



Healthcare Disparities in India: A Comprehensive Qualitative Analysis

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Abstract

India's healthcare system is still highly stratified, with underprivileged groups being disproportionately affected by differences in access, cost, and quality of care. Healthcare outcomes are still shaped by socioeconomic, geographic and systemic factors, which result in notable disparities in service consumption. Although financial protection mechanisms and legislative initiatives have attempted to address these issues, their efficacy has been constrained by gaps in healthcare financing, inconsistent implementation, and ineffective governance.

This study uses a thorough examination of data on healthcare accessibility, inefficiencies in the public and private sectors, and financial burden to critically explore the structural impediments that lead to these inequities.

The study emphasizes how urgently fundamental changes are required, such as more investment in public health infrastructure, more regulatory monitoring of commercial healthcare providers, and strategic budgetary policies. Opportunities to overcome healthcare gaps are presented by technological innovations like telemedicine and AI-driven diagnostics, but infrastructure limitations and digital literacy still limit their accessibility. This study adds to the continuing conversation about building a more resilient and equitable healthcare system in India by pointing out important policy gaps and proposing remedies.

All-around reforms with emphasis in equity, efficiency, and financial protection would emphasize India's complete bridging of the healthcare gap. A combination of both public and private strengths, adapted to the needs of the underserved populations, is critical toward putting together a robust and inclusive healthcare system.

Keywords:

Healthcare disparities, Healthcare access, Out-of-pocket expenditure, Health insurance, Public-private healthcare

1. Introduction

Healthcare is often considered a fundamental right, yet access to quality healthcare services remains a privilege for many in India. Due to structural, demographic, and socioeconomic variables, the nation's healthcare system is characterized by notable disparities in access, utilization, and cost. Marginalized groups, such as those based on caste, gender, income, and geography, continue to be disproportionately impacted by disparities in healthcare affordability and accessibility. Although the goal of public health policies and treatments is to close these gaps, the results of these initiatives vary by state and demographic group. The vulnerabilities of underprivileged groups are made worse by the combined burden of communicable and non-communicable diseases as well as growing out-of-pocket (OOP) costs. The purpose of this study is to critically analyze the disparities in healthcare access and utilization that currently exist in India.

This study critically examines the existing inequalities in healthcare access and utilization in India, identifies key challenges, and proposes policy recommendations for a more inclusive and financially sustainable healthcare system.

The Burden of Healthcare Inequality in India

The public and private sectors, the wealthy and the

poor, and the urban and rural populations are all sharply contrasted in India's healthcare system

. Scheduled Caste (SC) and Scheduled Tribe (ST) women are 1.37 times more likely than upper-caste men to be denied access to healthcare, according to research by Ahmed and Mahapatro (2023), which emphasizes how gender and caste greatly impact healthcare access. Even though India wants to provide universal healthcare, these disadvantaged populations still face institutional obstacles that prevent them from accessing it.

India's public health spending is still woefully low, which results in poor infrastructure and regional differences in access to treatment. States with higher per capita healthcare spending did not always have better health outcomes, according to Das and Guha's (2023a) suggesting inefficiencies in governance and resource allocation. These results highlight the necessity of focused budgetary measures that guarantee the fair allocation of medical resources.

Regional and Demographic Disparities in Healthcare Utilization

Inequality in healthcare is a deeply ingrained structural issue as well as an economic one.

According to Chakraborty and Chakraborti (2015), the socioeconomic class still plays a significant role in determining access to healthcare, with wealthier people benefiting more from it while underprivileged communities continue to be neglected.

Yadav and Jena (2022) looked at disparities in the use of maternal healthcare services and discovered that the poorest women have the least access to postnatal care and professional birth attendance. The study found that media exposure and education were crucial in closing these gaps, highlighting the necessity of more focused awareness campaigns and enhanced healthcare outreach initiatives

Impact of Income Elasticity on Healthcare Demand

In India, the demand for healthcare services is mostly determined by income elasticity. Dubey (2024) highlights that although households must spend money on healthcare, the cost varies greatly depending on income levels. Because lower-income households are more sensitive to medical costs, necessary healthcare may be completely avoided, or treatments may be put off. In order to stop future marginalization, this disparity emphasizes the necessity of subsidized healthcare programs aimed at economically disadvantaged groups.

The Private Sector and the Rising Cost of Healthcare

The commercialization of services, which frequently puts profit ahead of patient welfare, has been brought about by the private sector's domination in India's healthcare system. Datta and Chaudhuri (2020) discovered that excessive treatment prices frequently result in patients experiencing financial hardship, which forces them to forgo essential medical care. The inefficiencies of the public healthcare system make people seek out more expensive private options, which further increases their dependency on private healthcare.

