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Sustainable Development of Healthcare System in Nepal through Social Determinants of Health

Kabita Khatiwada, PhD Scholar
Faculty of Humanities and Social Sciences, Pokhara University, Nepal

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Corresponding Author:
Kabita Khatiwada
kabitakhatiwada664@gmail.com

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ABSTRACT

The rural populations of Nepal face geographic and economic barriers while marginalized groups encounter discrimination in healthcare. The objective of this study was to survey the healthcare associated individuals to understand the factors affecting access and development of healthcare facilities. A cross-sectional survey was conducted with the healthcare receivers and providers using a questionnaire. This study surveyed 291 individuals, including 200 patients and 91 healthcare providers. Among them, 66.5% of providers worked in private hospitals, 53% of respondents were female, and 58% of patients were from urban areas, with significantly higher private hospital utilization. Financial constraints were the primary patient barrier (48.5%), followed by lack of information (28.5%). No significant differences were found between hospitals regarding these barriers. However, female patients reported significantly higher financial constraints. In total, 44.5% of patients used government insurance, 28% private, 27% out-of-pocket, and 55.5% reported good health status. Patients perceived significantly better quality of care in private hospitals and higher rates of misbehavior from providers in government hospitals. In conclusion, the survey revealed significant disparities in healthcare access in Nepal, with financial constraints and information gaps posing major barriers, especially for women. Urban patients perceived better care in private hospitals, while reporting more misbehavior in government facilities. Therefore, addressing financial constraints through targeted findings and improving information spreading, particularly for rural populations and women, are critical steps toward equitable healthcare access.

KEYWORDS: Healthcare system, financial constraints, hospitals, marginalized groups

INTRODUCTION

Healthcare is a basic human right, yet accessing quality medical care often depends on social and economic privileges around the world (Tengiz, 2021). In Nepal's case too, due to poverty and diversity of ethnicity, accessing equitable healthcare facilities is still a major problem (Kabeer, 2014). The major challenges are caste-based discrimination, division of ethnicity, gender biases, and sociodemographic structures, which are not new in the context of Nepal. Similarly, the status that holds an individual in society is very critical for health assessment (Jones et al., 2017). It has been seen that lower socioeconomic status can lead to several barriers in accessing health resources such as financial constraints, transportation, delay, insurance, etc. Families with kids with low economic conditions may face many challenges that could create a barrier to accessing healthcare services (Lazar et al., 2018). The gross domestic production of Nepal is very low which worsens these factors affecting the quality of healthcare services (Wagstaff, 2002). One important factor is geographical structure which creates barriers and prevents people of rural areas from accessing healthcare services (Eberth et al., 2022). Moreover, the government is trying to eradicate this issue by building roads and infrastructures where needed to keep up with the demand (Frenk et al., 2010). Other factors are gender and caste which is still the most important barriers in rural areas. Due to the diverse ethnicity, Nepal poses a unique context of barriers that worsen the health care outcome (Dahal, 2023). Although it is rarely seen in city areas, an individual of a higher caste has better health outcomes than a lower one.

The history of Nepal shows discrimination from the upper caste to the lower caste, which is the main reason for this barrier to persist till now. Proper education and the right policy focusing on eradicating these issues can assuage this situation. Similarly, education and income can significantly affect the health outcome of an individual. An educated individual can have a better health outcome due to the higher status in society. Similar to education, high income can significantly increase the quality of healthcare services. Several national and international organizations including the government are addressing these issues. Their effort has significantly impacted the equal access of healthcare services to these minorities. Despite this progress, several challenges still remain to provide high-quality health care to the citizens. According to Desai and Kulkarni (2008), disparities in the healthcare system are influenced by social factors like socioeconomic status, caste, ethnicity, gender, and geographic location. Due to the limited research and scientific evidence, the exact cause for these disparities is unknown. Many existing studies offer only the general insights and fails to explore the endemic issues in the Nepal hospital system that significantly impacts the health outcome in diverse communities. As the hospital system is the major source for these factors to exist, it is necessary to study and understand the perspectives of patient seeking health service and the health care provider such as administrative staff, doctors and nurses.

