



HEALTHCARE POLICY REFORMS AND THEIR INFLUENCE ON ACCESS TO AFFORDABLE MEDICAL SERVICES IN LOW- AND MIDDLE-INCOME COUNTRIES

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Abstract

Access to affordable medical services remains a major challenge in low- and middle-income countries (LMICs), despite growing policy commitments to universal health coverage, primary healthcare strengthening, and financial protection. Many reforms have expanded formal coverage, yet households continue to face out-of-pocket payments, medicine costs, transport expenses, and unequal service availability. This article examines how healthcare policy reforms influence access to affordable medical services in LMICs, with particular attention to health financing, universal health coverage, primary healthcare, equity, and implementation barriers. The study adopted a qualitative documentary research design using thematic analysis. Six secondary data sources published or updated between 2020 and 2024 were used, including reports and databases from the World Health Organization, World Bank, UNICEF, and the DHS Program. Data were extracted using a structured matrix covering reform type, access outcomes, affordability, financial protection, equity dimensions, and implementation challenges. The analysis identified six major themes: health financing reform, universal health coverage expansion, primary healthcare strengthening, affordability and financial protection, equity in healthcare access, and implementation barriers. Reforms improved access when they reduced direct payments, expanded pooled financing, strengthened frontline services, and targeted vulnerable populations. However, weak governance, inadequate funding, workforce shortages, medicine stock-outs, and rural-urban disparities limited effectiveness. Healthcare policy reforms can improve affordable access in LMICs when they combine financing reform, primary healthcare investment, and equity-focused implementation. Formal coverage alone is insufficient without financial protection and reliable service availability.

Keywords: Healthcare policy reform; Universal health coverage; Affordable healthcare; Low- and middle-income countries.

1. Introduction

Affordable medical services are one of the key public health and development challenges in low- and middle-income countries (LMICs). Despite the numerous LMICs that have implemented healthcare policy changes to increase the coverage of services, enhance primary healthcare and lessen financial burden, significant portions of the population still suffer delayed care, unmet health requirements, and excessive out-of-pocket spending. All of these issues have become more evident during the post-pandemic time, when the COVID-19 demonstrated the instability of health systems, the lack of financing, and the inequalities in access to the necessary services. Discussions about the policy in LMICs have consequently shifted to the question of how to construct more resilient, equal, and financially protective health systems (Kodali, 2023; Tediosi et al., 2020). Universal health coverage (UHC) has been a primary policy goal in health as it is targeted that everyone should be able to access the health services required without financial strain. In LMICs, the advances made towards UHC, however, are not uniform and they are usually limited due to limited public funding, decentralized insurance policies, ineffective governments, and inequitable distribution of health services. One of the most widespread reform strategies has been health insurance expansion, yet the gains in coverage do not necessarily result in effective access or financial coverage. As LMICs reveal, health insurance has been growing in certain settings but there are still gaps in the coverage of populations, government spending, and insuring against personal health expenditure (Hooley et al., 2022). This means that the reform of healthcare should not be evaluated based on the formal coverage alone, but the level to which it will alleviate real obstacles experienced by families.

Another dimension of access, especially in terms of affordability, is essential. Households in most LMICs still pay directly to consultations, medicines, diagnostics, transport, and inpatient care. These payments would postpone treatment, decrease compliance with care and send families into financial hardship. Protecting financial risks is thus a fundamental aspect of healthcare reform, particularly in areas where out-of-pocket expenditures are still high. In LMICs, as Rahman et al. (2022) point out, financial safeguards against out-of-pocket spending on health care will be essential to the fair movement towards UHC. Securing income in case of illness is also a relevant issue since medical payments are not the only source of health-related financial hardship. The income lost to sickness can further impoverish people and lower the capacity of households to seek prompt care (Thorpe et al., 2020). Thus, the concept of affordability must be interpreted as fairly wide as to encompass both direct healthcare expenditures as well as indirect economic effects of illness.

Another significant path by which policy reforms can enhance access is by strengthening primary healthcare (PHC). Well-developed PHC systems would help make the communities closer to the necessary services, decrease the number of visits to hospitals that are not necessary, promote prevention, and enhance continuity of care. The Lancet Global Health Commission on financing PHC believes that people-centred primary healthcare needs to be a long-term investment, with proper purchasing, community focus, and the correspondence of funding to service provision (Hanson et al., 2022). The PHC reforms have become particularly important in the post-pandemic period since health systems must address the risks of infectious diseases, the burden of chronic diseases, maternal and child health needs, and emergency preparedness on the community level. Alegre et al. (2024) believe that PHC in LMICs must be reinforced with structural changes, especially in the post-pandemic era.