Gaddam and Rao (2023) looked at the prevalence of catastrophic health expenditures in India and found that the financial burden of healthcare is especially high for lower-income groups, with OOP healthcare costs continuing to push millions of people into poverty, especially in regions with restricted access to public healthcare services like Uttar Pradesh and Bihar.

The Role of Health Insurance and Policy Interventions

Financial protection is still insufficient even with the existence of numerous government-sponsored health insurance programs. Kumar and Duggirala (2021), discovered that a large number of insured people continue to have high out-of-pocket costs, indicating coverage gaps and ineffective implementation.

Bhatia et al. (2021), who examined impact of pro-poor policies on maternal health outcomes came to

the conclusion that although government efforts have increased access to healthcare for mothers, regional disparities still exist. In order to guarantee that healthcare benefits reach the most disadvantaged populations, the report recommends improved budgetary policies and governance structures.

Fiscal Transfers and Healthcare Infrastructure

Although the goal of fiscal transfers is to reduce healthcare inequalities among Indian states, they frequently fail to guarantee fair access to healthcare. The impact of fiscal policies on public healthcare infrastructure was examined by Harikrishnan and Hiremath (2024), who discovered that undeveloped states fail to expand healthcare accessible despite higher budgets because of poor resource utilization.

The Need for Systemic Reform

Das and Guha (2023b) looked at the connection between infrastructure development and public health spending and discovered that higher spending by itself does not always translate into better healthcare results.

By recommending policy solutions that can close current gaps and build a more inclusive, effective, and fiscally sustainable healthcare system, this study seeks to add to the expanding conversation on healthcare reforms in India.

Literature Review

Important studies on healthcare inequities, hospital efficiency, financial strains, and public-private healthcare solutions in India are reviewed in this overview of the literature. It draws attention to geographical differences in public healthcare spending, systemic injustices, inefficiencies in private hospitals, and difficulties in financing healthcare for aging populations.

The first group of research works demonstrate the strong impact of demographic identity on healthcare access. For instance, Ahmed and Mahapatro (2023) prove that SC/ST women face a significantly higher rate of denial than upper-caste men, because of the demand-side factors such as stigma and lack of health-seeking behavior, though NSS data fails to capture this issue. Using the "health capability" concept, Chakraborty and Chakraborti (2015) claim that the socioeconomic position is still the key determinant of access in spite of the legislative

measures. Pro-rich healthcare inequity is confirmed by Akhtar and Chowdhury (2023) for preventive and curative care, and by Majumder et al. (2023) due to the fact that the better-developed states have better healthcare infrastructure and more healthcare personnel compared to rural and semi-urban regions in spite of the national programs such as Ayushman Bharat.

Analyzing the state-level healthcare budget for several decades, Das and Guha (2023a, 2023b) show

that greater expenses fail to result in greater outcomes and COVID-19 preparedness because of the poor management and misallocation of resources. The same results were obtained by Harikrishnan and Hiremath (2024) who applied the convergence modeling and found that the fiscal transfer helps little and poorer states remain grouped after wealthier ones. There is a positive correlation between the public spending and reproductive healthcare utilization, especially in rural areas, according to Das (2017).

Datta and Chaudhuri (2022) prove that private establishments provide 75% of outpatient services and 62% of inpatient care in the whole country due to poor regulation that allows price-setting based on profit and leads to the increased costs for lower-income patients. Using the Data Envelopment Analysis approach for 25 private hospitals, Chitnis and Mishra (2019) discovered inefficient use of capital that increases the patient cost. Yadav and Ray (2022) confirm that private institutions increase healthcare access but operate mainly in urban and richer regions that increases healthcare inequality. Such process belongs to the broader phenomenon of healthcare "financialization" across the globe when the corporate investments improve the healthcare infrastructure but put the patient welfare below the financial considerations, according to Hunter and Murray (2019). This phenomenon has its roots in the colonial and post-liberal history of India, according to Sodhi and Singh (2016), though Esposito et al. (2012) present the case evidence that "shared value" model micro-hospitals, mobile hospitals, and telemedicine help to provide the affordable private healthcare in underserved regions.

A number of studies describe the regressive impact of out-of-pocket expenditures. Hooda (2017) and Gaddam and Rao (2023) find that the rural households pay the greatest part of catastrophic expenses that are made via borrowing or selling assets. Thakur and Sangar (2020) confirm that the lower-income population spends more share of income on healthcare expenses due to insufficient insurance coverage. Garg et al. (2022a, 2022b, 2023) prove that even the institutional delivery and government insurance fail to prevent OOP payments especially concerning diagnostics, transportation, and medicine and that the pandemic decreased the non-COVID hospitalization of poorer families. Over 60% of breast cancer patients experience catastrophic expenditures in spite of the government assistance programs, according to Mohanty et al. (2024). At the same time, Rahman et al. (2022) and Feng et al. (2024) find that the OOP spending on chronic diseases (hypertension, NCDs) increases rapidly, with insurance increasing access and not adherence.

