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GOVERNMENT STRATEGY IN TACKLING POOR ACCESS TO PUBLIC SERVICE IN INDIA

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Abstrak

Artikel ini membahas fasilitas kesehatan di pedesaan India. Permasalahan ini menarik untuk dikaji karena terdapat kesenjangan antara fasilitas kesehatan di kota dan desa, baik dari segi peralatan medis maupun sumber daya manusia yaitu tenaga kesehatan. Tujuan dari penelitian ini adalah untuk mengetahui kebijakan Pemerintah India mengenai pemerataan akses dan fasilitas kesehatan di pedesaan. Penelitian ini menggunakan analisis deskriptif kualitatif dan mengolah data melalui bibliografi VOSviewer untuk memberikan gambaran data grafis tentang bagaimana fasilitas kesehatan di pedesaan. Metode deskriptif kualitatif harus memperhatikan validasi data. Oleh karena itu, penelitian ini menggunakan triangulasi data. Temuan dari penelitian ini adalah bahwa menyediakan perawatan kesehatan yang efektif untuk penduduk pedesaan di seluruh negeri, yang telah berusaha untuk menutup kesenjangan antara fasilitas kesehatan di daerah perkotaan dan pedesaan. Misi Kesehatan Pedesaan Nasional (NRHM) telah melaksanakan reformasi struktural yang signifikan untuk sistem kesehatan pedesaan, termasuk peningkatan ketersediaan sumber daya manusia, administrasi program, infrastruktur fisik, keterlibatan masyarakat, pendanaan perawatan kesehatan, dan pemanfaatan teknologi informasi.

Kata kunci : Kebijakan, Fasilitas Kesehatan, Pemerintah

Abstract

This article examines health facilities in rural India. This problem is interesting to study because there is a gap between health facilities in cities and villages, both in terms of medical equipment and human resources, namely health workers. The purpose of this study was to determine the Indian Government's policies regarding equitable access and health facilities in rural areas. This study uses descriptive qualitative analysis and processes data through the VOSviewer bibliography to provide an overview of graphic data on how health facilities in rural areas are. The qualitative descriptive method must pay attention to data validation. Therefore, this study used data triangulation. The findings of this study are that providing effective health care to rural populations across the country, that have attempted to close the gap between health facilities in both urban and rural areas. The National Rural Health Mission (NRHM) has implemented significant structural reforms to the rural health system, including enhancements to human resource availability, program administration, physical infrastructure, community engagement, health care funding, and information technology utilization.

Keywords: Policy, Health Facility, Government

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A. INTRODUCTION

India's healthcare system is in a crisis in its history. India's health system bears a considerable share of the world's health burden, accounting for 23% of all childhood deaths and 25% of all maternal fatalities (WHO 1999). Countries across the globe are continuously looking for methods to improve the efficiency of their respective healthcare systems. Effective and efficient use of allowed resources is a critical performance component that must be considered. Recently, the quality of governance inside the healthcare system has emerged as a critical criterion for assessing the system's overall health. The World Health Organization describes healthcare governance as a broad spectrum of strategic and regulatory responsibilities necessary for achieving Universal Health Coverage.

Report on the Health Survey and Development Committee (1946), popularly known as the Bhore Committee Report, served as an important foundation for India's present health policies and systems, which were based on the recommendations of the committee (Revised Guidelines New Delhi Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of India 2012., n.d.). A three-tiered healthcare system to offer preventative and curative health care in rural and urban regions while lessening the reliance on private practitioners laid the groundwork for today's public healthcare systems, which are still in use today. All of this was done to guarantee that primary care was accessible to everyone, regardless of their socio-economic condition. As a result of public health systems' failure to offer access to high-quality care, private healthcare systems have developed at the same time, with their proportion of the market increasing steadily and gradually over time. As a result of the incapacity of public health systems to offer access to high-quality treatment, private healthcare systems have developed at the same time, with the continuous and gradual growth of private healthcare services over the last several decades (Nair et al., 2022).

India launched its first national population program in 1951; nevertheless, it took until 1983 for the country to adopt its first National Health Policy (NHP), to provide primary health care to all Indians by the year 2000. The United Nations Development Programme set a high bar for itself by establishing a network of basic health care facilities that relied on healthy volunteers and simple technology, as well as a functioning referral system and an integrated network of expert institutions. The National Health Program (NHP) 2002 expanded on the NHP 1983 by decentralizing health services, using the private sector, and increasing total public spending on health care. Additionally, the study stressed the importance of boosting the use of non-allopathic medicines such as Ayurveda, Unani, and Siddha, as well as the importance of developing decentralized state decision-making mechanisms (Bowser et al., 2019).