Well-defined service priorities are also required in healthcare reforms. Necessary bundles of health services are common to inform resource allocation, establish entitlements and enhance equity in low-income and lower-middle-income nations. Nonetheless, their success hinges on the realistic funding, implementation capacity and compatibility with the population health requirements. Alwan et al. (2023) propose that the necessary health service packages can help the transition to UHC, but only when nations transition beyond policy design to effective delivery, financing, and monitoring. This is significant since in most LMICs benefit packages are officially described, but patients can still be short of medicines, diagnostic unavailability, ineffective referral systems, informal payments.

The issue of equity continues to be a focus when it comes to the assessment of healthcare policy reforms. Service coverage can mask cross-income, cross-rural, cross-gender, and cross social vulnerability inequalities at the national level. Hone et al. (2024) discovered that UHC progress is linked to health outcomes, but disparities are still large among LMIC populations. On the same note, recent data indicate that the extent of coverage of basic health services is directly connected with poverty rates, with disadvantaged populations commonly experiencing more obstacles to care (Guerra et al., 2024). Such results suggest that reforms need to be intentional to equity. The healthcare reforms might also increase coverage without specific measures to cover the poor, rural, informal-sector, and marginalized groups, leaving the most vulnerable groups underinsured.

The COVID-19 pandemic also revealed that the health financing policies are of the core of health system resilience. During the pandemic, countries implemented various financing options, such as increased

government expenditure, emergency acquisition, and entitlement/payment reforms. These reactions carry consequences to UHC since emergency pandemic funding should be converted to enhanced long-term frameworks (De Foo et al., 2023). Reform after the pandemic thus needs more investment but also improved governance, social protection integration, and improved accountability mechanisms (Tediosi et al., 2020). It is against this backdrop that the current article seeks to explore the healthcare policy reforms and how they affect the accessibility of affordable medical services in LMICs. The analysis is concerned with the impact of reforms regarding UHC, health financing, PHC empowerment, essential service packages, and equity policies on affordability and access. It also takes into account implementation obstacles that restrain the effectiveness of reforms. The article, based on thematic analysis of recent sources of international health policy and empirical literature on the topic, helps to comprehend in which circumstances healthcare reform can enhance equitable and affordable access within the LMICs.

2. Methodology

2.1 Research Design

The current research has assumed a qualitative documentary research design with the use of thematic analysis to understand the impact of healthcare policy reforms on the access to affordable medical services in low- and middle-income countries. It relied on secondary data collected using international health policy reports, international health expenditure databases and cross-country health indicators. Qualitative design was suitable since the objectives of the study were to explain policy trends, reform focus, affordability issues and barriers associated with access instead of testing one statistical association. The thematic analysis facilitated identification of common issues in various policy and data sources such as health financing, universal health coverage, primary healthcare strengthening, financial protection, and equity in healthcare access.

2.2 Data Sources

Six completed secondary data sources published in 2020-24 were used in the study. These sources were chosen as they offer authoritative and internationally comparable data on healthcare access, affordability, health financing, primary healthcare, and service coverage in low- and middle-income nations. The primary sources were the Tracking Universal Health Coverage: 2023 Global Monitoring Report by the World Health Organization and World Bank that offered evidence on coverage of UHC services and financial hardship (World Health Organization and World Bank, 2023). Primary healthcare reform, health system capacity, and service delivery indicators were analyzed with the help of the Primary Health Care Measurement Framework and Indicators (World Health Organization and United Nations Children's Fund, 2022).

The WHO report Global Spending on Health: Emerging from the pandemic and the WHO Global Health Expenditure Database sources were the additional health financing evidence, where the authors provided information on public health spending, out-of-pocket spending, and financial protection (World Health Organization, 2024a, 2024b). The database to support the comparative interpretation of health system and population health indicators across countries was the World Bank Health, Nutrition and Population Statistics database (World Bank, 2024). Patterns of household-level utilization of these services, maternal and child health, rural-urban differences, and wealth-based inequalities were also identified using the DHS Program STATCompiler (The DHS Program, 2024).

2.3 Inclusion and Exclusion Criteria

The research incorporated data sources which satisfied four criteria. To begin with, it was necessary that the source was published or revised during 2020-2024. Second, it must have contained information that was pertinent to healthcare access, affordability, service coverage, financial protection or health policy reform. Third, the source could not have left out data or policy evidence that applied to the low- and middle-income countries. Fourth, the source needed to be created by a well-known international organization or global health data organization.

