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The National Health Policy, 2017: Health Seeker's Profile and Accrued Benefit Analysis

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Abstract

The landscape of health is fast changing in developing countries. India being a signatory to the Alma Ata Declaration on "Health for All" has transformed the landscape of health in the country through Constitutional guarantees, plans, and policy measures. Constitutional bindings like those like Art 21, 38, 39(A) and the Directive Principles of State Policy have put compulsion on the Government of India to take measures for the universalization of health care and this is one of the ambitious targets of the 12th five-year plan aimed at comprehensive health care security to all. It mandates the country to ensure affordable, accountable, appropriate promotive, preventive, curative, and rehabilitative health care services and equitable access to health care to all citizens of India despite their caste, class, gender, religion, etc. In this context. In 2017, the Government of India introduced its health policy to provide coverage to the entire population of the developing country, i.e., India. It was a welcome initiative on the part of the country. After 6 years, the present article tries to map the health seekers' profile and how far benefits of health reform have been accrued by them. The researchers in this article have employed descriptive design with quantitative methods of data collection in the city of Bhubaneswar. The study concludes that the 2017 Healthcare policy has undoubtedly addressed the discrepancies in healthcare services to the population in terms of gender, age, and economic status, but still finds private healthcare services to cover more commoners and ensure services to them.

Keywords: Health Care Seekers, Health Caregivers, Health Policy 2017, Universalization of Health.

Introduction

Health serves as the bedrock for enhancing human capital within a society. Optimal health signifies an individual's full potential harnessed for self-discovery and self-fulfillment. Healthcare services for the entire population ensure health services without discrimination, allowing people to live a disease-free life of longevity. Thus, these measures aim at inclusivity, increasing accessibility, and quality.

Indian Commitments to Health for All

India, being a signatory to the Alma Ata Declaration, has also been in the process of transforming its health policies (1). Much before this, the Government of India was a signatory to Article 25 of the Universal Declaration of 1948, which obligated the country to grant the right to a standard of living adequate for the health and well-being of all individuals. In consonance with Article 21 of the Constitution of India, which guarantees the fundamental right to life and personal liberty, the right to health is much more embedded in the right to life with dignity to translate the constitutional mandate into practice. In Directive Principles of State Policy, Articles 38, 39, 42, 43, and 47 make it obligatory for the state to effectively utilize the right to health (2). The National Policy of Health, 2017 was enunciated to ensure wellness for all citizens of India through universal health coverage and the delivery of quality healthcare services at an affordable cost. It has also expanded the public health expenditure of the country and established health and wellness centers at public health center (3).

Literature Overview

Previous studies stated that the national health policy of 2017 became a landmark policy that aims to cover 100 million poor and vulnerable families, totaling 500 million individuals, with health insurance coverage. It also aims to instill social responsibility among private healthcare providers to cater to the needs of the poor. The National Health Policy 2017 is based on the idea of health inequity based on social determinants of the health of the country (4). It tries to close the gap

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between the vulnerable and non-vulnerable trying to ensure health care services to the downtrodden and the commons. It is expected to build a positive climate for the healthcare industry of the country. Dehury, et.al. (2023, 5) are critical of the Health policy of 2017. To the authors, the universalization of healthcare is only for curative care instead of being for holistic health (5). They have expressed that the Indian experience indicates the health sector as a profitable commercial venture for the private parties which may not allow the health policy to operate the private parties hardly would cater to the needs of the vulnerable and marginalized, where the public hospitals are likely to get abide by the prescriptions of the policy which will keep the goals half reached. Equity, accountability, affordability, inclusive partnership, and decentralization are key principles of the NHP (National Health Policy) 2017.They mentioned that for the first time, National Health Policy 2017 insists that healthcare is not only the responsibility of the public sector it is also to be shouldered by the private partners. They are apprehensive that with the low spending of 1.15% of the GDP (Gross domestic product) on public health very difficult to build infrastructure. Further, the private sector though brought into policy paper may not volunteer to provide quality service to the marginalized and vulnerable at a lower cost (6). National Health Policy 2017 which has made the historic declaration to bring the private sector as a strategic partner to deliver quality and health care services affordable. To her challenges loom large around the policy due to inadequate facilities, infrastructure health providers, which is likely to plague the policy and make it sticky to paper. The literature points out that absolute property which brings health socks to millions of Indians. He cites examples of absolute hunger which brings chronic anemia and malnutrition among children (7). All these foregoing reviews are anticipation where real-time surveys have not been included. So, in this article, the researchers have tried hard to make a real-time assessment of the impact of the policy by taking the stakeholders' profiles and the benefits accrued by them in reality.

