The Accessibility, Affordability and Availability of Health Care Services at Govindpuri Slum Area of South Delhi: A Cross Sectional Study

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Abstract— Background: In spite of numerous government intervention programs to bring about changes in the health care delivery system throughout India, still there are numerous challenges that need to be overcome as many people still do not have access to primary health care services to cater for their health challenges, especially the slum dwellers, who are largely low income earners.

Methods: A cross sectional study was conducted during Jan 2019- May 2019 among 200 persons residing in Govindpuri slum area of South Delhi. A structured questionnaire comprising of both open and closed ended questions was used as a tool for data collection and was analyzed using Microsoft Office Excel and valid inferences were drawn.

Results: 91% of the respondents claimed that the distance from their homes to health care facilities was either not trekkable or very far which denotes lack of Accessibility. 97% of the respondents earn less than Rs.15, 000 monthly, out of which 91% requires a means of transport to health care facilities, thus it can be said that health care services are relatively unaffordable to them. Only 9% of the respondents claimed the distance between their homes and the health care facilities was trekkable, which denotes lack of Availability of Health care facilities in the area.

Conclusions: The study revealed that Govindpuri slum area is lacking the Accessibility, Affordability and Availability of healthcare services like it’s the case in other slum areas, and so there is the urgent need for government intervention to improve health care delivery in slum areas.

Keywords: Accessibility, Affordability, Availability, Health Care Services, Slum Area

I. INTRODUCTION

The people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare [1].

A. Accessibility:
What is the proximity of health care services to the populace? And the ease of contact between the health providers and those in need.

B. Affordability:
Are you willing to pay the amount your health care provider is willing to charge or is the provider willing to accept what you are willing to pay?

C. Availability:
When the need arise, can you get to see your physician or you have to wait for a long time in order to get to your health care provider.

D. Slum:
The UN operationally defines a slum as “one or a group of individuals living under the same roof in an urban area, lacking in one or more of the following five amenities”:
1) Durable housing (a permanent structure providing protection from extreme climatic conditions);
2) Sufficient living area (no more than three people sharing a room);
3) Access to improved water (water that is sufficient, affordable, and can be obtained without extreme effort);
4) Access to improved sanitation facilities (a private toilet, or a public one shared with a reasonable number of people);
5) Secure tenure (de facto or de jure secure tenure status and protection against forced eviction) [2].

Accessibility, affordability and availability of healthcare services are critical to a good health, but unfortunately the rural and vulnerable section of the society is either lacking one or all of them.

Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process [1].

One of the key policy principles of National Health Policy (NHP) 2017 states that “Reducing inequity would mean affirmative action to reach the poorest. It would mean minimizing disparity on account of gender, poverty, caste, disability, other forms of social exclusion and geographical barriers. It would imply greater investments and financial protection for the poor who suffer the largest burden of disease”[3].

Also “As costs of care increases, affordability, as distinct from equity, requires emphasis. Catastrophic household health care expenditures defined as health expenditure exceeding 10% of its total monthly consumption expenditure or 40% of its monthly non-food consumption expenditure, are unacceptable”[3].

One of the objectives of National Health Policy (NHP) 2017; progressively achieve Universal Health Coverage:
1) Assuring availability of free, comprehensive primary health care services, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases in the population. The Policy also envisages optimum use of existing manpower and infrastructure as available in the health sector and advocates collaboration with non-governmental organizations on pro-bono basis for delivery of health care services linked to a health card to enable every family to have access to a doctor of their choice from amongst those volunteering their services[3].

2) Ensuring improved access and affordability, of quality secondary and tertiary care services through a combination of public hospitals and well measured strategic purchasing of services in health care deficit areas, from private care providers, especially the not-for-profit providers[3].

3) Achieving a significant reduction in out of pocket expenditure due to health care costs and achieving reduction in proportion of households experiencing catastrophic health expenditures and consequent impoverishment”[3].

And so therefore the only way government can make healthcare services affordable to the populace especially the low income earners is to invest a great proportion of the annual budget into health as only 1.15% of India’s GDP goes to health.

The constitution of India considers the “right to life” to be fundamental and obliges the government to ensure the “right to health” for all [4],[5].

To a significant extent, India’s health sector has been shaped by its federal structure and the federal–state divisions of responsibilities and financing. The states are responsible for organizing and delivering health services to their residents. The central government is responsible for international health treaties, medical education, prevention of food adulteration, quality control in drug manufacturing, national disease control, and family planning programs. It also sets national health policy including the regulatory framework and supports the states [6].

The draft National Health Policy prepared in 2015 proposes that health be made a fundamental right and views government’s role as critical [7]. If accepted, it would clarify, strengthen, and prioritize the role of government in shaping the health system.