Kumar and Duggirala (2021) note the existence of inefficiencies in administrative processes and

ongoing gaps in insurance coverage in India. Bhatia et al. (2021) found that pro-poor maternal health policies have lowered maternal mortality in the country overall, though

underdeveloped areas are behind. Kazibwe et al. (2024), reviewing 45 works from LMIC countries, conclude that insurance reduces maternal morbidity via increased use of institutional deliveries and prenatal services but fails to address indirect costs. Gopalan et al. (2014) and Forbes (2012) converge on the conclusion that demand-side financing and microhealth insurance increase the accessibility to medical help in conjunction with solid institutional support, but there is a risk of exclusion of the most vulnerable people due to lack of knowledge and enrollment barriers.

We encounter the recurring theme of institutional deficiencies once again. Duran et al. (2015), in their study of AIIMS, conclude that even leading public institutions fall victim to political influence and administrative inefficiency. Vishnu et al. (2023) identify understaffing and administrative risks as major operational issues faced by South Indian public hospitals amid the pandemic. Nyland and Pettersen (2015) demonstrate that combination of market and bureaucracy in the form of hybrid controls allows increasing the effectiveness of resource utilization but may be detrimental to care quality when overused. Sutterer et al. (2022) suggest using optimization algorithms to allocate beds, while Kumar (2022) and Malik and Shankar (2023) reveal that organizational flexibility and nursing self-management improve the patient outcomes but face institutional resistance. Tiwari (2022) establishes a connection between human capital and financial performance in 84 healthcare firms, and Akintoye and Chinyio (2005) point out the risks of accountability associated with Private Finance Initiative funding for hospitals.

Panda and Mohapatra (2021) state that while digital healthcare solutions help to make healthcare more accessible, they raise concerns about misinformation and data privacy, which need regulation. Debata et al. (2013) and Gholipour and Esfandiar (2025) prove that medical tourism improves the state of healthcare infrastructure and stimulates investments, though an excessive focus on foreign patients crowds domestic access. Self and Basuoy (2017) and Malik et al. (2022) find that elderly patients choose costly private healthcare due to long queues in the public sector and that only a third of older adults get access to medical help, driven by financial and social exclusion. Surendran et al. (2024) reveal that even a solid public health system of Kerala has its access limitations including waiting time and administrative barriers. Sengupta et al. (2024) show that financial pressure and failure of communications lead to the conflicts between doctors and patients in private clinics, while Doyle et al. (2019) stress the necessity

of outcome-based evidence-based price-setting to ensure affordability without compromising innovation in expensive disciplines such as oncology. Ghia and Rambhad (2023) and Rautela et al. (2024) both argue for an integrated public-private approach, pointing out that partial reforms will not be able to tackle systemic fragmentation.

Methodology

This study examines healthcare disparities in India using a methodical and organized methodology. Data extraction, comparative analysis, topic classification, literature search and selection, and synthesis of findings are the five essential stages of the technique.

Literature Search and Selection Process

The research process commenced with an extensive literature search across peer-reviewed journals, government reports, policy documents, and global health databases such as PubMed, Scopus, JSTOR, Springer, and Wiley. Additionally, reports from organizations like the World Health Organization (WHO), the Ministry of Health and Family Welfare (MoHFW), NITI Aayog, and the National Sample Survey Office (NSSO) were incorporated to supplement the academic literature with policy-driven insights.

Boolean search queries, incorporating keywords such as "healthcare disparities in India," "financial burden of healthcare," "public vs. private healthcare in India," "health insurance effectiveness," "maternal healthcare inequality," and "regional disparities in healthcare access."

A multi-step filtering procedure was followed which included an initial screening of several hundred studies was chosen for consideration based on their applicability to India's healthcare disparities. Studies that employed out-of-date datasets, lacked empirical rigor, or concentrated on unrelated healthcare contexts were filtered out of the abstracts and conclusions. A final set of fifty high-impact publications were shortlisted.

The chosen studies include both qualitative and quantitative research, and they range from case studies and policy evaluations to statistical analyses of healthcare spending and a certain conceptual and literature-based analyses were included.

Thematic Categorization and Data Extraction

The literature was divided into seven major thematic areas to aid in an organized analysis:

The Burden of Healthcare Inequality in India; Regional and Demographic Disparities in Healthcare Utilization; Impact of Income Elasticity on Healthcare Demand; The Private Sector and the Increasing Cost of Healthcare; Health Insurance and Policy Interventions; Fiscal Transfers and Healthcare Infrastructure; The Need for Systemic Reform.

The research methodology, dataset reliability,

geographic focus, and policy implications of each study were carefully examined. In order to find recurring themes, discrepancies, and new trends among the research, the retrieved data was then methodically compared.