Objectives

The study intends to make a socio-economic profile mapping of the health seekers from public and private hospitals, their choice of hospitals to receive health care services, and the benefits they accrue from the health care system.

Locale and Sample Covered under the Study

The present study is situated in Bhubaneswar, the capital city of Odisha. This capital city is located strategically, and well connected by roads, railways, and air services. Further, the city houses a maximum number of private and public hospitals. The study has taken the response from the health seekers of the best and biggest public hospitals of the city i.e. Capital Hospital and SUM Hospital, privately managed and run hospitals. The study took 80 samples from each of the hospitals to assess their socio-economic background and their perception towards the concept of universalization of health care ensured by the Health Policy of 2017. It also assessed the nature of the care they received from the hospitals.

Methodology

The present study adopted an explanatory design and interview schedule case study method of data collection. The researcher prepared an exhaustive interview schedule, which is validated by expects of social science domain. As the interview schedule was developed taking the valuable suggestions of these esteemed experts into consideration, it has satisfactory degree of content validity. To test the reliability of the interview, schedule the investigator used split-half method.

$$r_{xy} = \frac{\dfrac{\sum x^1 y^1}{N} - C^1 x C^1 y}{x^1 y^1}$$

Where x', y' are the deviations from the assumed mean. N is the size of the sample, c'_x, c'_y are co-relation factors. The detail calculation of co-efficient of co-relation has given below,

$$Cy = \frac{\sum x^1 y^1 - Cx - Cy}{\sigma x . \sigma y} = \frac{201/26 - (-0.860)(-0.86)}{2.83 x 2.65} = \frac{7.88 - 0.7396}{7.4995} = \frac{7.1404}{7.4995} =$$

$$= 0.913 (HighlySignicant)$$

The value of r found **0.913** which is very high. Thus the interview schedule was very reliable.

Results

The socio-economic profile mapping of the respondents includes several markers that were collected from the respondents. Age becomes a vital determinant of the nature of health care sought by individuals. The age composition of the health seekers and the nature of the hospitals accessed by them are presented in Table 1.

As it becomes evident from the above table, maximum health seekers fall into the age group of 30-60, their share being 52.5 percent and the lowest being in the age group of more than 60 which is the greying age. The reason described by the respondents is their productive age-induced agility and purchasing power which helps them to access health care services without any dependence. The number of higher-age health seekers number is as low as 21.25 percent as they find it difficult to carry their ailing bodies to hospitals alone without having dependents at their services and as their purchasing power declines with withdrawal from remunerated work. Further, private hospital dependence is again high among the working age group i.e. 56 percent where they feel have a paucity of waiting time and can spend money for a quick and quality treatment.

Gender is a prominent determinant of access to health services and the nature of hospitals. The gender dimension of health care services have been highlighted by different researchers. Women's health is always given the least priority in families as still their role as the breadwinner is undermined and their income generation capacity is very low. He further stated that NHP, 2017 aims at reducing health impoverishment bringing the marginalized into the fold of the health care system (9, 10). This propelled the researchers to inquire about the gender composition of the health seekers in the study area. The gender composition of health seekers is presented in Table 2.

The above table makes it discernible that women and the third gender group access more government hospitals in comparison to males. Gender hierarchy is reflected in this. This provides a strong impression that even after the enactment of the National Health Policy, 2017 with its equity provisions women are progressively taking services from private hospitals which was a dream for many years.

Marital status and nativity constitute markers of the social profile of individuals. In this context, Desai et.al. (2023) suggested married status can both be a booster and preventer of health-seeking behaviour. Similarly, nativity determines access to health care services and in turn determines the health seeking behaviour of the people (11). Taking these twin points in account, the social profile analysis also included a probe ito the marital status and nativity of the respondents which is projected in Table 3.