Total health expenditures in India for 2013–2014 were 4.02 percent of GDP. Government expenditures amounted to 1.15 percent of GDP, which is lower than the average for low-income countries [8],[9]. Household out-of-pocket health spending was 69.1 percent of total health expenditures, making this a major component of the financing system.

Despite these various schemes, evidence indicates that by 2014, less than 20 percent of the population was covered by any form of health coverage [10].

Most of the services under health packages like the Central Government Health Scheme and Employees State Insurance Scheme are free. These remain the most generous of health coverage programs catering to a small section of the population, raising issues around equity.[7] Under the RSBY insurance scheme for the poor, hospitalization services are free, up to allowable amounts.

Despite the government’s indeterminate approach to recurring costs, its overall approach to health care has clearly evolved. In 1983, India’s National Health Policy adopted the Alma-Ata definition of primary health care to include “the provision of curative, preventive, promotive and rehabilitative health services.” This marked a shift in India’s attitude towards health care: previously, the focus had been on curative services; now, the stress was on integrated health services. As a result of this refocused approach to health care, India established 23,000 primary health care centers, 130,000 sub-centers and 150,000 health care institutions in rural areas [11].

In a statement to “The Lancet” about the general challenge with health care in India, Madabhushi Madan Gopal, Secretary of the Health and Family Welfare Department in the state of Karnataka, said: “The government lacks managerial skills and professionalism. We have also fallen behind in establishing community rapport and enabling convergence between the various departments that look at health, water and sanitation, etc.” Historically, Indian policy has been rural-centric. Though it is an imperfect system, the government has made considerable investment into a dedicated rural health care structure. But now, the country’s health care challenge has substantially grown to include the needs of urban health care. Because of shifting demographics caused by continuously increasing rural-to-urban migration, there needs to be a change in the Indian government’s lack of focus on urban health [11].

Though public health care services do exist in major cities, exploding urban populations mean that there are not enough primary health care facilities to cater to the public, nor have existing facilities been properly maintained. Health delivery for the urban poor is made even more difficult by their illegal and vulnerable status in cities. Most urban poor residents, then, are forced to consider private health care options, which are prohibitively – and, at times, dangerously – expensive. High out-of-pocket health-related expenditures are a key reason why many Indians fall further into poverty every year [11].

As rural health care models proliferate and are refined in India, it also becomes obvious that the needs of urban health care are becoming more relevant and immediate. There are significant costs – economic and health — to the conditions borne by the urban poor, and different models are needed to alleviate and promote the poor’s primary health care needs. There is no magic formula to health care delivery, but there does seem to be a growing climate of experimentation in reaction to an ill-equipped urban health care system. The private sector, in conjunction with the massive networks of the government, can be what tips the balance for the better and changes the urban health care story across the country [11]. This background was taken into consideration to study the accessibility, affordability and availability of health care services in Govindpuri slum area of South Delhi.
II. METHODS

A. Study Design
The study design employed here was a quantitative and cross sectional study. The study was carried out between Jan 2019 to May 2019 and submitted to Department of Public Health, Delhi Pharmaceutical Sciences and Research University (DPSRU) in partial fulfillment for the award of the degree of Masters in Public health (MPH), among the residents of Govindpuri slum area in South Delhi. The sample size for the cross sectional study was 200. The questionnaires were prepared using both open and closed ended questions to enable the respondents give their opinions regarding challenges of health care services like distance from their homes to hospitals, whether or not they visit same hospital for treatment as well as emergency, whether or not they are covered under any medical health insurance.

An informed consent form was issued to the participants stating clearly that they may choose not to respond to any question and their information would be kept strictly confidential and used only for the purpose of research and nothing more.

B. Inclusion Criteria
All persons between the ages of 18 to 50 and who were permanent residents of Govindpuri slum area.

C. Exclusion Criteria
Persons below the age of 18 and above 50, visitors and non-residents.

Socio-demographic characteristics include information regarding educational/marital/occupational status, family size, religion and monthly earning. The responses collected were analyzed using Microsoft excel sheet and presented in the form of tables, pie charts, doughnut charts and bar charts.

III. RESULTS
Socio-demographic data on Table 1 showed that the educational qualification of most of the respondents i.e. 48% were having primary level qualification, followed by secondary qualification with 29.5%, out of which 13.5% were literate but no formal education, 5.5% were non literate and 3.5% were graduate and above. Their monthly earning was found to be; Non earners (26%), less than Rs.5000 (8.5%), Rs.5001-10,000 (47%), Rs.10,001-15,000 (15.5%), and more than Rs.15,000 (3%). Which shows that majority of the respondents monthly earnings was Rs.5001-10,000 and only a few of them were earning more than Rs.15,000. Their occupational status showed a vast majority of the respondents i.e. 31% to be involved in different kind of businesses, where as 26% were full house wives, 15.5% were self-employed, 14.5 were earning regular salaries, 7.5% were involved into other sources of livelihood and the remaining 5.5% were daily wage laborers.