The sources were filtered out based on the following criteria: they had to be published after 2020 and had to be about high-income countries, as well as not be opinion-based literature that had no empirical, policy, or indicators-related data. The primary data sources in this section were not peer-reviewed articles since the study had institutional reports and international databases as the foundation of thematic analysis.

2.4 Data Extraction Procedure

A selected set of sources was manually extracted using a structured thematic extraction matrix to get the data. The following categories were incorporated in the matrix: type of reform, evidence on access, evidence on affordability, indicators of financial protection, equity dimensions, implementation issues, and policy implications. In the case of database sources, special focus was given to the indicators like out-of-pocket

expenditure, government health expenditure, coverage of services, maternal health service utilization, rural-urban disparities and disparities dependent on wealth. In case of policy reports, pertinent parts were checked in order to see the reform mechanisms, health system limiting factors, and cross-country trends.

2.5 Thematic Analysis

The analysis was conducted using thematic analysis. To become familiar with the evidence, the chosen sources were first read until familiarity occurred. Second, the baseline codes were created based on recurring words like universal health coverage, public financing, insurance expansion, primary healthcare, catastrophic health expenditure, out-of-pocket payments, rural access and vulnerable populations. Third, similar codes were put together under broader themes. The last themes were: reforms in health financing, primary healthcare, strengthening, affordability, and financial protection, equity in access to healthcare services, service availability, and barriers to implementation.

This was a deductive and inductive analysis. The article research objectives, especially, the emphasis on access and affordability, directed deductive coding. Inductive coding enabled emergence of new themes in the data, particularly the post-pandemic pressures in financing, unequal implementation of the reforms and the disparity between policy coverage and effective access to the services.

2.6 Trustworthiness and Rigor

To enhance the validity of analysis, the information was sourced to numerous authoritative materials as opposed to a single report or database. Triangulation was used by aligning WHO and World Bank reports on policy evidence with the quantitative indicators in the world databases. The same extraction categories were used in all the sources to ensure consistency. Recent sources of 2020 to 2024 further enhanced the topicality of the findings to the existing healthcare policy discussions in low- and middle-income nations.

3. Results

3.1 Overview of Documentary Data Sources

They were created by thematic analysis of six institutional data sources that were published or updated in 2020 to 2024. These sources included universal health coverage, primary healthcare measurement, health expenditure, household level service access and population health indicators. The documents and databases together offered proofs on the impact of healthcare policy reforms on the access to affordable medical services in low- and middle-income nations. The sources were categorized based on their contribution to the study in terms of analysis as presented in Table 1.

Table 1: Summary of Data Sources Used for Thematic Analysis

No.	Data source	Year	Main focus	Relevance to thematic analysis
1	WHO and World Bank, <i>Tracking Universal Health Coverage: 2023 Global Monitoring Report</i>	2023	Universal health coverage, service coverage, financial hardship	Used to examine progress and gaps in access, UHC coverage, and financial protection
2	WHO and UNICEF, <i>Primary Health Care Measurement Framework and Indicators</i>	2022	Primary healthcare systems, service delivery, health system capacity	Used to assess PHC reform, availability of services, and system-level access indicators
3	WHO, <i>Global Spending on Health: Emerging from the Pandemic</i>	2024	Health expenditure trends and post-pandemic financing	Used to analyze public spending, financial sustainability, and health financing reform
4	WHO, <i>Global Health Expenditure Database</i>	2024	National health accounts and expenditure indicators	Used to examine out-of-pocket spending, government health expenditure, and external financing
5	World Bank, <i>Health, Nutrition and Population Statistics</i>	2024	Cross-country health and population indicators	Used to support comparison of health system inputs, service use, and health outcomes
6	DHS Program, <i>STATcompiler</i>	2024	Household survey indicators	Used to examine rural-urban, wealth-based, maternal health, and service utilization inequalities

The sources reviewed demonstrated that there is no single policy instrument on healthcare reform in LMICs. Rather, reforms usually include a mix of health financing reforms, expansion of universal health coverage, empowerment of primary healthcare, insurance, and public spending reforms, and special interventions towards vulnerable populations. Nevertheless, it was also shown that reforming doesn't necessarily result in affordable access unless reforms are backed by sufficient financing, service provision and implementation capacity (World

3.2 Major Themes Identified from the Data Sources

The thematic analysis generated six major themes: health financing reform, universal health coverage expansion, primary healthcare strengthening, affordability and financial protection, equity in healthcare access, and implementation barriers. These themes are summarized in Table 2.