Table 1: Age-based use of health care services of the respondents

Age	Government Hospital		Private Hospital		Total	
	Sample	%	Sample	%	sample	%
< 30 Years	25	31	21	26	46	29
30-60 Years	39	49	45	56	84	52.5
> 60 Years	16	20	14	18	34	21.25
Total	**80**	**100**	**80**	**100**	**160**	**100**

Table 2: Gender disaggregated use of health care services by the respondents

Gender	Government Hospital		Private Hospital		Total	Percentage
	Sample	%	Sample	%		
Male	34	42	36	45	70	43
Female	50	62	40	50	90	56
Third gender	1	1	0	0	1	0.62
Total	**80**	**100**	**80**	**100**	**160**	**100**

Table 3: Marital status and nativity of respondents

Variables	Government hospital		Private hospital		Total	
Marital status and nativity	**Sample**	**%**	**sample**	**%**	**Sample**	**%**
Married	67	83	45	56	112	70
Unmarried	12	15	35	43	47	29
Widow	01	01	00	0	1	1
Bhubaneswar	40	50	12	15	62	38.75
Outside BBSR	30	37	52	65	82	52.25
Out of state	02	02	14	17	16	10
Total	**80**	**100**	**80**	**100**	**160**	**100**

As the table shows married people are more concerned about their health and wellbeing. Among the health seekers 70% are married and 29% are unmarried. They move to hospitals for treatment i.e. government hospitals, which provide cost-effective treatment than the qualitative and costly care in private hospitals. A married lady replied, "Why should I go to a private hospital when all the treatment and medicines are free in a government hospital". Unmarried health seekers may delay or hesitate for health care services but mostly they seek qualitative services from the private hospitals."

So far as nativity is concerned, the study noted that 50% of the respondents, who visited government hospitals and 15% who accessed private hospitals under study were mainly from the city itself. Government hospitals are easy to access for the marginalized city dwellers where they are ensured with the provisions of consultation and medicine as well which they do not get in private hospitals. Another old person replied, "This government hospital is near to my home and during an emergency, I can avail the treatment". In contrast, only 15% of respondents visited private hospitals, with a higher proportion (68%) coming from outside the city. Moreover, only a small percentage (2%) of government hospital visitors were from outside the state, while 17% of private hospital visitors were from outside the state. Patients who are in critical condition or life-threatening situations prefer private hospitals for prompt and hassle-free treatment.

Thus, the study concluded that in-city patients with a squeezed pocket avail the facilities of government hospitals which are more policy-driven and try to ensure universalization of quality health than the private hospitals which still function in a commercial profit-making capitalist mode. Private hospitals cater to the needs of the moneyed lot. So, to date, NHP 2017 is yet to gain ascendancy and the looping of private hospitals is still a myth, not a reality.

Education is a means to bring health awareness and to a great extent is a driver of health-seeking behaviour. Further, it brings sensitivity to public entitlements and provisions and empowers individuals to take advantage of the public policy provisions. Education is a powerful awareness creator of qualitative health services and also specialized health care (12). This led the researchers to document the educational qualifications of the respondents and correlate them with their availing of the nature of health facilities which is presented in Table 4.

Table 4: Educational status of respondents

Education level	Government Hospital		Private Hospital		Total	
	N	**%**	**N**	**%**	**N**	**%**
Primary	16	20	22	28	38	23.75
High school	35	44	38	48	73	45.25
Higher Secondary	23	28	10	12	33	20.62
Graduate	5	6	8	10	13	8.12
Post-graduate	1	1	2	2	3	1.87
Total	**80**	**100**	**80**	**100**	**160**	**100**

As it becomes discernible from the above table, education has not many roles to play in the health-seeking behaviour of the respondents. The study noted that health-seeking behaviour is getting progressively strengthened among people, which is a welcome indicator of development. During the survey one lady with primary level education in a care ward was interviewed, who brought her girl child for cancer treatment. She replied, "I must provide the best treatment to my child no matter even if I sell land which is meant for her marriage".Thus, the study noted that people's health consciousness is growing and their primacy given to health quality propels them to seek services from the best platform available even if it is a private hospital. Further, the massive drive about taking the services from private hospitals due to the Government's propaganda has brought a wave of consciousness driving the people towards private hospitals with demands.