Comparative Analysis and Synthesis of Findings

Each study was assessed for methodology, dataset reliability, geographic focus, and policy implications, then cross-compared to identify recurring themes, discrepancies, and emerging trends, covering trends in affordability and accessibility across income brackets, the effect of financial constraints on utilization, the efficacy of government interventions, and the role of fiscal and governance policy in service delivery.

Ensuring Objectivity and Reliability

Reliability was supported through four measures: prioritizing peer-reviewed research supplemented by conceptual analysis for theoretical grounding; balancing domestic and international studies while keeping India as the analytical focus; combining multiple data

sources (NSSO, NFHS, policy papers) for a fuller picture; and prioritizing studies published within the last two decades to ensure relevance to current healthcare dynamics. This approach provides a varied, interdisciplinary view of the systemic issues shaping healthcare access and affordability in India, and forms the basis for the strategic interventions and policy recommendations that follow.

Result And Analysis

A comprehensive comprehension of healthcare disparities in India has been made possible by the examination of fifty carefully chosen research papers. Disparities in healthcare access, the influence of financial protection plans, the involvement of economic variables, and inefficiencies in the public and private healthcare sectors are all reflected in the findings, which are grouped into major subject areas. These findings demonstrate the need for focused policy reforms as well as the ongoing gaps in healthcare delivery.

Healthcare Disparities and Socioeconomic Barriers

Caste, gender, location, and poverty are defining factors in determining who obtains quality care. Women from Scheduled Caste (SC) and Scheduled Tribe (ST) communities are 1.37 times more likely than upper-caste men to be denied healthcare treatment (Ahmed and Mahapatro, 2023) while rural communities still face challenges related to a lack of educated medical personnel, a lack of access to specialized care, and an inadequate healthcare infrastructure.

Regional and Demographic Variations in Healthcare Utilization

Some states receive disproportionately larger financial allocations for public healthcare, whereas others continue to receive inadequate financing while having higher illness loads, according to Das and Guha (2023a). Access to decent healthcare is now heavily influenced by one's state of residency due to the glaring disparities in healthcare infrastructure and service delivery that have resulted from this.

According to studies by Yadav and Jena (2022), impoverished women in rural regions use maternal health services much less frequently than those in wealthy metropolitan areas. It was discovered that media exposure and education were essential in raising women's knowledge of and use of healthcare services.

Economic Constraints and Financial Burden

According to Hooda (2017) and Gaddam and Rao (2023), millions of people are still forced into poverty by out-of-pocket (OOP) medical costs. Compared to wealthier households, lower-income households spend a disproportionately larger percentage of their wages on medical expenses, according to Dubey (2024). This implies that even small medical expenses can have a significant financial impact on those in lower socioeconomic groups, perpetuating cycles of illness and poverty.

The Private Sector and Rising Healthcare Costs

Datta and Chaudhuri (2020) discovered that private healthcare facilities, many of which function without strict regulatory monitoring, offer 75% of outpatient care and 62% of inpatient treatment in India. Chitnis and Mishra (2019) performance efficiency evaluations showed that private hospitals frequently underutilize or misallocate their resources, resulting in major inefficiencies. Financial pressures are exacerbated by this inefficiency, which raises patient costs.

Effectiveness of Health Insurance and Public Health Schemes

According to Kumar and Duggirala (2021), even though millions of people now have health insurance, many insured people still have to pay a large amount out of pocket because of coverage gaps, a lack of network hospitals, and complicated procedures. Bhatia et al. (2021), highlights that the health programs won't be able to completely close the gaps in healthcare access until structural inefficiencies in policy implementation are addressed.

Public Health Expenditure and Fiscal Policy Challenges

According to Harikrishnan and Hiremath (2024), healthcare service delivery is still uneven among areas despite higher government spending. Disparities in state-level healthcare administration and governance inefficiencies are primarily to blame for this. Financial investments by themselves are

insufficient unless they are supported by robust institutional systems that guarantee efficient use of resources.

The Need for Systemic Reform

The combined findings of these studies demonstrate how despite efforts to increase access to healthcare through government programs and legislative changes, there are still significant gaps in their implementation and outcomes. Nyland and Pettersen (2015) argue that increased public investment, better governance, and increased regulation of private healthcare providers are all required. This study demonstrates that regional variations, financial constraints, and social disparities still have a major influence on healthcare accessibility in India. Despite progress, the effectiveness of public health initiatives and financial protection programs is constrained by implementation gaps and governance inefficiencies. In order to eliminate existing healthcare gaps, the findings emphasize the need for a thorough, well-regulated approach that strengthens public healthcare infrastructure, increases financial accessibility, and promotes technological advancements.

Discussion

The findings reaffirm that healthcare access is highly unequal, determined by socioeconomic position, regional variances, and the expanding commercialization of medical services. The healthcare system is still mostly reactive rather than preventive and systemic constraints still limit fair service delivery despite policy initiatives to increase healthcare coverage.

