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MATERNAL HEALTHCARE SERVICES: COMPARING ACCESS, QUALITY, AND PATIENT EXPERIENCE

Mrs. Sujata Panigatti[1], Dr. Sangeetha R Mane[2]
[1]*Research Scholar, Department of Social Work, Karnatak University Dharwad*
[2]*Professor, Department of Social Work, Karnatak University Dharwad*

ABSTRACT
This paper presents a comparative analysis of maternal healthcare services in public and private institutions. The study evaluates critical dimensions of healthcare delivery, including accessibility, waiting time, staff behaviour, provider communication, infrastructure, and overall satisfaction. Findings reveal a clear divergence in patient experiences across the two sectors. While public facilities are essential for marginalized groups, they are often associated with delays, poor communication, and disrespectful treatment. In contrast, private institutions, although less accessible to lower-income groups, demonstrate significantly higher satisfaction rates due to timely services, better infrastructure, and respectful care. The paper concludes with policy recommendations for improving public healthcare delivery and ensuring equity in maternal health services.
KEYWORDS: *Maternal Health, Public vs Private Healthcare, Patient Satisfaction, Quality of Care, India, Equity, Health Systems*

INTRODUCTION

Healthcare is a fundamental human right deeply tied to social justice and equity. Based on three decades of social work experience and research, this study emphasizes that health outcomes are shaped by social determinants like income, education, and social inclusion. Marginalized groups—such as rural populations, the poor, and women—face systemic barriers in accessing respectful and quality care, especially in maternal health. While institutional deliveries have increased, public facilities often remain overcrowded, understaffed, and lack dignity-oriented care, particularly for women from disadvantaged backgrounds. In contrast, private institutions offer better experiences but are largely accessible only to the affluent, reinforcing class-based healthcare inequities. A rights-based, person-centered approach is needed—one that integrates social work to improve communication, uphold dignity, and address broader determinants like nutrition, education, and autonomy. Social workers play a vital role in advocating for patient rights, bridging service gaps, and pressing for policy reforms that ensure accessible, affordable, and culturally sensitive care (World Health Organization, 2022; Banks et al., 2020). Ultimately, true healthcare equity goes beyond infrastructure. It demands systemic transformation to make care inclusive, accountable, and respectful for all—treating health not as a commodity, but as a public good central to human development.

2. REVIEW OF LITERATURE

Empirical studies show increased institutional deliveries after initiatives like NRHM and Janani Suraksha Yojana. Bellad et al. (2017) found a 96% institutional delivery rate in Karnataka, yet maternal mortality (103/100,000) and stillbirths (2.86%) remained high. This highlights that facility births alone aren't enough—issues like inconsistent ANC visits, weak referrals, and poor access in remote areas persist.

The private sector plays a major role in maternal care, with studies showing up to 80% of outpatient visits occur there, even among the poor. Despite free public services, hidden costs deter use. A recent study by Motappa et al. (2024) in Mangaluru found better outcomes and more ANC visits in private hospitals, highlighting ongoing quality gaps between sectors.

Cultural and familial dynamics further complicate service utilization. Vidler et al. (2016) revealed that decision-making power frequently resides with elder family members, particularly mothers-in-law and husbands, which can delay care-seeking in critical moments. These insights align with broader anthropological findings regarding gender hierarchies in reproductive health decision-making in South Asia.

Smith (2013), in a comparative policy analysis, attributed Karnataka's slower progress in maternal health outcomes to fragmented governance, weak political commitment, and underfunded local implementation mechanisms. Compared to Tamil Nadu's integrated and state-driven health delivery model, Karnataka lacked coordinated leadership, resulting in wide district-level disparities. Bellary district, for instance, had an institutional delivery rate of only 46 percent, compared to 82 percent in Kodagu.

Notably, the National Rural Health Mission (NRHM) has strengthened primary care infrastructure, mobilized community health workers such as Accredited Social Health Activists (ASHAs), and expanded incentive-based delivery programs like the Janani Suraksha Yojana. However, evidence indicates that these improvements have not adequately addressed the needs of women in hard-to-reach and underserved communities (International Journal for Equity in Health, 2017).