Therefore, the objectives of this study are to evaluate the extent to which the socioeconomic status, race ethnicity, and perception of the service provider create the barriers that significantly impact the health outcome. This study also addresses the major barriers in accessing healthcare service, patients' satisfaction, and experiences across different levels. Thus, it sought to answer the following questions: 1) How does socioeconomic status impact the utilization of healthcare services among rural populations in Nepal? 2) How do gender biases within the healthcare system affect women's access to and experience of healthcare services in Nepal? 3) What is the effect of geographical location on access to quality healthcare in Nepal? 4) How can interventions addressing social determinants of health contribute to the sustainable

development of Nepal's healthcare system? By answering these questions, this study is significant as it provides a detail understanding of how these social determinants affect the healthcare access and quality of healthcare services in Nepal. Identifying these specific barriers and inequalities in the healthcare system can help to fill the critical knowledge gap and provide research-based recommendations to the policymakers, healthcare providers, and the leaders. Finally, the findings can support efforts to reform Nepal's healthcare system, ensuring equitable treatment, and improved health outcomes for marginalized communities. The study will demonstrate the crucial link between health and sustainable development, highlighting the importance of addressing social determinants of health to achieve broader development goals. Addressing these systemic inequities is vital for advancing social justice, reducing preventable health issues, and promoting a more inclusive, high-quality healthcare system that serves all Nepali citizens effectively.

RESEARCH DESIGN AND METHODS

Study Design

This study utilizes a cross-sectional survey design to examine how socioeconomic status, race, ethnicity, and other factors influence access to and quality of hospital care among patients in various hospitals across Nepal. The study was based on the theory of social determinants of health which indicates that social and economic factors impact access to healthcare services. This study strictly follows the ethical guidelines provided by the Pokhara University research guidelines.

Sample Size

A minimum sample size of 300 participants from three different hospitals (Chitwan Medical College, Manakamana Hospital and Bharatpur Hospital) was collected as per the power analysis using the following equation (MacCallum et al., 1999). The analysis showed that the required sample size for the healthcare taker (patients) was 200 and for the healthcare provider the sample size was 100. The collection of samples was selective sample where the samples from two private hospitals and one government hospital were collected. The following formula was used to estimate the required sample size for the study.

$$n = \frac{z^2.p.(p-1)}{E^2}$$

Data Collection Methods

A structured questionnaire (supplementary) was used to assess the demographic information, access to care, quality of care, questions assessing patient satisfaction, perceived quality of treatment, and interactions with healthcare providers. Two types of survey questionnaires were prepared for the survey of healthcare providers and healthcare receivers. Surveys were distributed at various hospitals across Chitwan, mainly the three hospitals which are two private hospitals and a single government hospital, targeting different regions to ensure diversity. The two private hospitals were Chitwan Medical College and Manakamana Hospital and the government hospital was Bharatpur Hospital. Trained research assistants were administered to survey the hospitals in person, ensuring clarity and assisting with any questions participants may have.

Data Analysis Methods

The collected data were stored in Excel for basic statistical analysis and data visualization. SPSS version 26 (Statistical Package for the Social Sciences) was used for the analysis and visualization of the findings. The results of the survey were tabulated according to the answers from the survey takers. The tables consist of the different variables which are the questions and the frequency and percentage of each answer selected by the survey taker. Descriptive statistics was used to summarize the demographic characteristics. The chi-square test was used to examine the relationship between categorical variables. The p-value of less than 0.05 was considered as significant. The results were visualized in bar plots, boxplots or heatmaps as per the requirements.

Ethical Consideration

The ethical approval for the survey was provided by the Faculty of Humanities and Social Sciences, Pokhara University, Nepal.

RESULTS

A total of 291 individuals were surveyed for this study. Out of which, 200 were the patients and 91 were the healthcare providers.

Table 1 shows the demographic information of the patients visiting the hospitals. A total of 200 patients in the hospitals were surveyed for this study. Out of these, 33.5% were from government hospitals and 66.5% were from private hospitals. The total percentage of males and females was 47% and 53% respectively. The geographical analysis showed that 58% of patients were from the city area and 42% were from rural areas. The number of patients from the city area in the private hospital was 77.89% higher than those in the government hospital which was a significant difference. The marital status showed that 81% of the surveyed patients were married whereas 15% and 2% were unmarried and widowed respectively. Similarly, 89.5% of patients own a house and only 10.5% live on rent. The result also showed that 40% had higher education, 25% had secondary level education, 16.5% had primary, and 18% had no formal education. The percentage of unemployed patients was 50.5 and the employed was 38.5% and the rest were students.