Marginalized communities, particularly Scheduled Caste and Scheduled Tribe populations, continue to experience significant healthcare access gaps, as shown by Ahmed and Mahapatro (2023). According to Das and Guha (2023a) analysis, public healthcare spending is still uneven among states, which results in differences in healthcare infrastructure and service accessibility. These results imply that without deliberate resource allocation and governance improvements, raising healthcare spending by itself does not guarantee better health outcomes.

Healthcare costs sometimes put rural people in financial hardship, especially in areas with insufficient public healthcare services, as noted by Hooda (2017) and Gaddam and Rao (2023). Despite the fact that government health insurance programs are designed to offer financial security, Kumar and Duggirala (2021) discovered that a large number of beneficiaries still have to pay substantial medical costs because of inadequate coverage and ineffective program execution. This calls into question the actual efficacy of health insurance programs, which frequently pay for hospital stays but overlook charges for diagnostics, follow-up care, and prescription drugs, which account for a sizable

amount of a patient's overall spending.

As demonstrated by Datta and Chaudhuri (2020), both in-patient and out-patient care and frequently put profit ahead of affordability. Inefficiencies in private hospitals, when resource misallocation results in exorbitant patient expenditures, were also noted by Chitnis and Mishra (2019). These results demonstrate how urgently patient-centered regulations and transparent pricing systems are needed to guarantee that the private sector functions more fairly and public-private partnerships (PPPs) should also be used for cost regulation in addition to infrastructure expansion.

Telemedicine and AI-assisted diagnostics are two examples of digital health initiatives that have been acknowledged as instruments to close healthcare gaps (Harikrishnan and Hiremath, 2024). However, in order to ensure equal implementation, their success hinges on sufficient government investment and infrastructure development.

Despite offering a thorough analysis of healthcare inequities in India, this study has some limitations that should be noted. The results are based on secondary research. Furthermore, additional primary research using field surveys, patient interviews, and case studies could offer deeper insights into lived experiences of healthcare access and financial constraints, even if the evaluated studies provide insightful information about healthcare challenges at the national level. This discussion emphasizes how urgently systemic changes are required to improve the sustainability and accessibility of healthcare in India. A change from a curative to a preventative healthcare approach might greatly lower long-term healthcare costs and ease systemic burden.

Conclusion

Despite its size and diversity, India's healthcare system continues to face enduring issues that prevent many people, particularly those from disadvantaged and vulnerable backgrounds, from receiving high-quality care. Existing disparities in healthcare delivery are made worse by disparities associated with socioeconomic characteristics such as caste, gender, and poverty. Even though the nation has achieved significant progress in increasing access, rural and lower-income households still face significant financial hardships due to the unequal distribution of resources and the predominance of out-of-pocket expenses.

This study brings into sharp focus a call for a more integrated and efficient healthcare system that combines some of the best aspects of the public and private sectors. One that integrates policy-driven fiscal planning, efficient healthcare governance, and innovative technology adoption to create a sustainable and inclusive system. Strengthening public healthcare infrastructure, regulating private sector costs, and enhancing the reach of financial

protection mechanisms can collectively reduce inequalities.

India must make investments in the creation of fundamental healthcare infrastructure, bolster its human capital, and establish rules for accountability, openness, and sustainability in order to do this. Targeted interventions in underprivileged areas and fair resource distribution are necessary to overcome regional healthcare disparities. Service delivery can be enhanced by bolstering primary healthcare, making sure that rural areas have enough medical workers, and encouraging public-private partnerships. Digital health solutions like telemedicine and AI-assisted diagnostics offer a chance to improve accessibility and close gaps between urban and rural areas.

Systemic changes are required to address the pressing need to reduce inequalities in India's healthcare system. The study's conclusions and recommendations will significantly advance the current debate and further investigation into how to make healthcare more inexpensive and accessible while offering the best possible treatment to those who need it most. Policymakers, medical professionals, and civil society must all continue to be committed to ensuring universal and inclusive healthcare in India.

Limitations

Reliance on Secondary Data: The study mostly draws from published works and reports, which might not adequately reflect current legislative modifications or new developments in the medical field. Deeper understanding of patient experiences and systemic inefficiencies may be possible with primary data gathering methods like field surveys and interviews.

Regional Generalizability: Despite discussing regional discrepancies, the study did not perform a thorough examination at the state or district level. More detailed studies could more accurately pinpoint regional healthcare issues and the efficacy of policies.

Limited Analysis of Private Sector Dynamics: Although the function of private healthcare is mentioned, a more thorough analysis of pricing schemes, regulatory inefficiencies, and private sector governance will yield a more thorough knowledge of its effects.

Exclusion of Certain Social Determinants: Although the study concentrates on infrastructure and economic obstacles, it skips over aspects that could affect healthcare outcomes and access, such as gender bias, cultural attitudes, and environmental determinants.