Despite progress in institutional deliveries and ANC in Karnataka, gaps in quality, equity, and access remain. Public-private differences, poor postpartum care, and exclusion of

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marginalized groups hinder maternal health gains. A more inclusive, rights-based approach is needed.

3. RESEARCH METHODOLOGY

Measures: Primary data was collected using simple questionnaires and semi-structured interviews. The questionnaire asked about patient experiences and problems with maternal and child health services, focusing on waiting time, staff behavior, communication, and facility cleanliness.

Statistical Analysis: Data was analyzed using basic statistics. Frequencies and percentages showed the demographics and compared patient experiences between public and private healthcare. Results were shown in tables and figures.

Procedure: The study aimed to compare maternal and child health services from the patients' viewpoint. A total of 140 participants took part—80 from private and 60 from public centers. Participants included pregnant women and mothers of young children from both rural and urban areas of Dharwad district. Researchers visited healthcare centers to collect data through questionnaires and interviews, focusing on patient satisfaction and challenges in accessing care. This helped compare the quality of care between public and private facilities.

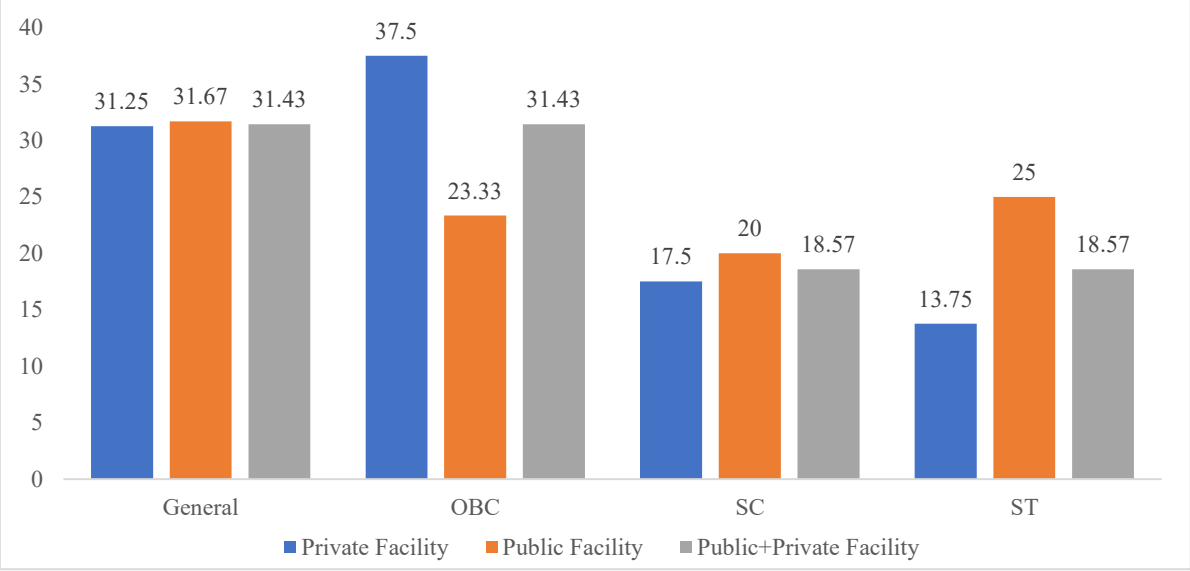
4. RESULTS AND DISCUSSION

The study found that 57% of respondents used private healthcare, while 43% used public facilities. Scheduled Caste and Tribe groups mostly relied on public care, showing ongoing social and economic barriers. Education also affected choices, with more educated people preferring private care.

Waiting times were longer in public hospitals, with many waiting over an hour, but most patients accepted this. Staff behavior was a concern—58% of public facility users reported disrespect, unlike in private centers where staff were mostly kind and helpful.

Family plays a big role in healthcare decisions, as 74% of patients were accompanied by relatives, highlighting the importance of involving families in health programs.