Table 1

Demographic Information of the Patients

Variables		Frequency	Percentage
Type of Hospital facility	Government	67	33.5
	Private	133	66.5
Age of the respondent	18-24	37	18.5
	25-35	26	13
	35-40	43	21.5
	45-54	12	6
	55-64	41	20.5
	above 65	41	20.5
Sex	Female	106	53
	Male	94	47
Geographic area of the respondent	Rural	84	42

	City	116	58
Marital status	Married	162	81
	Unmarried	30	15
	Other	8	4
Living Situation	Own	179	89.5
	Rent	21	10.5
Educational status	No formal	36	18
	Primary	33	16.5
	Secondary	51	25.5
	Higher	80	40
Employment status	Employed	77	38.5
	Unemployed	101	50.5
	Looking for work	1	0.5
	Student	9	4.5
	Retired	12	6
Average Monthly Income	No income	36	18
	<5000	8	4
	5000-10000	9	4.5
	10000-20000	40	20
	20000-40000	60	30
	40000-60000	21	10.5
	60000-80000	19	9.5
	>80000	6	3

The chi-square analysis of Table 1 showed that the patients from the private hospitals were significantly educated with a higher level of education as compared to government hospitals. Similarly, the time to reach the nearest private hospital was significantly lower than government hospital. However, there were no significant differences in the frequency of visits to hospital for checkups between both government and private hospitals.

Figure 1

Type of Hospitals Impacted by the Level of Education of the Patients and Time to Reach the Nearest Hospital

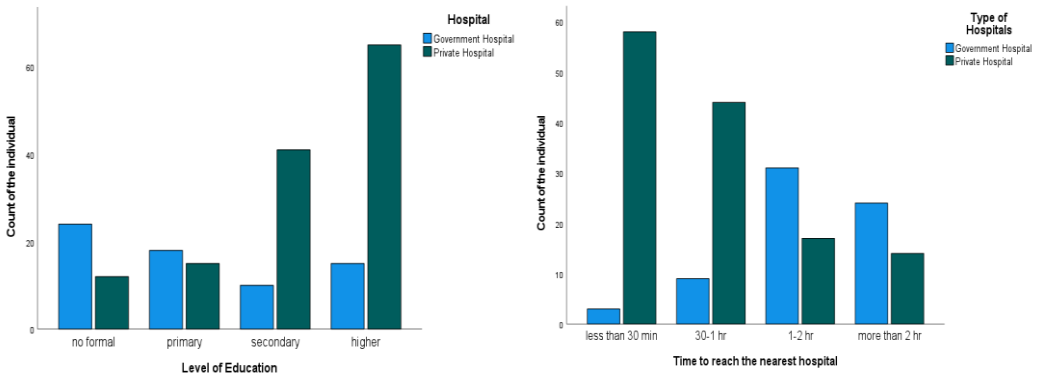


Figure 1 shows that the percentage of patients visiting private hospitals had a higher level of education. Similarly, the time to reach the hospital was higher in government hospitals than private hospitals.

The following table shows the access and experience with the healthcare services provided by the government and private hospitals.

Table 2

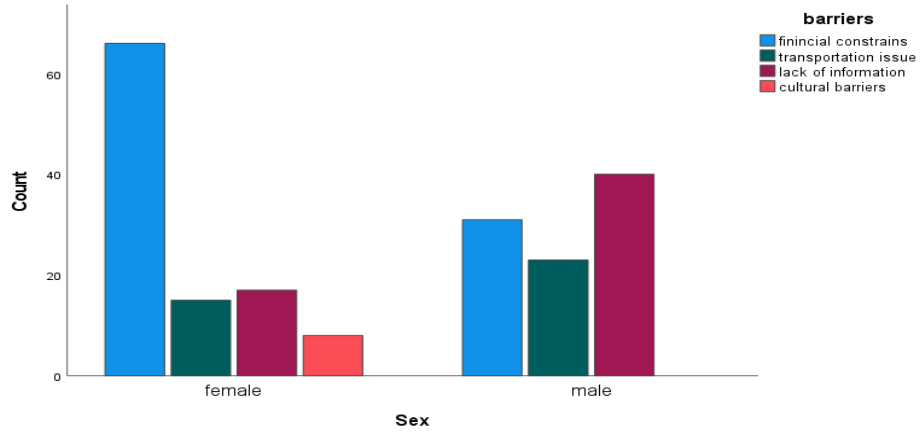
Access and Experience with the Healthcare Services

