire was followed in each household, gathering information on household demographics, employment, income, housing conditions, access to sanitation, water, electricity, major household expenditures, chronic ailments and other health-related factors, as well as access to Mohalla Clinics and other healthcare services. Information on the most recent major health expenditure by the households was also recorded.

Households were subsequently categorised into different socio-economic classes based on income quartile. These categories included very poor (A), poor (B), middle (C), and upper middle (D) households. In addition to the aforementioned classifications, households were also identified according to social groups and the age distribution of their members.

RESULTS

Among the total households surveyed, a majority—approximately 58 per cent—were from the 'Other' social group, followed by 29 per cent from Other Backward Classes (OBC) and 12 per cent from Scheduled Castes (SC). Notably, only a single household, constituting 1 per cent of the sample, was identified as belonging to the Scheduled Tribes (ST). Thus, the data indicates a predominant representation of households from the 'Other' category. When households are segmented according to income quartiles, the distribution across groups appears to be relatively balanced, indicating a near-uniform representation from each group once income levels are taken into consideration, with percentage share of very poor households at 26.4, poor 25.6, poor 25.6 and upper middle 22.4. The reported annual income earned in our sample ranged from as low as Rs 1250 to up to Rs 66 Lakhs. Members of the surveyed households were engaged in a range of occupations, including manual wage labour, petty self-employment, and salaried employment in both the government and private sectors. The housing conditions of economically better off households were markedly superior to those of poorer households, with the former residing in relatively larger, pucca houses.

Access to Healthcare: While private care is the biggest primary healthcare provider that is accessed by individuals on average, for treatment across gender, a large proportion of Dalits prefer government healthcare, with expenditure likely being a key factor in this trend (Table1)

The classification based on social criteria and economic criteria reveal that though households classified along social group criteria like SC and ST populations have limited access to private facilities but it is the income criteria which creates greater disparity in terms of access to healthcare provider (Table 2). There is caste hierarchy with respect to access to healthcare, especially for SC communities. More than half of the members from the SC community go to cheaper health facilities as they earn meagre incomes. They are financially strapped groups who can ill-afford private sector health facilities. The interlinkages between class and caste have been documented in several surveys(5,6,7). Thapa et al(2021)(8)in their review article on access to health in South Asia highlight that due to poverty, Dalits have limited access to healthcare as they are unable to miss their daily wages by visiting health centres along with the limitation of visiting quicker but much more expensive private health services. Similarly, Baru and others(2010)(9) point out the socio-economic inequities manifested in caste, class and gender differentials and inequities in availability, affordability and utilisation of health services. The Others and OBC social groups, on the other hand, have similar pattern of access to health care facilities. They primarily access private facilities

Table 1: Proportion of Healthcare provider accessed by the households, by Gender and Social group, in per cent

Healthcare Accessed	Males	Females	All	SC	ST	OBC	Others	All
Government	43	32	37	54	100	27	35	37
Private	48	48	48	35	0	58	48	48
Semi-Government	2	3	3	0	0	4	3	3
Mohalla Clinic	7	16	13	12	0	10	14	13

Source: Survey Data

The services at private healthcare providers are often exorbitant forcing the marginalised and the poor to reach out to government and free primary health care centres for basic health services. Close to sixty percent of middle and upper middle-income groups get treated at private facilities; on the other hand, the same high proportion go to public health centres (government and Mohalla clinics) from the very poor and poor income groups (Table2).

Table 2: Proportion of healthcare provider accessed by the households, by income group in per cent

Healthcare Accessed	Very poor (A)	Poor (B)	Middle (C)	Upper middle (D)	All
Government	49	43	27	25	37
Private	37	41	59	57	48
Semi-Government	2	4	2	5	3
Mohalla Clinic	12	13	12	14	13
All	100	100	100	100	100

Source: Survey Data

Access to Mohalla Clinic: Our survey's reference healthcare provider was Mohalla Clinic, though the access to other alternatives was investigated as part of our questionnaire, for the set of households that were interviewed.

The close proximity of a Mohalla clinic made it a preferred choice of the patients over local dispensaries and hospitals. The affordability (no payment towards fee, medicines and diagnostic tests) and accessibility along with skilled staff added to it being a more attractive health facility. Though government health centres and hospitals also provide free consultation and medicines at subsidised rates, they are often overcrowded and the waiting time is long. The respondents felt that the main drawback of the Mohalla clinics had been the limited tests that were conducted in-house. Even with this limitation, some patients learned about their medical condition like diabetes or hypertension through free checkups and free doctor consultations. This timely intervention, if implemented, across all ailments for all sections of the society would contribute hugely to the community health.

The age profile of those visiting the Mohalla clinics in our sample point to the fact that the proportion of the population making use of Mohalla clinics is predominantly from the age group of 35 to 59 years, followed by young population below 15 years of age. There is no asymmetry in terms of income groups which accessed Mohalla Clinics with 24% each from income groups A, C and D and income group B formed 28% of the total but among the social group classification, Others formed the largest social group visiting the clinic. In our sample 68% respondents belonged to Others, 20% to OBC and 12% to SC.