Table 2: Major Themes Emerging from the Documentary Data

Theme	Description	Supporting data sources
Health financing reform	Reforms focused on increasing public health expenditure, reducing dependence on out-of-pocket payments, and improving pooled financing	WHO, 2024a; WHO, 2024b
Universal health coverage expansion	Policies aimed at expanding service coverage and reducing financial hardship caused by healthcare payments	WHO & World Bank, 2023
Primary healthcare strengthening	Reform efforts aimed at improving first-contact care, essential services, community-based delivery, and integrated health systems	WHO & UNICEF, 2022
Affordability and financial protection	Concerns related to household health spending, catastrophic expenditure, user fees, and medicine affordability	WHO & World Bank, 2023; WHO, 2024b
Equity in healthcare access	Differences in access by income, geography, gender, age, and rural-urban location	DHS Program, 2024; World Bank, 2024
Implementation barriers	Constraints such as inadequate financing, weak infrastructure, shortages of workers, and fragmented governance	WHO & UNICEF, 2022; WHO, 2024a

Affordability, service coverage and equity were the most common themes. These themes were present both in policy reports and in global databases, which means that the issue of healthcare availability in LMICs is influenced by non-financial and financial aspects. Although financing reform is also significant, the results indicate that affordability cannot be weighed outside of the reality of actual availability of health workers, medicines, facilities, and primary care services.

3.3 Healthcare Policy Reforms and Access to Medical Services

The review revealed that in a number of LMIC settings, healthcare policy reforms have helped to generate access especially where policy reforms are associated with universal health coverage and primary healthcare reinforcement. The UHC monitoring evidence highlighted that service coverage is a key measure of reform progress. Nevertheless, the same source also emphasized that the movement towards universal health coverage has been uneven, and that numerous countries still have gaps in providing coverage of the necessary services and financial insurance (World Health Organization and World Bank, 2023).

Primary healthcare reform became a significant avenue of enhancement of access. The WHO and UNICEF framework highlighted that robust primary healthcare frameworks need accessible health care centers, necessary medicines, health workers, proper referral, and community involvement (World Health Organization and United Nations Children Fund, 2022). This implies that any insurance-based reforms or financing reforms that are aimed at only raising the insurance cover might not be complete unless they enhance frontline service capacity. Figure 1 illustrates the thematic correlation between the policy reform and the access to health care based on the sources reviewed.