Technology and Digital Divide: Although the study emphasizes AI-driven solutions and telemedicine, it falls short in examining digital literacy, data

protection issues, and regional differences in technology uptake that could impede successful deployment.

Longitudinal Impact of Policies: Because of data limitations, the study does not evaluate the long-term efficacy of healthcare policy. Future research should monitor the effects of policies throughout time to determine their efficacy and sustainability.

Future Scope

Primary Data Collection for Deeper Insights: To supplement secondary data analysis, future research should include field surveys, patient interviews, and case studies to gather personal experiences, particularly in underprivileged populations.

State-Specific and Micro-Level Analysis: Policies can be better tailored for greater impact by taking a more detailed approach that concentrates on district-level healthcare infrastructure, governance effectiveness, and region-specific issues.

Evaluation of Long-Term Policy Outcomes: To gauge the practical efficacy of healthcare policies, such as public insurance plans, financial assistance initiatives, and regulatory frameworks, longitudinal studies evaluating their long-term effects are required.

Integration of Private Sector Reforms: Future studies should look at strategies to improve the private healthcare sector's affordability, accountability, and transparency. Public-private partnership options for cost-effective healthcare delivery should also be considered.

Expanding Digital Healthcare Research: In order to ensure fair healthcare delivery in both rural and urban settings, future research should examine the accessibility, implementation obstacles, and regulatory frameworks of digital technologies like telemedicine and AI-based diagnostics.

Addressing Broader Social Determinants of Health: To provide a more comprehensive approach to policy formation, future research should incorporate gender-related, cultural, and environmental elements that affect healthcare outcomes and access.

Alternative Healthcare Finance Models: Examining sustainable funding options, such as community-based health insurance and creative public funding schemes, can help lessen the financial strain on disadvantaged groups.

Strengthening Preventive Healthcare Measures: Early detection programs, community-based healthcare initiatives, and awareness campaigns should be the main focus of future research that evaluates the efficacy and viability of switching from a curative to a preventive healthcare approach.

References

1. Ahmed, S., & Mahapatro, S. (2023). Inequality in Healthcare Access at the Intersection of Caste and Gender. *Contemporary Voice of Dalit*, 15(1_suppl), S75-S85. <https://doi.org/10.1177/2455328X221142692>
2. Chitnis, A., & Mishra, D. K. (2019). Performance Efficiency of Indian Private Hospitals Using Data Envelopment Analysis and Super-efficiency DEA. *Journal of Health Management*, 21(2), 279-293. <https://doi.org/10.1177/0972063419835120>
3. Sahoo, P. M., Rout, H. S., & Jakovljevic, M. (2023). Consequences of India's population aging to its healthcare financing and provision. *Journal of Medical Economics*, 26(1), 308-315. <https://doi.org/10.1080/13696998.2023.2178164>
4. Das, T., & Guha, P. (2023a). Pattern of Public Healthcare Expenditure and Preparedness for COVID-19 in India: An Interstate Analysis. *Journal of Health Management*, 25(4), 903-917. <https://doi.org/10.1177/09720634231215390>
5. Datta, P., & Chaudhuri, C. (2022). Is Profit Motive Infecting Indian Private Health Care Sector? *Journal of Health Management*, 24(2), 222-232. <https://doi.org/10.1177/09720634221088064>
6. Doyle, J. J., Hawryluk, E., Niemira, J., & Wood, B. (2019). Evidence-Based Valuation in Oncology: Lessons Learned from a Case Study. *Therapeutic Innovation & Regulatory Science*, 53(3), 403-411.
7. Dubey, J. D. (2024). Income Elasticity of Demand for Healthcare and Change Over Time: Across the Income Groups in India. *Journal of Health Management*. <https://doi.org/10.1177/09720634241263392>
8. Debata, B. R., Sree, K., Patnaik, B., & Mahapatra, S. S. (2013). Benchmarking healthcare tourism enablers in India using ISM. *Benchmarking: An International Journal*, 20(6), 716-743. <https://doi.org/10.1108/BIJ-10-2011-0079>
9. Self, S., & Basuroy, S. (2017). Factors influencing healthcare choices by the elderly in India: role of social interactions. *International Journal of Social Economics*, 44(9), 1231-1251. <https://doi.org/10.1108/IJSE-12-2015->