Due to India's federalized government structure, the union and state governments are responsible for the administration and operation of the country's health system. The Union Ministry of Health and Family Welfare is responsible for implementing a range of national programs in the areas of health and family welfare, the prevention and control of major communicable diseases, the promotion of traditional and indigenous systems of medicine, and the establishment of standards and guidelines to guide state governments' decision-making. Additionally, the Ministry provides technical assistance to states in a variety of ways, including assisting them in avoiding and managing the spread of seasonal disease outbreaks and epidemics. While the state controls public health, hospitals, sanitation, and other components of public health, health is considered a state concern. In comparison, areas with broader national implications, such as family welfare and population control, medical education, food adulteration prevention, and pharmaceutical manufacturing quality control, are co-managed by the federal and state governments. (2008) (Mai & Sood).

To provide enough access and amenities, the government must develop a plan to meet the objectives. Specifically, education and public policy. Around the world, public health education and practice have grown into a transdisciplinary academic subject. describe transdisciplinarity in public health as "the integration of two or more disciplines, the development of fundamentally new conceptual frameworks, perspectives, and methodologies, and the synthesis of different approaches to solving public health concerns in real-world settings". A

transdisciplinary approach to elucidating the challenges and solutions associated with the growing complexity of global public health issues is necessitated by the interconnections between population health, the environment, globalization, and climate change, as well as political–demographic–socioeconomic–cultural dimensions. Worldwide, public health education and training are being recast as coordinated, university-affiliated transdisciplinary programs focused on methodically fostering the talents and abilities of a diverse pool of academic graduates from a diverse range of nations. National regulatory bodies for public health education in the United States of America, the United Kingdom, the European Union, Australia, and New Zealand, as well as Southeast Asia, Singapore, and China have accredited public health programs and institutions, ensuring that they meet minimum quality standards for program inputs, processes, outcomes, and performance against evidence-based standards and practices specific to the countries (Ilangovan et al., 2022).

Since the dawn of recorded history, pandemics and civilizations have marched in lockstep with one another. It has already dealt with several endemic and pandemic diseases, including measles, cholera, dengue fever, and smallpox, in addition to the present COVID-19 outbreak, among others. Numerous epidemics have occurred, including the cholera pandemic (1817–1899), the polio epidemic (1970–1990), the smallpox epidemic (1974), the plague of northern India (2002), the dengue epidemic (2003), the SARS epidemic (2003), the meningococcal meningitis epidemic (2005), the Chikungunya outbreak (2006), and the Gujarat jaundice outbreak (2006). (2006). (2006). As a result, the Indian government has devised and implemented a variety of public health projects to address the population's health issues and challenges (1983, 2002, and 2017). Although the most current national health policy (NHP) 2017 aims to offer universal healthcare through a "Health in All" approach, COVID-19 has aggravated the issue, resulting in a huge number of infected persons succumbing to the disease. Due to this, the critical issue is whether India's National Health Program (NHP) has provided enough infrastructure to deal with the continuing pandemic. When measured in absolute terms, we can see that the country's national health spending has increased considerably over the last several decades. The country's percentage share of gross domestic product (percent GDP) is, on the other hand, stable at approximately 4 percent, significantly outpacing the growth trend in other globally prominent BRICS markets. National infrastructure has come a long way in terms of capacity expansion, especially given the rate at which it is now developing (Gauttam et al., 2021).

When it comes to public policy in India, public health has been given a major place. In a democratic society, health policies used to be essential in determining how health issues and concerns would be addressed. Indian health policy began immediately after independence and grew more thorough with the 1946 release of the Bhore Committee Report on behalf of the Indian government. The Bhore Committee proposed that a three-tiered strategy be implemented to offer preventative and curative healthcare in rural and urban regions. These proposals included the construction of a public healthcare system, the hiring of healthcare employees on the government payroll, and a focus on private practitioner utilization.