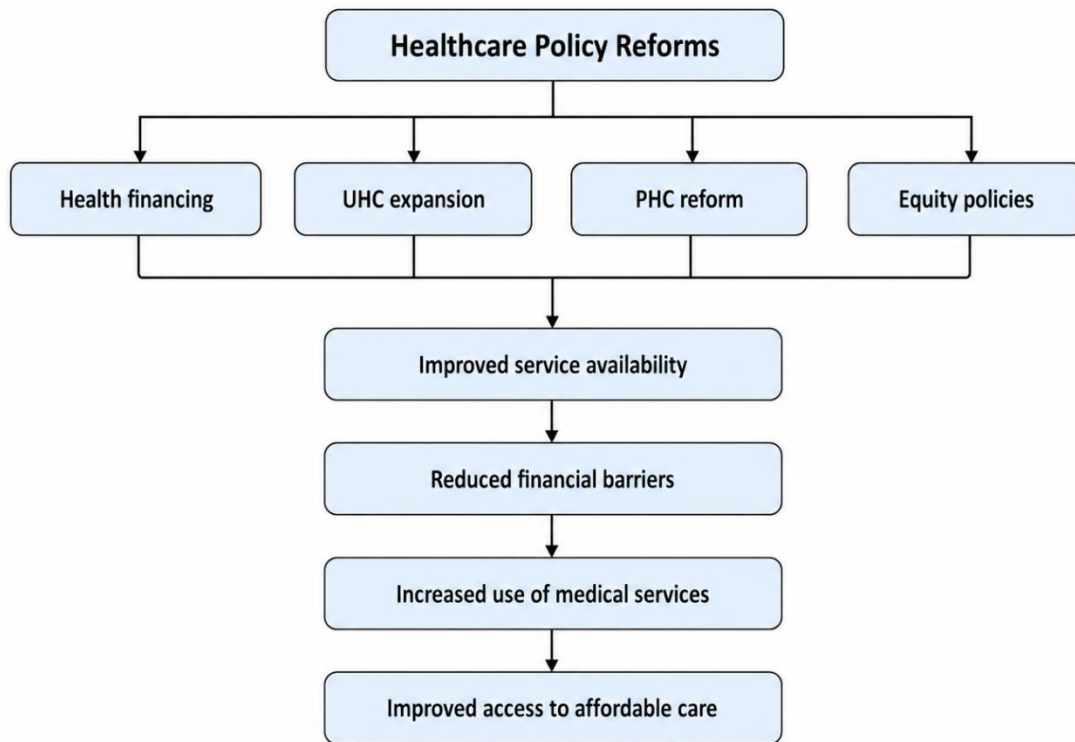


Figure 1: Thematic Pathway Linking Healthcare Policy Reforms to Access

Policymaking as depicted in Figure 1 has several channels of impact on access. Direct payment barriers can be lowered with health financing reforms, and primary healthcare reforms can enhance access to services. Policies that are equity-oriented can also assist in access by the rural and poor and vulnerable groups. But these pathways require the power of implementation.

3.4 Influence of Reforms on Affordability and Financial Protection

One of the most powerful themes studied was affordability. The WHO and World Bank UHC report noted that financial hardship was one of the key obstacles to attaining universal health coverage, particularly as households are forced to overburden themselves with out-of-pocket payments to seek medical services (World Health Organization and World Bank, 2023). Likewise, the WHO Global Health Expenditure Database also offers indicators that enable comparing out-of-pocket expenditure, government health expenditure, and external health financing between countries (World Health Organization, 2024b).

The results indicate that reforms are more prone to enhance affordability by cutting down on direct user payments and enhancing prepaid or publicly funded systems. Such mechanisms will consist of tax-funded health services, subsidized insurance, national health insurance schemes, and special exemptions of vulnerable groups. Yet affordability benefits can be minimal where the benefit packages are small, the medicines are not in accessible facilities, or when the patients have to get private care even with formal cover. Table 3 sums up the impact of the key areas of reform on affordability and access.

Table 3: Influence of Healthcare Policy Reforms on Access and Affordability

Reform area	Influence on access	Influence on affordability	Key limitation identified
Universal health coverage reforms	Expands formal entitlement to essential services	Can reduce financial hardship if coverage is comprehensive	Coverage may be incomplete or unevenly implemented
National health insurance schemes	Improves access for enrolled populations	Reduces direct payment at point of care	Informal workers and poor households may remain excluded
Primary healthcare strengthening	Improves first-contact care and local service access	Reduces need for expensive hospital-based care	Requires sustained investment in workforce and infrastructure

Public health expenditure reform	Expands publicly funded services	Reduces dependence on household out-of-pocket spending	Fiscal constraints may limit scale and continuity
Essential medicines and service package reforms	Improves availability of basic treatment	Reduces private spending on medicines and diagnostics	Stock-outs and procurement weaknesses may persist
Equity-targeted policies	Improves access for rural, poor, women, children, and marginalized groups	Can reduce unequal financial burden	Targeting systems may be administratively weak

The findings imply that affordability is not realized by simply proclaiming healthcare reform. It relies on the reform altering the reality of the cost burden on households. Out-of-pocket payments continue to be a challenge to affordable care in many LMICs, especially when it comes to outpatient care, diagnostics, medicines, and chronic disease management (World Health Organization, 2024a; World Health Organization, 2024b).

3.5 Equity Patterns in Access to Medical Services

One key issue that occurred within the data sources was equity. The evidence presented by the World Bank health indicators and DHS STATCompiler shows that the population access to medical services differs with income groups, rural and urban groups, and demographic characteristics (DHS Program, 2024; World Bank, 2024). Such sources are especially significant as they can be used to examine whether the reforms are targeting the most affected populations by healthcare barriers.

The thematic analysis revealed that policy reforms can enhance the national coverage indicators and leave inequalities that remain large. As an illustration, the rural populations might be underserved due to distance to facilities, inadequate transport, shortages of health workers, and poor infrastructure. On the same note, less affluent families might still defer treatment when such services demand informal payments or when the necessary drugs are not stocked at state hospitals. Women, children, elderly persons and individuals in remote communities may also feel more vulnerable in case the policy reforms lack supportive implementation mechanisms. Figure 2 shows the key equity barriers as related to the affordable access of healthcare.