Employment status again determines health-seeking behaviour and people's move towards public or private hospitals. It brings disparity in the health outlook of the individuals. Exposure to employment makes people more conscious about quality health care. Employed people have a voice and purse to bear the burdens of health care even in private hospitals. Further, the constraint of time at their disposal often drives them to private hospitals where they note a high degree of professionalism. Viewed from all these angles, the researchers tried to include employed status and its linkage with hospital services accessed to documentation in the study submitted in Table 5.

The table transpires that employed men and students have greater access to private hospitals because of their consciousness to get quality consultation and services, the constraint of time. They often are engulfed with a feeling that government hospitals are pro-poor and do not have the facilities for high-order tests. Cleanliness, professionalism, and quality health services are only available in private hospitals which saves their time and lives even if they are costly.

Healthcare costs in India have surged due to four primary factors: medical inflation, high out-of-pocket spending, inadequate public health investment, and low healthcare expenditure (13). These factors taken together make universalization of health a distant dream for the marginalized in the country. Keeping these adversities and unavoidability in view, the government introduced health card facilities for the BPL population to ensure quality health care and to avoid health care disparities among the population. A health card serves as identity proof and contains comprehensive details about the holder's health insurance plan. It allows cashless payment for hospitalization and treatment expenses, aiming to minimize out-of-pocket costs. To provide universal health coverage and minimize out-of-pocket expenses there are various provisions of health insurance schemes. Odisha government introduced the BSKY card (Biju Swasthya Kalyana Yojana) for families below the poverty line and those not covered by the scheme, offering insurance coverage of five lakhs. Apart from this various corporate houses have also provided health insurance and government employees have the facilities to reimburse all their health expenses. Health cards are the instruments that can materialize the broad targets of NHP, 2017. Keeping these presumptions in view, the study tried to locate the number of respondents who have possession of health cards. The outcomes of the query is presented blow in Table 6.

Table-5: Employment status of health seekers

Occupation	**Government Hospital**		**Private Hospital**		**Total**	
	N	**%**	**N**	**%**	N	%
Employed	24	30	44	55	68	42.5
Unemployed	37	46	12	15	49	30.62
Student	8	10	19	23	27	16.87
Business	11	13	5	7	16	10
Total	**80**	**100**	**80**	**100**	160	100

Table 6: Possession of health cards

Health Card type	Government Hospital		Private Hospital		Total	
	N	%	N	%	N	%
BSKY	23	28.75	22	27.5	45	28.12
Private Insurance	03	3.75	06	7.5	9	5.62
BPL	13	16.25	10	12.5	23	14.37
Reimbursement	02	2.5	04	5	7	4.37
Not at All	39	48.75	38	47.5	77	48.12
Total	**80**	**100**	**80**	**100**	**160**	**100**

The table illustrates the distribution of health card possession among patients in government and private hospitals. Among government hospital patients, 28.75% hold BSKY cards, 3.75% have Private Insurance, 16.25% possess BPL(Below poverty line) cards, 2.5% use Reimbursement, and 48.75% have no health cards. In private hospitals, 27.5% own BSKY cards, 7.5% have Private Insurance, 12.5% possess BPL cards, 5% use Reimbursement, and 47.5% have no health cards. Overall, across both types of hospitals, the majority (48.12%) of patients do not possess any health card, with BSKY being the most common card type with 28.12%. respondents having the same. Thus the study could discover that to date issuance of health cards to all the needy people has not yet been ensured which is likely to defeat the very purpose of NHP, 2017. Without a card or health insurance, the marginalized fail to avail of health care services in private hospitals which is too high and they have no stake there.

The number of times a patient visits a hospital depends upon various factors like the condition of the patient, treatment regimen, and overall quality of services provided in the hospital. The frequency signals the trust in health services and medical dependency of the patients. Patients seeking medical advice for minor ailments might necessitate fewer visits, whereas those requiring extended care or prolonged hospital stays will naturally visit more frequently. So, a cardinal question was put before all the health seeker respondents "What is the frequency of their hospital visit and which type of hospital they do visit?" The responses collected is codified in Table 7.