- 0340
10. Gaddam, R., & Rao, K. R. (2023). Incidence, Inequality and Determinants of Catastrophic Health Expenditure in India. *Journal of Health Management*, 25(1), 30–39. <https://doi.org/10.1177/09720634231153226>
 11. Gopalan, S. S., Das, A., & Mutasa, R. (2014). What makes Health Demand-Side Financing Schemes Work in Low- and Middle-Income Countries? A Realist Review. *Journal of Public Health Research*, 3(3), 304. <https://doi.org/10.4081/jphr.2014.304>
 12. Sodhi, C., & Singh, P. (2016). Health service system in transition: influence of British and US healthcare systems on India. *International Journal of Health Governance*, 21(4), 204–221. <https://doi.org/10.1108/IJHG-03-2016-0020>
 13. Forbes, D. J. (2012). Healthcare provision in rural India: does micro health insurance help or hinder? *International Journal of Health Care Quality Assurance*, 25(3), 216–225. <https://doi.org/10.1108/09526861211210439>
 14. Esposito, M., Kapoor, A., & Goyal, S. (2012). Enabling healthcare services for rural and semi-urban segments in India. *Corporate Governance*, 12. <https://doi.org/10.1108/14720701211267847>
 15. Hooda, S. K. (2017). Out-of-pocket Payments for Healthcare in India: Who Have Affected the Most and Why? *Journal of Health Management*, 19(1), 1–15.
 16. Ghia, C., & Rambhad, G. (2023). Implementation of equity and access in Indian healthcare: current scenario and way forward. *Journal of Market Access & Health Policy*, 11(1). <https://doi.org/10.1080/20016689.2023.2194507>
 17. Chakraborty, R., & Chakraborti, C. (2015). India, Health Inequities, and a Fair Healthcare Provision: A Perspective from Health Capability. *Journal of Human Development and Capabilities*, 16(4), 567–580. <https://doi.org/10.1080/19452829.2015.1105201>
 18. Rautela, S., Panackal, N., & Sharma, A. (2024). Integrated healthcare system in India: a conceptual framework. *Journal of Integrated Care*, 32(3), 285–302. <https://doi.org/10.1108/JICA-01-2024-0002>
 19. Yadav, A. K., & Jena, P. K. (2022). Explaining changing patterns and inequalities in maternal healthcare services utilization in India. *Journal of Public Affairs*, 22, e2570. <https://doi.org/10.1002/pa.2570>
 20. Kumar, R., & Duggirala, A. (2021). Health Insurance as a Healthcare Financing Mechanism in India. *Vikalpa*, 46(2), 112–128. <https://doi.org/10.1177/02560909211027089>
 21. Tiwari, R. (2022). Nexus between intellectual capital and profitability with interaction effects: Indian healthcare industry. *Journal of Intellectual Capital*, 23(3), 588–616. <https://doi.org/10.1108/JIC-05-2020-0137>
 22. Panda, A., & Mohapatra, S. (2021). Online Healthcare Practices and Associated Stakeholders. *Vikalpa*, 46(2), 71–85. <https://doi.org/10.1177/02560909211025361>
 23. Akintoye, A., & Chinyio, E. (2005). Private Finance Initiative in the healthcare sector: trends and risk assessment. *Engineering, Construction and Architectural Management*, 12(6), 601–616. <https://doi.org/10.1108/09699980510634155>
 24. Gholipour, H. F., & Esfandiar, K. (2025). Does medical tourism promote growth in healthcare sector? *European Journal of Health Economics*, 26, 233–241. <https://doi.org/10.1007/s10198-024-01700-3>
 25. Vishnu, C. R., Anilkumar, E. N., Sridharan, R., et al. (2023). Statistical characterization of managerial risk factors: state-run hospitals in India. *OPSEARCH*, 60, 812–834. <https://doi.org/10.1007/s12597-023-00633-4>
 26. Bhatia, M., Dwivedi, L. K., Banerjee, K., et al. (2021). Pro-poor policies and improvements in maternal health outcomes in India. *BMC Pregnancy and Childbirth*, 21, 389. <https://doi.org/10.1186/s12884-021-03839-w>
 27. Rahman, T., Gasbarro, D., & Alam, K. (2022). Financial risk protection against noncommunicable diseases: trends in Bangladesh. *BMC Public Health*, 22, 1835. <https://doi.org/10.1186/s12889-022-14243-0>