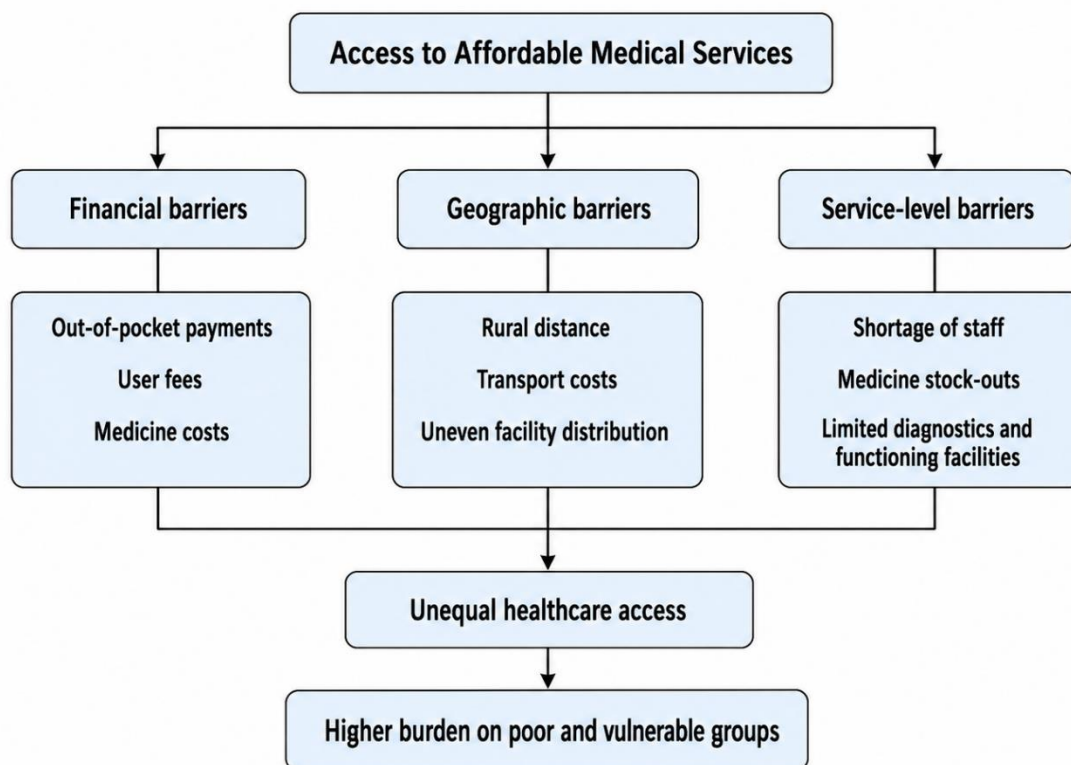


Figure 2: Equity Barriers Affecting Access to Affordable Medical Services

As Figure 2 suggests, there are overlapping health care access barriers. Although reforms are associated with lower formal user fees, indirect costs including transportation, lost wages, purchasing personal medicine and

diagnostic costs can still decrease effective access. As such, equity-based reform must not just be insurance expansion. It also demands full availability of service delivery and safeguarding against the indirect expenses.

3.6 Implementation Barriers Limiting Reform Effectiveness

The discussion revealed that a number of implementation barriers exist that would restrict the impact of healthcare policy reforms on affordable access. Poor and unsustainable funding was the first obstacle. The evidence of WHO expenditure indicates that the health financing is a significant factor of the capacity of the system, especially during the post-pandemic period, when most countries were under fiscal strain and had competing claims to public spending (World Health Organization, 2024a).

The second hindrance was poor primary healthcare facilities. The WHO and UNICEF primary healthcare frameworks point to the need to not only commit to policy but also provide inputs to effective PHC including the availability of workforce, medicines, governance systems, information systems, and community orientation (World Health Organization and United Nations Children's Fund, 2022). In areas where these inputs are low, reforms might increase formal coverage with no change in practical access.

Fragmented governance was the third impediment. In most LMICs, service delivery can be split between the government providers, the private providers, donor-funded agencies, insurance providers, and the decentralized authorities. Such fragmentation may undermine accountability, efficiency, and complicate the process of ensuring uniform access across the regions.

The fourth impediment was population coverage to effective coverage. A reform can be officially applicable to a population, yet it may be unable to receive timely, affordable, and quality care. This difference is significant since access does not always equal policy coverage. Good access implies services that are acceptable, affordable, quality and available.

3.7 Summary of Key Results

In general, thematic analysis demonstrated that healthcare policy reforms have the potential to enhance access to affordable medical services in LMICs, yet their impact relies on funding, the capacity to implement reforms, service provision, and equity orientation. It is evident that universal health coverage expansion, greater investment in primary healthcare, and financial protection mechanisms should be combined to form a strong reform (World Health Organization and World Bank, 2023; World Health Organization and United Nations Children's Fund, 2022; World Health Organization, 2024a), which is the strongest evidence of the reviewed sources.