The data reveals that for major health conditions like heart attack, kidney failure etc, only 23% of the patients got admitted to government hospitals, rest got treated at private hospitals. Fifty percent of these patients had to take loans or borrow from family to cover the medical bills. Further, for minor ailments, women tend to access cheaper/free health care facilities like Mohalla clinics much more frequently than men (76% against 24% for men), though larger proportion of men (58%) have access to some health care facility or the other. This implies that men get treated at relatively more well-equipped health centres, including private hospitals. This gender disparity is noted by several research studies in India(10,11,12). A probable explanation apart from the gender discrimination that can be inferred from this is the limited accessibility for women in a society which makes it somewhat arduous for them to travel long distance for their treatment, given other household chores and outside work responsibilities that they have. Vaccination and polio drops for children below 5 years of age are predominantly provided through Anganwadi workers who are committed to child development and nutrition and some are connected with the public health centres with the help of ASHA (Accredited Social Health Activists) workers. The National Family Health Survey -5 (NFHS-5)(13)providing information on health and nutrition, covering all states and union territories, shows an improvement in complete immunisation of children in the age group 12-23 months over the previous NFHS(14). This all states- level data shows that 77% children in this age group are fully immunised. In our sample, close to ninety percent of children below 5 years of age get vaccination through Anganwadi workers. The pre-natal and post-natal care is not accessed in the same measure. Close to $1/4^{th}$ of mothers do not go to any facility for pre- or post-natal care. Around 50% access non-private health centres for pre-natal care which drops to just 30% for post-natal services. Post-natal care is not prioritised.

Expenditure on Health: A major challenge that any developing economy faces in the health domain is the limited support provided by the government. In India, the government expenditure in GDP falls

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short of 2% as reported in Economic Survey 2024-25(15). Limited public funding and very high out of pocket expenditure on health are some of the critical factors of impoverishment. The predicament of the poor is exacerbated with poor infrastructure and limited amenities. They can ill-afford expenditure on preventive care like check-ups, vaccination etc, which increases expenditure on curative care due to neglect and lack of medical diagnosis. It is well documented that investment in preventive healthcare significantly mitigates escalating healthcare expenditures, especially complications arising out of chronic ailments.(16,17) As recent as 2019, the COVID-19 pandemic highlighted the urgent need for preventive measures like RT-PCR tests, antigens tests and vaccination to prevent huge economic burden and loss of lives.

For our sample, the reported average expenditure incurred on health is Rs. 39618 per annum as Table 3 indicates. According to Economic Survey Statistical Appendix(18), the projected estimate of per capita income for the year 2023-24 is Rs. 1.84 Lakhs. This implies that if the survey figures are taken as representative average medical expenditure, almost a quarter of the income is spent on health.

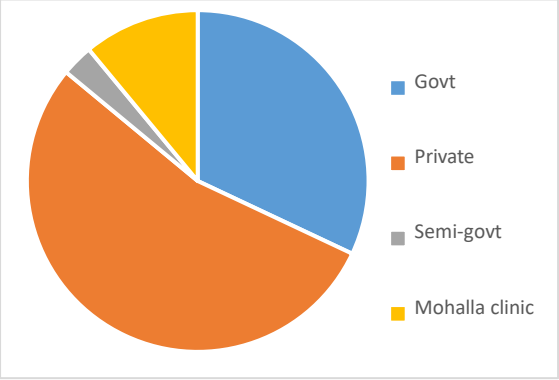
Table 3 Expenditure on Health (combining both IPD and OPD), by gender

Gender	No of people who incurred any expenditure (number)	Percentage of people who incurred any expenditure (in per cent)	Share of expenditure incurred (in per cent)	Average expenditure incurred (in Rs.)
Males	85	58	51	35018
Females	62	42	49	45925
Total	147	100	100	39618

In the households we surveyed, 147 individuals had access to some form of healthcare facilities, with 58 percent being men. The expenditure share is relatively higher among women, with an average spending of Rs. 45,925. The average medical expenditures on different heads as part of outpatient department (OPD) include medicines, doctor's fee, diagnostics tests and other miscellaneous charges; the maximum expenditure is on medicines. Close to 85% of the total expenditure goes into medicines. The consultation fee and diagnostic tests form 15% of total expenditure.

A detailed therapeutic analysis indicates a significant proportion of individuals access private care for acute ailments. 65% of the patients visit health facilities for acute ailments and in that more than half of them go for private care (Figure 1).