28. Manna, S., Singh, D., Ghosal, S., et al. (2023). Out-of-pocket expenditure for institutional deliveries in India: findings from NFHS-5. *BMC Public Health*, 23, 1474. <https://doi.org/10.1186/s12889-023-16352-w>
29. Feng, Z., Chen, Q., Jiao, L., et al. (2024). The impact of health insurance on hypertension care in India. *BMC Public Health*, 24, 2287. <https://doi.org/10.1186/s12889-024-19759-1>
30. Malik, E., & Shankar, S. (2023). Empowering nurses: self-managed organizations in Indian healthcare. *BMC Nursing*, 22, 477. <https://doi.org/10.1186/s12912-023-01647-5>
31. Kazibwe, J., Tran, P. B., Kaiser, A. H., et al. (2024). The impact of health insurance on maternal and reproductive health service utilization in LMICs: a systematic review. *BMC Health Services Research*, 24, 432. <https://doi.org/10.1186/s12913-024-10815-5>
32. Surendran, S., Joseph, J., Sankar, H., et al. (2024). Exploring the road to public healthcare accessibility in Kerala, India. *International Journal for Equity in Health*, 23, 157. <https://doi.org/10.1186/s12939-024-02191-7>
33. Mohanty, S. K., Wadasadawala, T., Sen, S., et al. (2024). Catastrophic health expenditure and distress financing of breast cancer treatment in India. *International Journal for Equity in Health*, 23, 145. <https://doi.org/10.1186/s12939-024-02215-2>
34. Garg, S., Tripathi, N., & Bebarta, K. (2023). Does government health insurance protect households from OOP expenditure for institutional deliveries in India? *BMC Research Notes*, 16. <https://doi.org/10.1186/s13104-023-06335-w>
35. Garg, S., Tripathi, N., Ranjan, A., et al. (2022a). How much do government and households spend on hospitalisation in India? *Health Economics Review*, 12, 27. <https://doi.org/10.1186/s13561-022-00372-0>
36. Garg, S., Bebarta, K. K., & Tripathi, N. (2022b). Household expenditure on non-Covid hospitalisation during the pandemic in India. *Archives of Public Health*, 80, 108. <https://doi.org/10.1186/s13690-022-00857-8>
37. Sengupta, M., Ganguly, A., Roy, A., Chakrabarti, S., & Mukhopadhyay, I. (2024). Conflict Dynamics in Indian Healthcare: Primers of Conflict in Private Clinical Establishments of Kolkata. *Journal of Health Management*, 26(3), 460–471.
38. Thakur, R., & Sangar, S. (2020). Socioeconomic differentials in the burden of paying for healthcare in India. *Health Systems*, 11(1), 48–58. <https://doi.org/10.1080/20476965.2020.1848356>
39. Nyland, K., & Pettersen, I. (2015). Hybrid controls and accountabilities in public sector management: hospital sector case studies. *International Journal of Public Sector Management*, 28, 90–104. <https://doi.org/10.1108/IJPSM-07-2014-0085>
40. Sutterer, P., Kolisch, R., & Uzsoy, R. (2022). Valuation of hospital resources: an optimization approach using clearing functions. *IIE Transactions on Healthcare Systems Engineering*, 12(4), 245–262. <https://doi.org/10.1080/24725579.2022.2055236>
41. Yadav, P., & Ray, A. S. (2022). Private Sector Presence in Healthcare in India: Econometric Analysis. *South Asia Economic Journal*, 23(2), 171–200. <https://doi.org/10.1177/13915614221113406>
42. Malik, M. A., Singh, S. P., & Pattanaik, F. (2022). Economics of Healthy Aging in India: A Multidimensional Perspective. *IZA Journal of Labor Policy*, 12(4). <https://doi.org/10.2478/izajolp-2022-0004>
43. Akhtar, A., & Chowdhury, I. R. (2023). Socioeconomic inequity in healthcare utilization among individuals with cardiovascular diseases in India. *Health Economics*, 32(5), 1000–1018. <https://doi.org/10.1002/hec.4651>
44. Das, D. (2017). Public expenditure and healthcare utilization: reproductive health care in India. *International Journal of Health Economics and Management*, 17, 473–494. <https://doi.org/10.1007/s10754-017-9219-7>
45. Harikrishnan, K., & Hiremath, G. (2024). Inequality in Public Provision of Healthcare: Do Fiscal Transfers Matter? *Journal of Public Affairs*, 24, e2943. <https://doi.org/10.1002/pa.2943>
46. Kumar, P. (2022). Market-focused

- flexibility and innovative performance in public healthcare: Evidence from India. *Journal of Public Affairs*, 22(S1), e2809. <https://doi.org/10.1002/pa.2809>
47. Das, T., & Guha, P. (2023b). The puzzle of public health expenditure and healthcare infrastructure in India: An empirical investigation. *Regional Science Policy & Practice*, 1-37. <https://doi.org/10.1111/rsp3.12710>
48. Majumder, S., Roy, S., Bose, A., & Chowdhury, I. R. (2023). Understanding regional disparities in healthcare quality and accessibility in West Bengal, India. *Regional Science Policy & Practice*, 15(5), 1086-1113. <https://doi.org/10.1111/rsp3.12607>
49. Hunter, B., & Murray, S. F. (2019). Deconstructing the financialization of healthcare. *Development and Change*, 50(5), 1263-1287. <https://doi.org/10.1111/dech.12517>
50. Duran, A., et al. (2015). Public Hospital Governance in India. In D. Huntington & K. Hort (Eds.), *Public Hospital Governance in Asia and the Pacific* (pp. 222-255). World Health Organization. <http://www.jstor.org/stable/resrep28456>. 9