B. RESEARCH METHODS

Using a bibliometric evaluation of sustainability research, this study examines how government initiatives and inequitable distribution of health services in rural regions contribute to the problem of sustainability. According to current recommendations, a systematic review of the literature in the health sector should be conducted in three stages: planning the review, implementing the review, and reporting/disseminating the results. This technique was used for the sake of this study's analytical review. The bibliographic review technique is significant because it gives a classified perspective of the documents published in each study field, based on objective criteria for assessing and categorizing publications by keywords, and it is used to evaluate the quality of the documents produced. The use of software allows for the presentation of data graphically,

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for example, through the use of a category map.

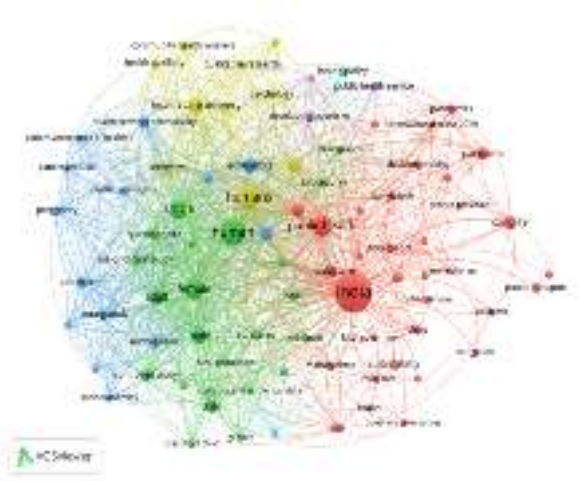

Figure 1. VOSviewer

In addition, the purpose of this study is to analyze how the Indian government's policies related to access and health facilities in rural areas. This study uses a qualitative method. This method focuses on understanding a phenomenon in-depth, is carried out in a naturalistic research environment, and generally provides a descriptive description of the behavior of the object under study. Researchers in parallel collect data with literature review techniques from various journals and articles and then perform analysis using the *VOSviewer* application to create a graphic description using certain keywords. By using the Vos Viewer application, it is hoped that you can get research updates so that you can conduct studies that have never been discussed and can provide useful input in science.

The data obtained and processed are then analyzed using qualitative analysis techniques, namely analyzing to obtain an overview and categories to be patterned. The patterns found are then interpreted according to the research analysis model. To process and analyze health services in a rural area in India using the VOSviewer application, data reduction, which aims to select and organize data into certain patterns, categories, and themes. The second is data display, which presents data in the form of sketches, synopsis, and matrices. Third, is the stage of conclusion.

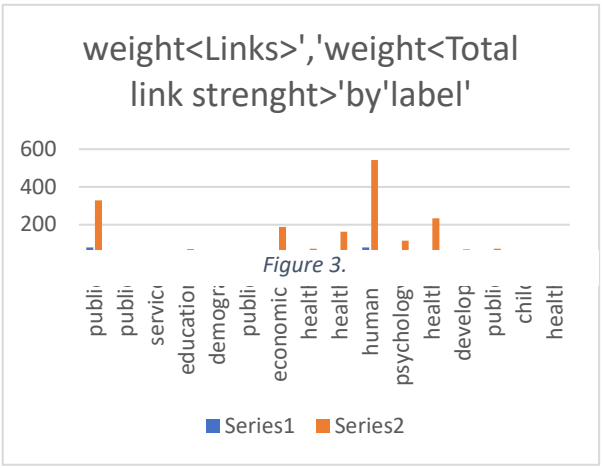

Figure 3.

The lines connecting the points shown on the map indicate the 'weight<Links>' and 'weight<Total link strength>' by label appear to form 6 cluster and the strength between these keywords gives a good idea of the strength of keywords relationships in health facilities research

Figure 2. VOSviewer

C. HASIL DAN PEMBAHASAN

India's healthcare system is a hybrid of public and private providers. However, the bulk of private healthcare providers, particularly those providing secondary and tertiary care, are concentrated in urban India. In rural regions, a three-tiered public health-care infrastructure has been developed based on demographic norms, as described below. The article on Urban Newborns examines the urban health system.

For India's health sector, the National Rural Health Mission (NRHM), which began operations in 2005, was a watershed point. Greater public expenditure on health care, lower inequalities, greater decentralization, and greater community participation in the operationalization of healthcare facilities based on IPHS (Indian criteria health system) are all intended outcomes of this initiative, with the primary goal of reducing maternal and child mortality. Also expressed the government aimed to expand health spending from 0.9 percent of GDP to 2-3 percent of GDP during the next five years. (Chokshi and colleagues, 2016).