The table contains a total of 160 patients, with 80 patients in each category of hospital (government and private). The majority of patients in both government and private hospitals visited for the first time, with 80% and 68%, respectively. Second-time visits are less common, with 15% to government hospitals and 17% to private hospitals. Third-time visits are still less with 5% to government hospitals and 15% to private hospitals.

Gender and property determine people's access to health, whereas the NHP, 2017 lays down that irrespective of their gender and economic class all people need to be covered under health services. Researchers have investigated whether property ownership influences hospital selection. Those possessing assets like land, buildings, jewelry, vehicles, stocks, bonds, and bank accounts are termed propertied individuals, while those without such assets are classified as non-propertied. The study aimed to understand whether gender and property ownership play a role in determining hospital choices among individuals and contribute for accessing health on a universal basis. The resultant responses are put into numerical forms in Table 8.

Table 7: Number of times visited the hospital

No of times	Government Hospital		Private Hospital		Total	
	N	%	N	%	N	%
1st time	64	80	54	68	118	73.75
2nd time	12	15	14	17	26	16.25
3rd time	4	5	12	15	16	10
Total	**80**	**100**	**80**	**100**	160	100

Table 8: Gender, property, and the choice of hospital

Gender	Types of hospital				Total	
	Government hospital		Private hospital			
	Propertied (%)	Non propertied (%)	Propertied (%)	Non propertied (%)	Propertied (%)	Non propertied (%)
Male	30(37.5)	4(5)	32(40)	4(5)	62(37.5)	8(10)
Female	2(2.5)	43(53.75)	8(10)	36(45)	10(6.25)	79(49.37)
Transgender	0	1(1.25)	0	0	0	1(1.25)
Total	**32(40)**	**48(60)**	**40(50)**	**40(50)**	**72(45)**	**88(55)**

The table above compares the preferences of propertied and non-propertied individuals for government and private hospitals. It reveals that 60% of non-propertied people and 40% of propertied people seek healthcare services in government hospitals. In private hospitals, 50% of the patients are propertied, and the other 50% are non-propertied. Overall, 55% of non-propertied individuals are seeking healthcare services over 45 % are propertied people. Further, males have an ascendancy over females in accessing health care in hospitals whether government or private. Both gender and ownership of property favour individuals in accessing better health services and women are in the rear end of property ownership and due to their gender are doubly disadvantaged in accessing quality health services in hospitals.

Discussion and Conclusion

Thus, the study notes that NHP 2017 is an ambitious health policy of the Government to universalize health care and to increase the availability of, access to, and affordability of all citizens irrespective of their diverse social and economic affiliations to quality health. NHP, 2017 is an equalizer to health care among the people of the country. The novelty it has introduced is to bring private hospitals to provide health care to all people irrespective of their age, gender, nativity, or economic class. But these provisions are still now trapped in papers without getting translated into practice.

The supply side is strong in advocacy, but weak in performance and the demand side is also very low due to lack of public consciousness. Social and economic diversities determine health seekers' care-seeking behaviour and institutional support, particularly from private hospitals is very dismal. Private hospitals have their aggressive agenda of profit-seeking where the aged, married, city-based, nonpropertied, and noninsurance card holders have very limited access. Level of education is established as a sa strong driver of health care. The study concludes that public sensitization about the health policy is still lacking which defeats the very purpose of the NHP, 2017 and the claimant's claim over health care providing institutions. Till now the benefits accrued are dismaying. There needs change in public perception about health care which needs to be ingrained among all citizens across gender, caste, class, marital status, ownership, etc. Further, health as a basic human right needs to be injected into each mind which will increase public demand for health care and change the health-seeking behaviour of the population.

Thus, it can be concluded that socio-economic determinants still play a dominant role in the health care sector and the benefits of health sector reforms are not accrued by all segments of the population for whom they are intended. Public awareness, massive mobilization, surveillance and monitoring of institutions, and covering health care under the Right to service act can make NHP, 2017 a reality in the country.

Abbreviation

NHP-National Health Policy
BSKY-Biju Swasthya Kalyan Yojana
BPL- Below Poverty Line
GDP- Gross Domestic Product
CNNS- Comprehensive national nutrition survey

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Manuscript is developed by first author and final modification is done by second author.

Conflict of Interest

The authors declare no conflict of interest.

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