Figure 1: Social Category-Wise Utilization of Public and Private Healthcare Facilities (%)



Source: Field Survey

Figure 1 shows how social categories influence the use of public and private maternal healthcare facilities. Among General respondents, usage is evenly split between private (31.25%) and public (31.67%) services, while OBCs show a preference for private care (37.5%) over public (23.33%), possibly due to better access or perceived quality. SC and ST groups rely more on public facilities—20% vs. 17.5% (SC) and 25% vs. 13.75% (ST)—reflecting structural and economic barriers. These patterns highlight persistent caste-based disparities and emphasize the need for public health policies that improve quality, inclusivity, and private sector regulation to address diverse community needs.

Table 1: Educational Status of Respondents Across Social Categories (%)

Education Status	General	OBC	SC	ST	Total
College	25.00	40.91	19.23	26.92	29.29
Grade 10	27.27	6.82	53.85	19.23	24.29
Grade 11-12	0.00	15.91	3.85	3.85	6.43
Illiterate	0.00	2.27	0.00	0.00	0.71
Passed grade 12	31.82	22.73	15.38	26.92	25.00
Primary level (Grade 1-5)	6.82	2.27	3.85	7.69	5.00
Secondary level (Grade 6-9)	9.09	9.09	3.85	15.38	9.29
Total (N)	44	44	26	26	140

Source: Field Survey

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Table 1 highlights educational disparities by social category among 140 respondents, impacting healthcare awareness and access. While most had college (29.29%), grade 12 (25%), or grade 10 (24.29%) education, few reached only primary (5%) or secondary (9.29%) levels, and illiteracy was rare (0.71%). OBCs had the highest college attainment (40.91%), while 53.85% of SCs stopped at grade 10, and only 19.23% reached college. STs had mixed levels, and the General group showed balanced higher education with no illiteracy. Low grade 11–12 representation, especially among SCs and STs, reflects systemic barriers and calls for targeted educational support to improve health outcomes.

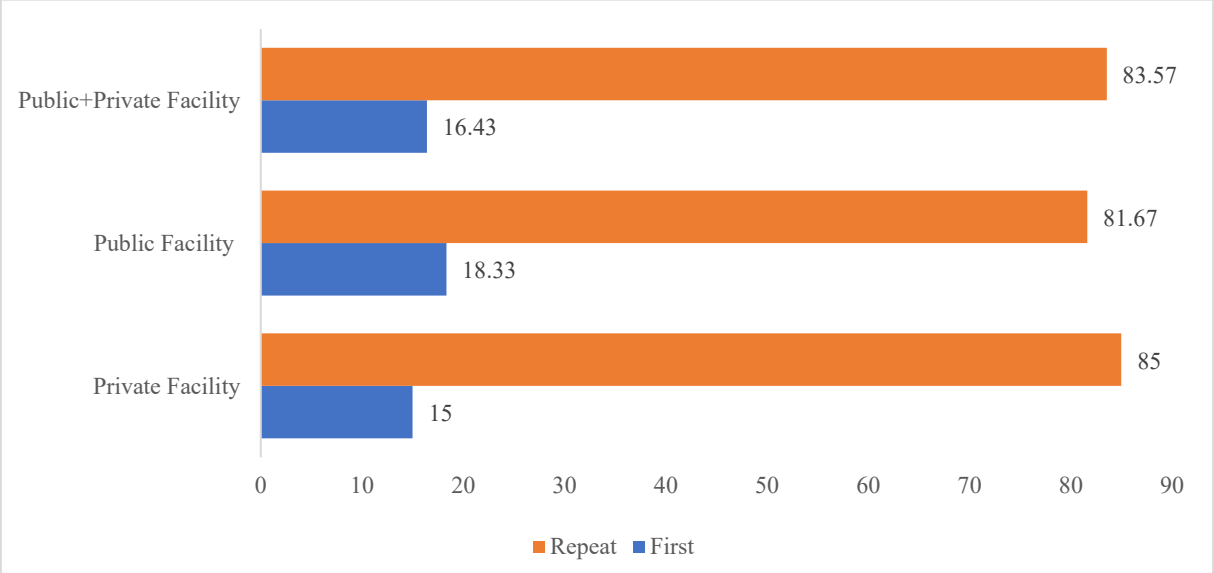
Table 2: Educational Status and Healthcare Facility Utilization (%)