Variables		Frequency	Percentage
How did you travel to the hospital?	Private	107	53
	Public	78	39
	Walked	15	7.5
How long did it take to reach the hospital?	<30 min	61	30.5
	30-1 hr	53	26.5
	1-2 hr	48	24
	> 2 hr	38	19
How often do you get a health check-up?	Once in 3 months	8	4
	Once in 6 months	22	11
	Once in a year	5	2.5
	Only when needed	165	82.5
Have you faced any barriers in accessing healthcare?	Financial constrains	97	48.5
	Transportation issue	38	19
	Lack of information	57	28.5
	Cultural Barriers	8	4
How do you pay for your health care and medical expenses?	Government insurance	89	44.5
	Private insurance	57	28.5
	Self-payment	54	27
How would you describe your general health?	Excellent	12	6
	Very good	3	1.5
	Good	111	55.5
	Fair	64	32
	Poor	10	5
How expensive is the health care service?	Very expensive	117	58.5
	Expensive	38	19
	Moderate	27	13.5
	Affordable	18	9

Table 2 shows the access and experience with the healthcare services. The result shows 53 % percentage used private vehicles for transportation whereas 39% used public vehicles. Similarly, 30 % took less than 30 minutes to reach the hospital, 26% took around 1 hour and the rest took more than an hour to reach the hospital.

Figure 2

Barrier's Patients Received According to Their Sex



The patients were surveyed to know if there are any barriers in accessing healthcare service which is represented in Figure 2. The patients answered financial constraints as the major barrier with 48.5%, with a lack of information about healthcare by 28.5% and 19%, and 4% as transportation issues and cultural barriers respectively. There was no significant difference in these barriers faced by the patients between government and private hospitals. However, it was found that females were found to have significantly higher financial constraints as a barrier than male patients. About 44.5% of patients use government insurance to pay for healthcare service, 28% use private insurance services, and 27% pays out from their pockets. Similarly, 55.5% of patients had good health status followed by fair (32%), excellent (6%), poor (5%), and very good (1.5%).

Table 3

Results of Healthcare Quality Received by Patients

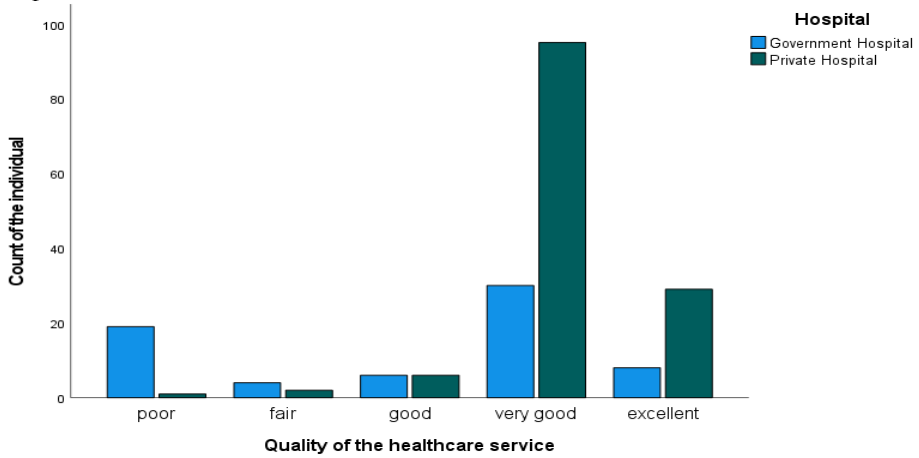
Variables		Frequency	Percentage
How would you rate the quality of care you received in this hospital?	Poor	20	10
	Fair	6	3
	Good	12	6
	Very Good	125	62.5
	Excellent	37	18.5
How would you rate the communication from healthcare staff?	Poor	9	4.5
	Average	107	53.5
	Good	84	42
Have you ever faced any form of misbehavior from health worker?	No	185	92.5
	Yes	15	7.5
What are the things that you hate about clinical check-ups?	Waiting list	134	67
	No air conditioner	20	10
	Unmanaged crowed	41	20.5
	Unwanted advice	5	2.5