The results also indicate that affordability is still a critical issue with households still paying out of pocket on medicines, diagnostics, consultations and hospital services. Thus, more reforms to decrease out-of-pocket costs and increase pooled financing can lead to better access to affordability (World Health Organization, 2024b). Lastly, equity is always an issue. Household-level and cross-country indicators have provided evidence that without a policy choice to target social, geographic, and economic barriers, the poor, rural, and vulnerable population may not benefit as much as reforms can offer (DHS Program, 2024; World Bank, 2024).

4. Discussion

The findings suggest that healthcare policy reforms in low-and middle-income countries may enhance access to the affordable services but the effectiveness of these reforms depends on the interaction between financing, governance, the availability of services, and equity-oriented reforms. The thematic results indicated that reforms surrounding universal health coverage, strengthening primary healthcare, financing by the government, and equity policies have been most effective when combined and not applied as standalone interventions. This serves to support the greater thesis that access to healthcare is not solely based on the formal presence of a reform, but whether or not the reform lowers financial obstacles, enhances service preparedness, and expands to disadvantaged populations.

The findings also revealed that affordability is a key issue in LMIC health systems. In those jurisdictions where nations have established insurance schemes or universal health coverage policies, households still may be subjected to out-of-pocket payments on medicines, diagnostics, transport, informal fees, and care in the private sector. This observation is in line with the recent evidence that out-of-pocket health spending is still closely linked with the health system financing institutions, income, and disparities in shared funding systems (Sofi & Yasmin, 2024). Thus, reforms that increase entitlement without decreasing direct household payments can be found to have small impacts on real affordability.

One of the key conclusions made in the results section was that health financing reforms impact affordability primarily by risk pooling, public financing, and decreasing out-of-pocket spending. Nevertheless, the analysis also revealed that insurances expansion is not necessarily equitable access generating. In most LMICs, insurance is not evenly spread among the income groups, employment, and place of residence. In their research

on 36 sub-Saharan African countries, Barasa et al. (2021) discovered that inequality in the coverage of health insurance is significant, with the poor and informally employed usually less likely to be insured. The rationale behind this is that informal sectors in many LMICs are vast, and it is not an easy task to make a contribution-based insurance model a fair policy.

The results are also consistent with the experience of social health insurance in Kenya, where insurance reforms have led to some progress on the way to universal health coverage, but have also suffered losses regarding equity, enrollment, financial sustainability, and population coverage (Nungo et al., 2024). This implies that social health insurance can only be able to provide affordable access when it is modeled with high subsidies to poor households, good enrollment systems as well as defined packages of benefits. Otherwise, insurance systems can advantage formal-sector populations and urban populations more than rural and low-income.

The findings discovered weak governance, poor service delivery, insufficient accountability, and lack of implementation capacity as some of the greatest hindrances to reform success. George et al. (2023) substantiate these findings, highlighting that leadership, accountability, regulation, transparency, and coordination are the ways in which health system governance can influence healthcare quality in LMICs. Governance is particularly significant since it is common that reforms involve numerous institutions to collaborate, such as ministries of health, insurance agencies, local governments, public providers, private providers, and donor-funded programs. The findings imply that policy change may not succeed in the implementation phase in cases where the governance systems are weak. Suppose, however, that access is not enhanced by insurance expansion due to delays in provider payment systems, lack of facility autonomy, ambiguous reimbursement policies, or corruption undermining trust by the government. Correspondingly, primary healthcare reforms can be merely symbolic unless the staffing, medicine supply chains, oversight, and data systems are reinforced. Therefore, the problem of governance is not an administrative matter. It is a fundamental predictor of reforms yielding any improvements in access, affordability, and quality.

The findings indicated that a primary healthcare strengthening is one of the fundamental routes in which access is enhanced by reforms. The reason behind this is that PHC systems offer first-contact care, preventive care, chronic diseases, maternal and child health services, and referral coordination. Nevertheless, the results also revealed that service availability is still unequal particularly in the rural and underserved regions. Zezai et al. (2024) also reported the barriers to the reinforcement of primary health systems to deliver person-centred multimorbid care in LMICs, such as workforce limitations, disconnected services, poor continuity of care, and inadequate inter-level health system integration.