Education Status	Private Facility	Public Facility
College	38.75	16.67
Grade 10	16.25	35.00
Grade 11-12	5	8.33
Illiterate	0	1.67
Passed grade 12	27.5	21.67
Primary level (Grade 1-5)	6.25	3.33
Secondary level (Grade 6-9)	6.25	13.33
Total	100	100

Source: Field Survey

The educational profile of respondents reveals important associations with their choice of healthcare facility for maternal or related services. Table 2 presents a comparative analysis of respondents' educational attainment and their preference for private or public healthcare institutions, reflecting both access and perception of service quality. Higher education levels were linked to greater use of private healthcare. Among college-educated respondents, 38.75% used private facilities versus 16.67% using public ones. Similarly, 27.5% of those with college or grade 12 education preferred private care. In contrast, less educated respondents relied more on public services—35% of grade 10 educated and most with only primary or secondary education used public facilities. The only illiterate respondent also accessed public care. These patterns highlight that education influences healthcare choices through better awareness, affordability, and expectations. Improving public healthcare quality is essential to ensure equitable access for less educated groups.

Figure 2: First-Time and Repeat Utilization of Healthcare Facilities (%)



Source: Field Survey

Understanding patterns of healthcare utilization—specifically whether patients are first-time or repeat visitors—provides important insights into perceived service quality, trust, and continuity of care. Figure 2 presents the distribution of first-time versus repeat visits across private and public healthcare institutions. A large majority (83.57%) of respondents were repeat visitors, indicating strong service re-utilization. Repeat visits were slightly higher in private facilities (85%) than in public ones (81.67%), suggesting trust, satisfaction, or limited alternatives drive return visits in both sectors. Public facilities had a higher share of first-time users (18.33%) compared to private ones (15%), likely due to their affordability and accessibility, especially for new or low-income patients. In contrast, private services appear to cater to a stable, returning clientele. These patterns underscore the importance of maintaining service quality and continuity in both sectors. Public facilities, in particular, should leverage first-time visits to strengthen outreach and patient education.

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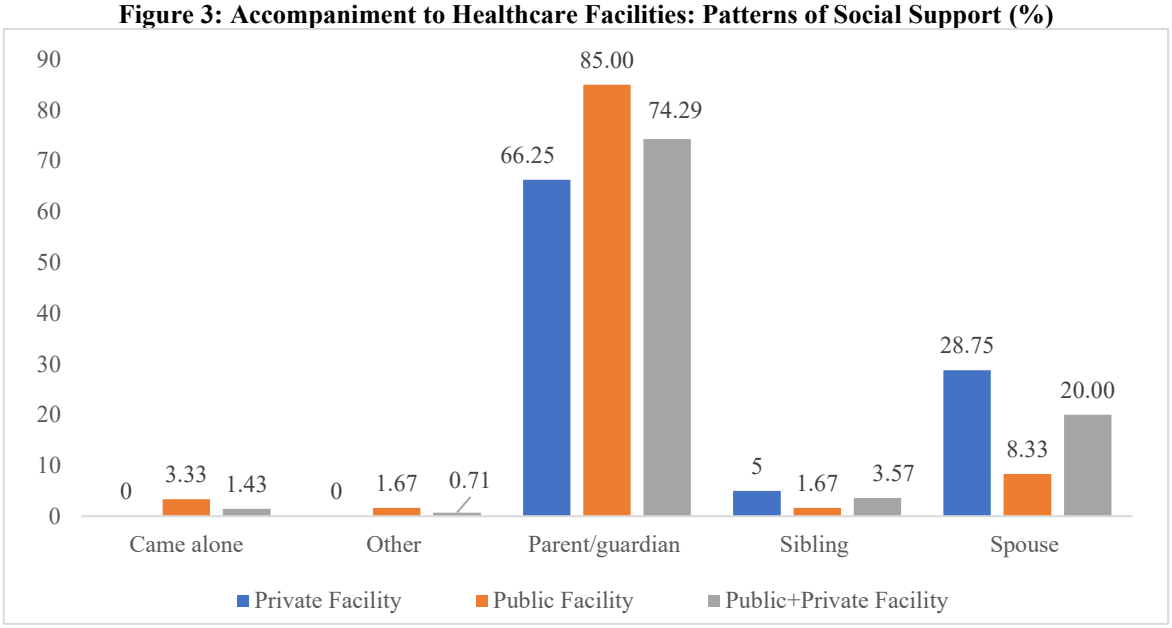
Table 3: Sources of Awareness about Healthcare Facilities (%) (Multiple Choices)