Table 3 represents the affordability of healthcare services in government and private hospitals. The majority of the patients believed that the healthcare service was

very expensive (58%) followed by expensive (19%), moderate (13.5%), and affordable (9%). Even though a higher number of patients expressed the healthcare service is very expensive from the private hospitals, there were no significant differences in this response between the patients from the government and the private hospitals.

Figure 3

Quality of Healthcare Service Received by the Patients in Government and Private Hospitals



The response from the patients displayed in Figure 4 showed that the quality of the healthcare service they received from the private hospitals was significantly better than the government hospitals. Similarly, the result shown in Table 4 found that patients in government hospitals are more likely to get misbehavior from the healthcare provider than in private hospitals. The survey results found that 67% of patients hate the long waiting time in the hospital, 20% hate the unmanaged crowd, 10% complain about the air condition, and 2.5% hate unwanted advice.

Table 4

Survey Results of the Importance of Social Support and Literacy

Variables		Frequency	Percentage
How important is support to your recovery?	Not Important	14	7
	Moderately Important	69	34.5
	Extremely Important	117	58.5
How confident are you in understanding the information provided by your healthcare providers?	Not confident	8	4
	Slightly confident	8	4
	Moderately confident	52	26
	Very confident	128	64
	Extremely confident	4	2

Table 4 shows the importance of social support and literacy for the recovery of the patient. Only 7% said that social support is not important while 93% of patients said that social support is extremely important. Similarly, 64% of the patients showed that they are very confident on understanding the information provided by the health care provider.

Table 5
Demographic Information of the Healthcare Providers

Variables		Frequency	Percentage
Role in Healthcare facility	Doctor	8	8.8
	Nurse	83	91.2
Sex	Female	85	93.4
	Male	6	6.6
Type of healthcare facility do you work	Government hospital	37	40.7
	Private hospital	54	59.3
Economic Status of patient population you usually serve	Low income	34	37.4
	Mixed	40	44
	High income	17	18.7

A total of 91 healthcare providers were surveyed for this study which is represented in Table 5. Out of these 40.7% were working in government hospitals and 59.3 percentage were working for private hospitals as represented in Table 5. This survey also found that 93.4% of healthcare providers were female whereas only 6.6 were male. Interestingly, all of the males had a profession as a doctor and all the females were nurses. Similarly, the average age and the experience of the surveyed population were 25.93 years and 38.39 months respectively. The chi-square test results showed that a significant number of patients in the government hospitals were low-income. Similarly, the patients visiting the private hospitals were primarily mixed and had higher incomes.