In contrast, this point of view examines how the Indian government formulates policies connected to improving public health in rural regions, as well as initiatives to increase both the availability of healthcare facilities and the availability of healthcare specialists, based on

analysis of big data. These initiatives are extremely essential in promoting the development of the overall quality of public health in rural regions, and they should not be overlooked. The general health of rural populations will therefore improve over time as a result of numerous assistance from both infrastructure and human resources, such as medical personnel and nurses.

Analyze how access and quality of health facilities in rural India are based on data obtained from Scopus. Using the related keywords “Public Services” and “Health Access” and generating 6 clusters (each color represents one cluster) with several terms such as 'humans', 'public health', 'health care delivery', 'economics', based on the data from Scopus. Figure 1. Shows a network of keywords based on an analysis of 56 articles related to research on public services.

The analysis was conducted on 56 articles based on the most frequently occurring keywords used as part of the sample. Based on the analysis of the articles, the most prominent areas are the topics that are analyzed more. The results of the VOSviewer image group keywords into 5 groups. The details of each group are India (red cluster), human (green cluster), economy (blue cluster), health policy (light blue cluster), public health services (purple cluster), and Health care system (yellow cluster).

Table 1. VOSviewer Cluster

Cluster	Item	Total
1	Public health Public service service quality, etc	34 (39,53%)
2	Education Demography Public policy, etc	22 (25,58%)
3	Economics Health care cost Health service, etc	14 (16,28%)
4	Humans Health care delivery Psychology, etc	11 (12,79%)
5	Developing countries Public health service	3 (3,49%)
6	Child health care Health policy	2 (2,33%)

Table 1. shows the percentage level of each cluster which represents the link strength of each cluster. cluster 1 is the highest, reaching 39.5% with 34 keyword items including "Public health", "Public service", "service Quality" and others. the second cluster reached 25.8% with 22 keyword items including "education", "Demography", "Public Policy" and others. cluster 3 reached 16.28% with 14 keyword items including "Economics", "Health care cost", "Health service" and others. cluster 4 reached 12.79% with 11 keyword items including "Humans", "Health care delivery", "psychology" and others. cluster 5 reached 3.49% with 3 keyword items including "Developing countries", "Public health service", and others. cluster 6 reached 2.33% with 2 keyword items including "Child health care", and "Health” policy.

Table 1. shows that some clusters are grouped into 6 clusters. This analysis for keyword clusters observed through VOSviewer shows an increase, year on year, in studies linking sustainability to Healthcare

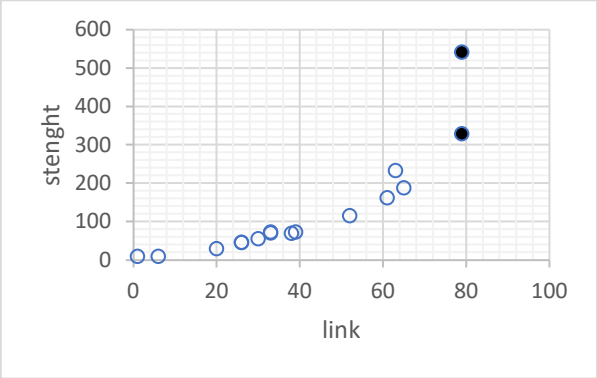

Figure 4.

facility variables in India, such as Health Services, Medical Devices, and equity in Healthcare facilities. Picture 3. shows that some clusters are grouped into 6 clusters. The analysis for keyword clusters observed through VOSviewer shows an increase, year on year, in research linking sustainability related to health facilities in India through various policies made by the government, with various strategies including increasing the availability of human resources, program administration, physical infrastructure, community involvement, health care funding, and utilization of information technology.

The Strenght Of Public Health In Rural Areas

To determine national goals and priorities for development investments, India employs a 5-year planning process. Priorities for family planning, 19 centrally sponsored disease control programs, and the expansion of primary care services to rural areas under the minimum needs program were articulated

and implemented across the country through this process. Despite rhetoric about integrating programs and strengthening local decision-making, the plans' funding system has reinforced a series of parallel disease control programs and a separation of health and family welfare programs. It has also institutionalized a centrally-based rigid approach to personnel and health-care facility planning based on population norms with little regard for workload, the presence of the private sector, or local epidemiological considerations.