Sources of Awareness	Private Facility	Public Facility	Public + Private Facility
Parents	78.75	88.33	82.86
Friends	5	0.00	2.86
Community Members	5	3.33	4.29
Community Health Workers	11.25	11.67	11.43
Hospital Outreach Workers	0	91.67	39.29
Newspaper	62.5	0.00	35.71
Social media	18.75	0.00	10.71
School/Teacher	0	75.00	32.14
Others	5	0.00	2.86

Source: Field Survey

Understanding how individuals become aware of healthcare facilities offers important insights into the channels of health communication and community engagement. Table 3 summarizes the distribution of information sources influencing healthcare-seeking behaviour, disaggregated by public and private sector utilization. Parents were the main source of health information for 82.86% of respondents, across both private (78.75%) and public (88.33%) sectors. Public facility users also relied heavily on hospital outreach workers (91.67%) and school teachers (75%), while private users reported newspapers (62.5%) and social media (18.75%) as key sources. Community members (4.29%) and health workers (11.43%) had limited influence, and no respondents cited TV/radio. These patterns show public awareness is driven by institutional outreach, while private sector users rely more on media. Enhancing community-level engagement and broadening communication channels can improve healthcare access and equity.

Figure 3: Accompaniment to Healthcare Facilities: Patterns of Social Support (%)