Figure 4
Survey Results of the Patients of Different Socioeconomic Backgrounds

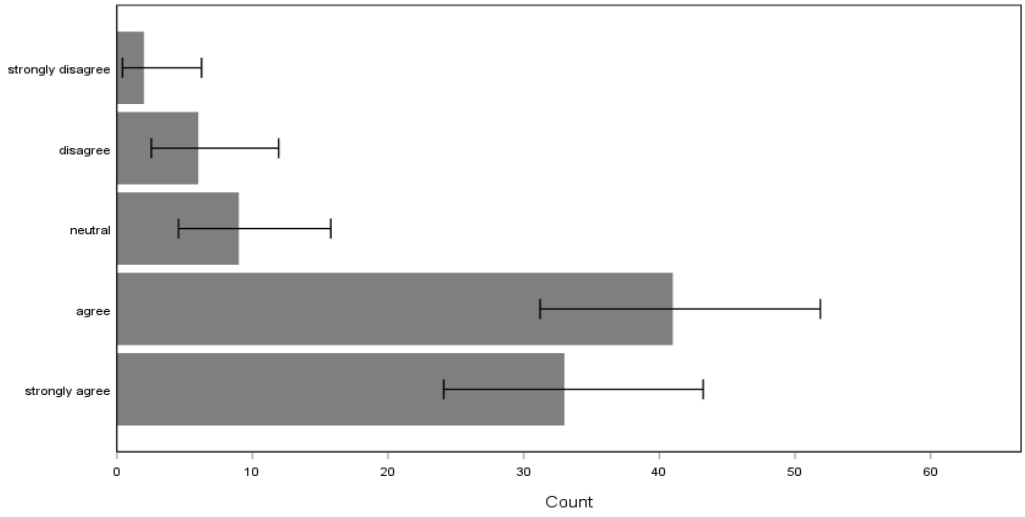


Figure 4 shows that healthcare providers believe that patients from lower socioeconomic backgrounds face barriers to receiving the same quality of healthcare as higher-income patients. The majority of the healthcare providers agreed with this statement.

Table 6
Perception of Socioeconomic Status and Healthcare

Variables		Frequency	Percentage
Do you consider a patient's socioeconomic status when making medical decisions?	Never	6	6.6
	rarely	15	16.5
	sometime	26	28.6
	often	29	31.9
	always	15	16.5
Do patients from lower socioeconomic backgrounds face barriers to receiving the same quality of healthcare as higher-income patients?	Strongly agree	33	36.3
	Agree	41	45.1
	Neutral	9	9.9
	Disagree	6	6.6
	Strongly disagree	2	2.2
Do patients from lower socioeconomic backgrounds have different health outcomes compared to higher-income patients?	Strongly agree	14	15.4
	Agree	39	42.9
	Neutral	13	14.3
	Disagree	25	27.5
Any influence of socioeconomic status on a patient's ability to adhere to treatment plans?	No influence	4	4.4
	Minor	16	17.6
	Moderate	27	29.7
	Major	44	48.4

Table 6 shows the perception of socioeconomic status and healthcare. The survey revealed that 64% of healthcare providers believed that patients from lower socioeconomic backgrounds are more likely to delay seeking medical care due to cost concerns. However, only 8.8% of subjects disagreed and the remaining 27.5% were neutral about this. Similarly, 48.4% of healthcare providers believed that socioeconomic status has a major influence on the patient's ability to adhere to the treatments. Likewise, 29.7% agreed that it has moderate influence, followed by 17.4% for minor and only 4.4% for no influence. The chi-square analysis showed that whether a patient chooses any types of hospital, the majority of healthcare providers still believe that lower socioeconomic background is more likely to delay seeking medical care. However, a significant number believed that patients from the private hospitals are more likely to be influenced by their socioeconomic background.

Table 7
Treatment Decision and Practices

Variables		Frequency	Percentage
Have you ever altered a treatment plan based on a patient's financial constraints?	Never	22	24.2
	Rarely	2	2.2
	Sometimes	26	28.6
	Often	10	11
	always	31	34.1
	Strongly agree	5	5.5

Do you feel that patients from lower socioeconomic backgrounds are more likely to delay seeking medical care due to cost concerns?	Agree	53	58.2
	Neutral	25	27.5
	Disagree	5	5.5
	Strongly disagree	3	3.3

Table 7 shows the treatment decisions and practices provided to the patient as per their socioeconomic status. Similarly, Table 8 shows the impact of baseness and education in healthcare.

Table 8

Impact of Biases and Education in Healthcare

Variables		Frequency	Percentage
Have you received formal training on how to provide equitable care to patients of all socioeconomic backgrounds?	Yes	29	31.9
	No	47	51.6
	Not sure	15	16.5
Do you feel that more training is needed to address socioeconomic biases in healthcare?	Strongly agree	34	37.4
	Agree	39	42.9
	Neutral	11	12.1
	Disagree	5	5.5
	Strongly disagree	2	2.2
Do you believe your institution supports equitable treatment for patients regardless of socioeconomic status?	Strongly agree	6	6.6
	Agree	27	29.7
	Neutral	26	28.6
	Disagree	12	13.2
	Strongly disagree	20	22

Table 8 shows the importance of formal training on equitable access to healthcare facility. The survey revealed that the majority of the healthcare providers (51.6%) had not received any sort of formal training regarding the equitable care to patients of all socioeconomic backgrounds. Only 31.9% had received training and 16.5% were unsure about this. About 80.3% of the surveyed healthcare providers agreed that they feel that more training is needed to address socioeconomic biases in healthcare. Only 7.7% disagreed whereas 12.1% were neutral about this.