The National Rural Health Mission's (NRHM) objectives from 2005 to 2012 included providing effective health care to rural populations across the country, with a particular emphasis on 18 states with deficient public health indicators or infrastructure, and increasing rural people's access to equitable and affordable primary health care that is accountable and effective. Additionally, the aim includes enhancing disadvantaged women's and children's access to equitable, cheap, accountable, and effective primary health care. The mission categorizes states and districts as high- or low-focus on infant and maternal mortality rates, with high-focus

states receiving more financial and technical support than low-focus states. It has evolved gradually but steadily into a substantial financial and health-sector reform strategy aimed at supporting state-run healthcare institutions. It is critical to recognize how the health transition has become a driving force for policy and program changes in the health sector. A demographic transition (shift from high mortality and fertility to low mortality and fertility), an epidemiological transition (shift in the dominant pattern of disease from malnutrition and communicable diseases of childhood to chronic diseases of adulthood), a social transition (shift from low to high knowledge and expectations of the health system), and technological development of diagnostic and therapeutic modalities are all part of the health transition. The profound effects are demonstrated by increasing life expectancy from 49 years in 1970 to 63 years in 1998, and halving infant mortality from the 1950s to 1990, though rates now appear to be stagnant.

The National Rural Health Mission (NRHM) has implemented significant structural reforms to the rural health system, including enhancements to human resource availability, program administration, physical infrastructure, community engagement, health care funding, and information technology utilization (Haider et al., 2021). The aim included a goal of expanding the number of healthcare delivery venues and the facilities provided at those locations. Auxiliary Nurse Midwife (ANM) education was likewise a high priority, as was expanding the capacity of medical schools at the graduate and postgraduate levels. There has been a rise in the number of health centers, newborn care units, and renovated existing facilities, allowing health services to provide for an increased number of women and children. Special efforts have been made to encourage

community engagement, including the development of village health committees and patient welfare committees at public health-care institutions. It was feasible to track the delivery of assistance to the mother and newborn using information technology. All of this has been made feasible by greater federal financial assistance and increased utilization rates. Between 2005 and 2013, the federal government invested more than 17 billion dollars (Panda et al., 2020).

D. CONCLUSION

Indian policymakers are now confronted with a slew of new challenges. Our analysis shows that some commonality in approaches to addressing them is required. Most importantly, there is a need to make the health system more pro-poor and client-friendly, as well as to take better advantage of the private sector while combating the private market's failures. Improving healthcare quality and accountability are also important strategic themes, as are approaches that empower ordinary citizens to manage their health conditions and be better consumers of healthcare services. These common themes lend support to the notion that better centralization of health policy and strategy is required.

The central government's command and control role is changing, and the Union Ministry of Health and Family Welfare must adopt new roles to meet these changes. It must provide leadership in critical areas of national health system oversight, particularly in identifying priorities. A key goal for India is to provide complete health facilities that are equal and there isn't a gap within the city. With National Rural Health Mission's (NRHM)

objectives from 2005 to 2012 included providing effective health care to rural populations across the country, It has created policies that allow for the development and implementation of comprehensive to increase the facilities of health care programs in the rural area. The pace at which the targets have been met thus far and are projected to be met in the future, however, necessitates a greater emphasis on framing Health Systems of policies in terms of increasing the capacity of existing human resources, increasing the allocation of funds, and identifying areas through operational research that can improve the quantity and quality of health in India, particularly in rural areas. These policies must be operationalized and implemented immediately.

In this paper, we also argue for more separation of health policy approaches in India, which is a significant departure from the past. More explicit and comprehensive state health policies and strategies are required now more than ever. States in the early stages of the health transition must devote more attention and resources to addressing the health transition's unfinished business. Much of this would require strengthened public-sector programs, as well as increased collaboration with the private sector on these issues.

In India, the groundwork has been laid for healthcare reform. The context and processes used for health policy point to new roles and issues for central, state, and local governments to address. Citizens should play a larger role, and there should be more innovation in dealing with the private sector. Reform strategy at the state and federal levels is now required, as is the implementation of ideas to reform the health care system. If India's economy continues to grow at its current rate, if the country's numerous healthcare systems can learn from one another, and if equity is pursued with greater zeal, India will have enormous opportunities to improve the health of all segments of its society.

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