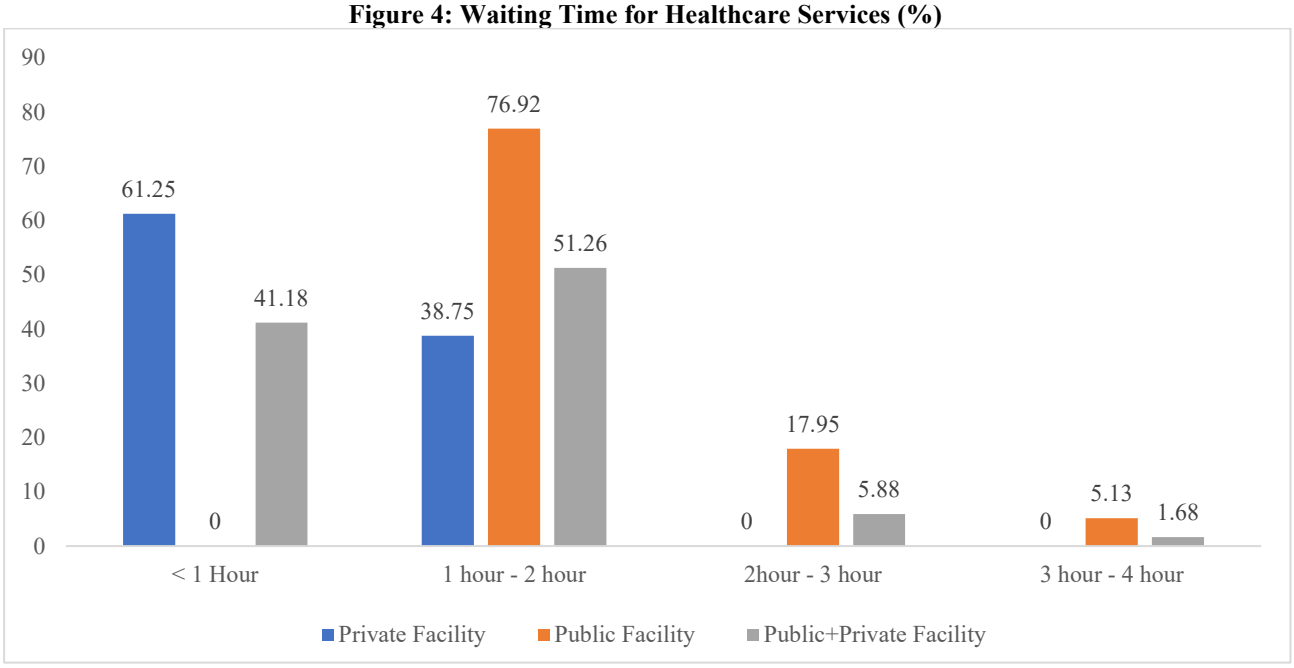


Source: Field Survey

The nature of accompaniment to healthcare facilities offers valuable insights into the familial and social structures that influence health-seeking behavior, particularly in maternal and youth healthcare contexts. Figure 3 presents the distribution of individuals who accompanied respondents to healthcare facilities, disaggregated by type of facility. The data shows that 74.29% of respondents were accompanied by parents or guardians, with this trend more common in public facilities (85%) than private ones (66.25%). This highlights the strong role of family, particularly in public healthcare access and for younger or dependent patients. Spouses accompanied 28.75% of private facility users but only 8.33% in public settings, reflecting differences in marital status, autonomy, and economic background. Siblings were rarely companions (3.57%), and just 1.43%—all public users—visited alone, indicating limited autonomy in healthcare visits. These findings underscore the influence of family in healthcare decisions. Enhancing service utilization may require engaging family members, while improving accessibility, safety, and privacy in public facilities could encourage greater patient independence.

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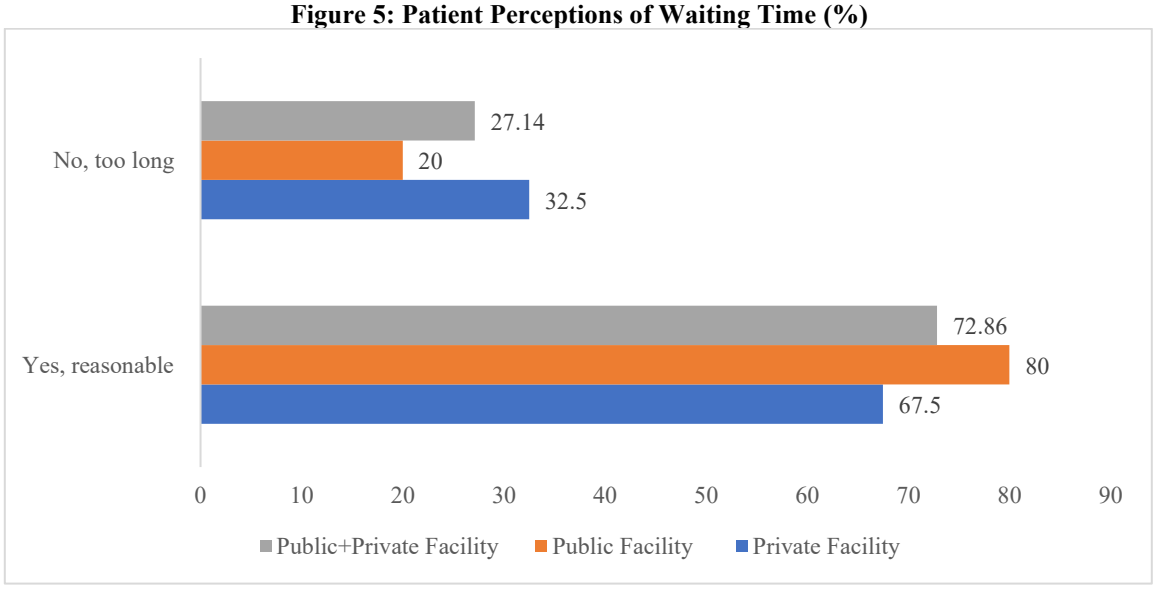
Figure 4: Waiting Time for Healthcare Services (%)



Source: Field Survey

Waiting time is a key measure of healthcare efficiency and impacts patient satisfaction and care continuity. Figure 4 highlights stark differences between sectors: 61.25% of private facility users were seen within an hour, and all within two hours. In contrast, no public facility users were seen within the first hour, and 23.08% waited over two hours. All delays beyond two hours occurred in public facilities, indicating systemic issues like understaffing and overcrowding. Improving public sector efficiency through better scheduling, digital tools, and workflow management is crucial to ensure timely, equitable care.