### Table 1: Socio-demographic data of respondents

<table>
<thead>
<tr>
<th>Variables</th>
<th>numbers</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Literate</td>
<td>11</td>
<td>5.5</td>
</tr>
<tr>
<td>Literate but no formal education</td>
<td>27</td>
<td>13.5</td>
</tr>
<tr>
<td>Primary</td>
<td>96</td>
<td>48</td>
</tr>
<tr>
<td>Secondary</td>
<td>59</td>
<td>29.5</td>
</tr>
</tbody>
</table>

### Table 2: Health care facilities visited for emergency and treatments.

Table 2 reflects the reasons for the choices of different hospitals were to avoid long queue and slow response associated with government hospitals in case of emergency and the cost of private hospitals in case of treatment. So it becomes a necessity to switch hospitals based on the health issue at hand. 59.5% of the respondents also claimed despite the private hospitals and private clinics being expensive, they chose to visit them in case of emergency, however despite the long queue 83.5% of them still patronizes the government hospitals because they have no other option. According to a study conducted by Chhabra et al which reveal that poor people preferred to go to tertiary health care institution because of economic reasons [12].

<table>
<thead>
<tr>
<th>Why do you choose that hospital in case of emergency?</th>
<th>Close distance</th>
<th>Affordable</th>
<th>Fast response</th>
<th>Closeness and Affordability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>3.5</td>
<td>121</td>
<td>60.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>17</td>
<td>8.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>19</td>
<td>9.5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Why do you choose that hospital for treatment?</th>
<th>Close distance</th>
<th>Affordable</th>
<th>Fast response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>157</td>
<td>78.5</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17</td>
<td>8.5</td>
</tr>
</tbody>
</table>
Table 3: Reasons for preferring a health care facility for emergency and treatment.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordability</td>
<td>18%</td>
</tr>
<tr>
<td>Both Affordability and Closeness</td>
<td>8.5%</td>
</tr>
<tr>
<td>No other option</td>
<td>73.5%</td>
</tr>
</tbody>
</table>

Table 3 reflects that only 18% of the respondents claimed Affordability to be the reason they visit a particular health care facility in case of emergency, whereas 8.5% claimed both Affordability and closeness then it’s clear that health care services are unaffordable to the residence of Govindpuri slum area.

Table 4: Whether or not the respondents have any medical health insurance, and if they know about Jan Aushadhi Scheme.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aware of JanAushadhi Scheme?</td>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>100</td>
</tr>
<tr>
<td>Do you have any medical health insurance?</td>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4 shows that despite government claims to have various forms of health insurance for the low income citizens like Rashtriya Swasthya Bima Yojana (RSBY), none of the respondents were having any medical health insurance which denote lack of Affordability in health care services in Govindpuri slum area. Also 36% of the respondents gets their medicines from government hospitals whereas 30% from dispensary, this indicates lack of Affordability considering the fact that none of the respondents is aware or benefitting from Jan Aushadhi scheme, a government program aimed at making quality medicines available at affordable prices for all, particularly the poor and disadvantaged, through exclusive outlets “Pradhan Mantri Bhartiya Janaushadhi Kendras”, so as to reduce out of pocket expenses in healthcare.

In order to bring changes to the health care services structure in Govindpuri slum area, the government needs build health care facilities with all the necessary equipments which is affordable and will cater for the needs of the residents. Also make medical health insurance available for the dwellers of not just Govindpuri but other slum areas in order help curb the menace associated with out of pocket expenditures on health.

A. Limitations

The study was conducted in urban slum only. It would be better if it had been compared with accessibility, affordability and availability of health care services at rural areas also.
However due to time constraint, lack of enough resources to do the study were limitations. And also not enough studies were done that covers all the three parameters of accessibility, affordability and availability of health care services at slum areas it was difficult to get the base data.

IV. CONCLUSIONS

This study revealed that there is a general scarcity of health care services at Govindpuri slum area which makes the dwellers travel far away to distant places as long as 10 kilometers away in order to get health care services at government hospitals despite long queues and not so good services which were attributed to government hospitals and in case of emergency they go to private hospitals which although provide quality health care but are expensive for the fact that they do not have any medical health insurances. Thus the government needs to provide basic health care facilities to the dwellers of Govindpuri slum area which will cater for their health at all time.

Funding: No funding sources
Conflict of interest: None declared
Informed consent: Duly signed Consent form was offered to the participants.

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[8] Central Bureau of Health Intelligence, National Health Profile, 2016