DISCUSSION

A cross-sectional survey was carried out with health care receivers and healthcare providers regarding the impact of socioeconomic conditions on equitable access of the health care service. The findings showed that women visited hospitals more often than men. There could be some gender-related factors such as reproductive health needs or family care responsibilities. These findings align with the research conducted on the females which showed that females have three times higher chance of being hospitalized than males (Rost et al, 2011). Women's higher hospital visit rates may be influenced by maternal health during the reproductive years, but older women may also visit hospitals more often due to longevity and the higher rates of chronic conditions. But

the insignificant relationship showed further research could be explored to understand the gender related issues.

The education status showed that the majority of patients had average education levels with notable proportion with lacking formal education. In contrast, the research on the literacy rate of Nepal showed that around 70% of the population are educated (GC & Shrestha., 2014). This trend shows that the increasing number of patients in the hospital lacks formal education. There was also a significant correlation of the education status with the quality of health service they received. This finding aligns with the previous research which showed the significant relationship in the quality of health service they received and the educational levels (Verma et al., 2020).

The survey found that 42% of patients were from the rural areas while 58% were from the urban areas. This geographical distinction proved to be significant in terms of the quality of care received, the time required to reach the hospital, and waiting times. Patients from urban areas reported significantly better quality of care and shorter waiting times. These findings align with the broader literature on healthcare facility and the consumer satisfaction in urban and rural populations (Verma et al., 2020). Despite these differences between both groups, it was reported similar affordability of healthcare services, which suggests that the financial barriers to access may be more evenly distributed (McMaughan et al., 2020). The negative correlation between education level and waiting time at the hospital is an interesting finding. However, other research showed no correlation between the education levels and the waiting times in the hospital (Jones et al, 2017). The correlation on this factor could be exclusive in Nepal as there was no other information reported about this. This suggests that the patient in Nepal with higher education are more likely to get the healthcare service faster than others. This could reflect disparities in how different education levels interact with and navigate the healthcare system, highlighting the importance of health education in improving healthcare access and efficiency.

The survey found that the financial constraint was the primary barrier to healthcare access, followed by a lack of information about healthcare services. This finding aligns with existing research on the socioeconomic factors affecting the healthcare utilization (McMaughan et al., 2020). Low in the financial condition can affect the patient ability to afford healthcare and timely checkups. Cultural barriers, though still present, were the least significant factor in limiting access to healthcare in this study, which may reflect the increasing availability of culturally competent care in the healthcare system. Despite the financial and informational barriers, patient satisfaction with the quality of care was overwhelmingly positive, with the majority rating their care as very good. Communication from hospital staff was also reported as excellent, with very few patients indicating dissatisfaction with the quality of communication.

The chi-square analysis of the correlation between the socioeconomic and geographic factors with the hospital experiences indicated that the patients from the urban areas were more likely to receive better quality of treatment and experience shorter waiting times. These findings were similar with the existing literature showing the impacts of geographic areas and the quality of the health care received by the patients (Raghupathi et al., 2020). It could be because of the additional challenges such as limited resources, fewer healthcare providers, or less efficient service delivery, which contribute to longer wait times and lower perceived quality of care (Weiss et al., 2020).

The analysis of the sex of health worker shows that the nurse field is dominated by the females. The near total dominance of female in the study suggests that the

majority of health workers are females, requiring further investigation. Understanding the factors is essential for promoting the gender diversity in the healthcare facility. Similarly, slightly a higher number of employees in the private sector could be because of the better compensation and facilities provided. However, this could also be resulted by ease of getting hired by the private hospitals rather than the government hospitals. As the government hospitals follow a strict examination to select the new employee, it will be easier to get hired in the private hospitals.