Figure 5: Patient Perceptions of Waiting Time (%)



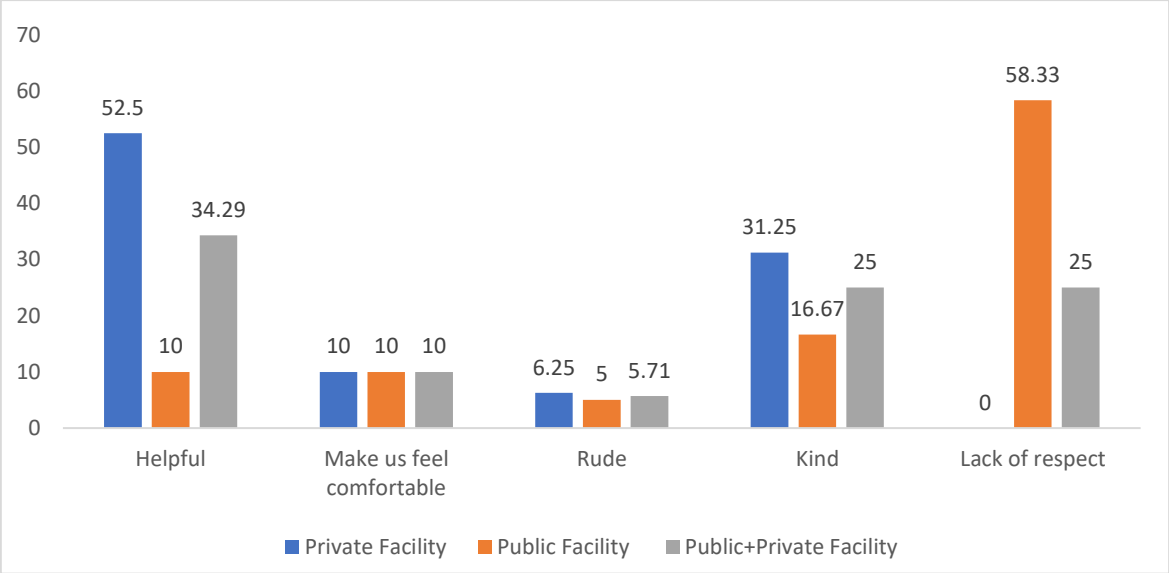
Source: Field Survey

Perceptions of waiting time serve as an important measure of patient satisfaction and institutional responsiveness. Figure 5 presents respondent evaluations of whether the time spent waiting to receive healthcare services was reasonable or excessively long, disaggregated by type of healthcare facility. Overall, 72.86% of respondents found the waiting time reasonable, while 27.14% felt it was too long. Interestingly, 80% of public facility users were satisfied despite longer waits, compared to 67.5% of private users. This contrast likely reflects differing expectations—public users may be more tolerant of delays, while private users, paying higher fees, expect quicker service. Only 20% of public users were dissatisfied, versus 32.5% in the private sector, suggesting that perceived satisfaction is influenced more by context and expectations than actual wait times. These insights highlight the need to improve efficiency in public healthcare, while in private settings, managing expectations and enhancing communication are key to improving patient satisfaction.