Figure 1: Health Care Providers for Acute Ailments



The rising incidence of non-communicable diseases like Diabetes and hypertension, cardiovascular ailments co exists with high prevalence of communicable diseases like tuberculosis and other infections and respiratory ailments. The highest proportion of ailments are still Infections and respiratory ailments which form 27% of all ailments for women and 30% for men. This is comparable with some of the non-communicable diseases like Endocrine, metabolic and Cardiovascular ailments- they stand at 22% for women and 32% for men (Table 4). This upward bias towards infections including gastrointestinal and respiratory ailments is similar to the NSSO data on Health. The National Sample Surveys on Health have also documented high incidence of acute ailments (71st and 74th rounds).(19,20)

Mohalla clinics provide curative care for ailments like diabetes and cardiovascular but as mentioned earlier, preventive treatment and pathology services are limited. In 2018, Health and Wellness Centres (HWCs) were set up to prioritize primary health care with special focus on the non-communicable diseases (NCDs) in rural areas, for early detection and access to public facilities to address the rising incidence of NCDs. A recent study(21) has analysed the effectiveness of these centres in rural Chhattisgarh and found it to be having positive impact on early detection of NCDs.

Table 4: Gender based access to healthcare, by nature of ailment, in per cent

Nature of ailment	Proportion of women (in per cent)	Proportion of men (in per cent)
Infections &Respiratory	27.21	30.11
Endocrine, metabolic, nutritional, cardiovascular	22.80	32.25
Psychiatrics and neurological	1.47	4.30
Gastrointestinal	11.03	9.68
Musculo-skeletal	10.29	6.45
Obstetric	8.09	
Genito – Urinary	3.68	3.23
Skin, Ear and Eye	7.36	3.23
Blood disease	1.47	0.00
Injuries	0.74	9.68
Other	5.88	1.08
All	100 (136)	100 (96)

Note: The figures presented in parentheses represent the numerical data

In the survey, we collected information on the most recent major ailments for which households incurred significant expenditure. For these major ailments, households, irrespective of gender, social group, or caste, predominantly accessed private healthcare providers. Women accessed 5 private hospitals out of 6 and men went to 4 private centres out of 6. Similarly, among all social groups and income categories, only 24% went to government hospitals and the rest 76% relied on private care. Despite affordable government hospitals, private care is preferred for the personalised care it provides and the perceived superior health services in the private sector. Apart from superior quality of care(22), access to private hospitals by the poor has been analysed in terms of Sen's entitlement approach(23,24). Entitlement to healthcare through income and awareness play an equally important role in accessing better health facilities as the availability of these facilities.

Access to basic amenities: For analysing the basic amenities, we considered both owned and rented households. Dalit households exhibit the lowest levels of access to various household amenities, including housing. Access to toilets, which are essential for preventive healthcare, is particularly limited among Dalit community. According to WHO Factsheet(25), as per WASH-related burden of disease estimates,1.4 million people die due to poor sanitation, water and hygienic conditions. Improvement in water, sanitation and hygiene (WASH) can significantly reduce air-borne and water-borne infections. In our survey, there was only one household belonging to ST category and they had access to basic amenities. On the income scale, there was no noticeable difference in the other amenities.

DISCUSSION

This paper has critically examined the gendered nature of healthcare access. Household expenditure on healthcare is gendered, shaped by socio-economic structures that prioritise male needs. It shows how public health systems, while expanding coverage, are often limited to specific health ailments resulting in marginalisation of women's healthcare.

Discrimination on the basis of social grouping was found on a limited scale in our survey but economic factors play a much more crucial role in access to quality health care. Dalits access cheaper healthcare providers more than all the other social groups. Even for basic amenities, their needs remain unmet. The women patients have limited access to private health services. In our sample, three-fourths of the patients were women against one-fourth men. The average health expenditure is close to a quarter of the total income.

With the epidemiological transition and technological advancement in medical sciences, the incidences of communicable diseases have been declining, while the non-communicable diseases show an upward trend. But the respiratory and infectious ailments still remain predominant in disease burden, requiring medical intervention despite a surge in non-communicable diseases like hypertension and diabetes. Addressing the challenges that people face for primary health care requires addressing the social determinants of health. Deeply entrenched socio-economic inequalities create hurdles in accessing the means and opportunities for quality health.

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Conclusion

There is a need for large number of Primary Health Centres, much more than those already exist. The diagnostic tests must be available at the health facilities for timely intervention for both non-communicable and communicable diseases. For better health outcomes and to mitigate health disparities, special treatment and benefits through medical cards to the disadvantaged sections including women, poor and Dalits must be offered. There is a need for the Participatory Community Needs Assessment Approach which emphasises decentralised planning and monitoring to enhance the reach and quality of Primary Health Centres (PHCs), with community participation playing a crucial role in strengthening the overall planning process.

Recommendation

The inclusive process of decentralised planning and monitoring can significantly enhance the reach and quality of Primary Health Centres (PHCs), with community participation playing a crucial role in strengthening the overall planning process

Limitation of the Study

It was a time bound research study, as a consequence of which, limited number of households could be covered. A more extensive survey with detailed questionnaire is planned for future research.

Relevance of the Study

A detailed analysis of the role of socio-economic factors in primary health care in the city of Delhi was carried through primary survey.

Authors Contribution

All authors have contributed equally.

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The primary survey was carried out with the support of the Miranda House Research Fund.

Conflict of Interest

There are no conflict of interest

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Declaration of Generative AI and AI Assisted Technologies in the Writing Process

The authors haven't used any generative AI/AI assisted technologies in the writing process.

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