This is especially applicable since LMICs are becoming more exposed to a dual burden of infectious diseases and chronic non-communicable diseases. Multimorbidity is increasing, and more than episodic care is needed to offer affordable care. It needs long-term, collaborative and person-focused services. The results consequently indicate that PHC capacity, chronic care integration, availability of essential medicines, and referral systems should be the focus of reforms. In the absence of such factors, patients might still be tempted to stay with hospital-based or personal care that can raise the spending of the household and decrease the affordability.

Even though barriers to rural access are frequently discussed in the context of LMIC policymaking, the findings also highlight the significance of urban poverty. The poor urban population, particularly slum dwellers, can be physically near the health facilities, yet have significant economic constraints, inadequate living standards, informal jobs and poor access to quality public services. Teixeira de Siqueira-Filha et al. (2021) emphasize the economic cost related to the search of healthcare among slum residents, direct costs, indirect costs, and opportunity costs. This confirms the results that geographic proximity is not necessarily the same as effective access.

Thus, the equity-based reforms should take into consideration rural and urban deprivation. The national coverage indicators may fail to capture intra-urban disparities and the care under-the-radar expenses of care among the informal settlements. The reform needs focused funding, the availability of PHC services in under-served cities, and the shield against non-direct expenses like transportation, lost income, and re-hospitalization.

The results also indicate that improved financing mechanisms need quality information about costs, payments and service utilization. Digital technologies can assist in health financing through enhancing the enrollment, claims management, tracking payments, detecting fraud, and identifying qualified beneficiaries. According to Pioch et al. (2024), digital technologies are becoming more applicable to health financing in LMICs, especially where the systems have to enhance the efficiency of administration and financial security. Nevertheless, digital financing cannot be regarded as a one-size-fits-all solution. It requires digital infrastructure, data governance, digital access of less digitally accessible populations, and anti-exclusion safeguards to be effective.

Another crucial implementation issue is cost accounting. Guinness et al. (2022) present the argument that accounting of healthcare costs may aid in pricing and reimbursement in LMICs. This is directly applicable to the findings since ineffective reimbursement rates may undermine the participation of the providers, promote

informal payments, or compromise the quality of the services. Realistic benefit plans, fair reimbursement prices, and a more efficient allocation of resources can be designed by the governments with the help of the accurate cost accounting.

There are four key policy implications in the discussion. To begin with, LMICs are advised to enhance pooled and publicly funded programmes to cut down on direct household payments. Second, the insurance reforms should have equity safeguards, particularly of poor, informal-sector, rural and urban-slum populations. Third, the investment in primary healthcare must be approached as the base of affordable care, especially chronic and multimorbid care. Fourth, governance, digital financing systems, and cost accounting would be enhanced to enhance implementation, accountability, and sustainability.

In general, the results validate that healthcare policy reforms can enhance access to affordable medical services in LMICs, but reforms should go beyond the formal coverage expansion. The real test of success lies in the reforms alleviating financial distress, enhancing primary care, resolving inequality and establishing governance structures that can transform the policy into real services delivery.

5. Conclusion

This paper looked into the impact of healthcare policy changes on affordability of medical services in low and middle-income nations. Judging by the thematic analysis of recent international health policy reports, expenditure databases, and household-based health indicators, the results indicate that reforms may enhance access provided they entail universal health coverage expansion, enhanced public financing, strengthening of primary healthcare, and equity-oriented implementation. Nevertheless, the research also demonstrates that policy reform has no impact without decreasing the real financial and practical barriers that the households encounter. Affordability is one of the greatest problems in most LMICs since out-of-pocket payments, the cost of medicine, the cost of diagnosis, the cost of transport, and informal payments still restrict the utilization of healthcare. The growth of insurance and UHC policies can result in better coverage in form, but the impact is not even when poor, rural, informal-sector, and urban-slum populations are not covered or sufficiently insured. On the same note, access is not only limited to financial entitlement but also to the availability of health workers, medicines, working facilities and good referral systems. The research comes to the conclusion that integrated reforms are the most effective healthcare reforms. Reform funding should be connected to investing in primary healthcare, stable governance, equitable reimbursement policies, electronic financial abilities, and special safeguards on vulnerable populations. In the absence of these conditions of support, reforms can strengthen inequalities or provide formal coverage lacking substantive access. Hence, LMICs need to focus on publicly funded and equity-based health systems that would decrease household spending and enhancing service access and quality. Further study is needed on country-specific reform outcomes in longitudinal data, evidence of implementation, and comparative analysis to establish which policy combination yields the best gains in affordable access to healthcare.

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