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Figure 6: Patient Perception of Support Staff Behaviour (%)

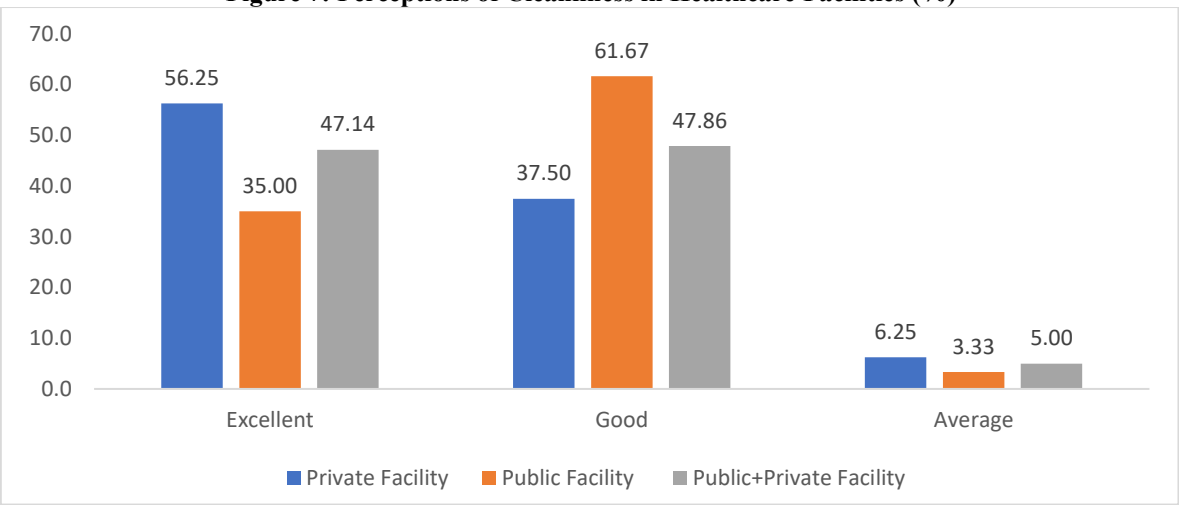
Support staff play a crucial role in shaping overall patient experience, particularly in public healthcare settings. Figure 6, Data reveals that private facility staff are more often perceived as helpful (52.5%) and kind (31.25%), with very few reports of rudeness or disrespect. In contrast, 58.33% of public facility users reported experiencing disrespectful behavior, while only 16.67% noted kindness and just 10% found staff helpful.



Source: Field Survey

These findings point to underlying issues such as inadequate training, lack of accountability, and poor workplace culture in public institutions. Addressing these challenges requires structured empathy and communication training, effective grievance redressal systems, and performance-based incentives to foster a more respectful, patient-centered approach in public healthcare.

Figure 7: Perceptions of Cleanliness in Healthcare Facilities (%)



Source: Field Survey

Cleanliness is a fundamental determinant of quality in healthcare settings, with direct implications for infection control, patient comfort, and institutional credibility. Figure 7 summarizes patient assessments of cleanliness across private and public healthcare facilities. The data shows high overall satisfaction with cleanliness in both sectors, with stronger ratings in private facilities. In private healthcare, 56.25% rated cleanliness as excellent and 37.5% as good, with no poor or unacceptable ratings—indicating consistently high hygiene standards, likely due to better resources and oversight. In public facilities, 35% rated cleanliness as excellent and 61.67% as good. Only 3.33% rated it as average, and none as poor—reflecting positive outcomes from initiatives like the Kayakalp Programme and Swachh Bharat Abhiyan. Overall, 47.14% of respondents rated cleanliness as excellent and 47.86% as good. While public facilities meet baseline hygiene standards, fewer top ratings suggest a quality gap. Continued investment in sanitation, regular monitoring, and visible cleanliness are essential to build patient trust and ensure equitable care experiences.

CONCLUSION

This study highlights significant disparities in maternal healthcare experiences between public and private institutions

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in India. While private facilities offer better communication, respectful treatment, and shorter wait times, access remains limited to those with higher socio-economic status. Public facilities, though crucial for marginalized communities, often lack patient-centered care, with issues like poor staff behavior, inadequate communication, and long delays. Patient satisfaction is shaped not just by clinical outcomes, but also by cleanliness, respectful interaction, and clear communication—areas where public services fall short despite improvements under schemes like NHM and JSY. Notably, 86.67% of public facility users wouldn't recommend their care. To improve equity, the study urges training for public health workers, stronger accountability, and better regulation of private providers. Integrating social work can also enhance patient support. True progress requires transforming both sectors to prioritize dignity, respect, and inclusive care for all women.

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