The chi-square test results showed that a significant number of patients in the government hospitals were low-income. Similarly, the patients visiting the private hospitals were primarily mixed and higher income. The study found that the healthcare providers from the government hospitals tend to consider the patients' socioeconomic status more than of the private hospitals. The possibility of socioeconomic difference in healthcare utilization and access is highlighted by this finding. Additionally, the finding that medical staff in government hospitals are more likely to take the patients' socioeconomic position into account that raises the possibility that they are more sensitive to the financial limitations and social difficulties that their patients confront (Arpey & Rosenbaum, 2017). Their professional judgment and treatment strategies may be impacted by this awareness. These results emphasize how crucial it is to take the socioeconomic issues into account when developing the healthcare policies and practices. Addressing the root causes of these gaps, such as care affordability, service accessibility, and cultural sensitivity, is necessary to guarantee all socioeconomic groups to have a fair access to high-quality healthcare.

The majority of the healthcare providers agreed with the statement that the healthcare receivers of the lower socioeconomic backgrounds face the barriers more than the higher-income patients. However, the analysis showed that regardless of the hospitals, the healthcare providers agreed to this statement. The constant consensus in both public and private hospital settings highlights how widespread these issues are, extending beyond the particular healthcare context. This agreement between the healthcare professionals can be a vital starting point for creating and putting into practice plans to lessen these obstacles. Healthcare institutions should take the proactive measures to enhance access, affordability, and the standard of treatment for this vulnerable population by recognizing the particular difficulties experienced by the low-income patients.

The high number of patients with the low socioeconomic backgrounds delays seeking a medical care. Similarly, half of health care providers believe that the socioeconomic status has a major influence on the patient's ability to adhere to the treatments. This study's findings highlight a widespread recognition among the healthcare providers of the significant barriers faced by the patients from the lower socioeconomic backgrounds in accessing healthcare (Schultz et al., 2018). The consistent agreement across both government and private hospital settings underscores the pervasiveness of these challenges, transcending the specific healthcare environment. This consensus among the healthcare providers can serve as a crucial foundation for developing and implementing strategies to mitigate these barriers. By acknowledging the unique challenges faced by the low-income patients, the healthcare systems can take the proactive steps to improve access, affordability, and the quality of care for this vulnerable population.

The findings of high percentage of health care providers with no formal training regarding equitable care to patient reveals a serious deficiency in healthcare professionals' education in providing the patients from all socioeconomic backgrounds

with equitable care. Given that socioeconomic determinants are known to have an impact on the health outcomes, it is troubling that more than half of the physicians questioned have not received any formal training in this area.

CONCLUSION AND IMPLICATIONS

In Nepal, the survey showed several important trends and disparities in the healthcare services provided to individuals. While the quality of care and the staff communication were rated high by the patients, the main barriers to receiving these services were the financial conditions. Similarly, the geographic location of the patients significantly affects the quality of service they receive in the hospitals. The majority of healthcare providers were unaware of the training that they received about the socioeconomic factors impacting the quality of healthcare received by the patients. To ensure equitable healthcare access, key interventions should focus on education, infrastructure, affordability, training, diversity, and policy. The health literacy level will improve if health education is integrated into the school curriculum and complemented by public awareness campaigns. These rural facilities can be extended with mobile services to fill access gaps. The findings of the study also suggest that it is necessary to address the financial barriers through the provision of subsidies and assistance to low-income, elderly patients. Training for the health providers to provide care that is equitable and culturally competent would improve a provision of service. Diversity of the workforce that is promoted and scholarship programs for underrepresented groups will create an even more inclusive system. Similarly, the policy and monitoring improvement on health care disparities will ensure equal resource distribution and better access for everyone. The findings of this study could contribute to improving health literacy, reducing financial barriers, and addressing regional disparities in the healthcare services that could help improve healthcare access and patient satisfaction across various demographic groups.

CONFLICT OF INTEREST DECLARATION

The author of the research declares that there are no conflicts of interest.

AUTHOR CONTRIBUTIONS

I declare that this manuscript is originally produced by me.

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ABOUT THE AUTHOR(S)

Kabita Khatiwada *has been working as Assistant Lecturer at Balkumari College and Nursing Director of Manakamana Hospital and Chairman of Mother Child Health Nepal (MOCHEN) NGOs. She is a professional with her commitment to enhancing the quality Healthcare and Sustainable development of quality healthcare education in Nepal. Currently pursuing her PhD in Development Studies at Pokhara University, Nepal. With a specialized focus on sustainable development of healthcare system in Nepal through social determinants of health, her work is instrumental in shaping the Healthcare of Nepal.*

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