

Original Research Article

A community based cross-sectional study on the health system responsiveness in the urban field practicing area of tertiary health care centre, Hyderabad

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Received: 14 December 2018

Revised: 17 January 2019

Accepted: 18 January 2019

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ABSTRACT

Background: According to WHO, responsiveness is an important goal of the health system, in addition to the two predominant goals of improving health and fairness of financing. Responsiveness includes non-medical aspects of health care. As the progress to universal health coverage is gaining pace, the present study has attempted to study the domains of responsiveness in the government and private health services and health care providers.

Methods: A community based cross-sectional study for a period of 3 months in the households of the urban field practising area. Sampling technique was simple random sampling. Assuming the prevalence of 50% and allowable error of 5%, 400 households were surveyed. KISH table method was used at household level. Study tool was World Health Survey responsiveness module questionnaire for the eight responsiveness domains-prompt attention, dignity, communication, autonomy, confidentiality, choice, quality of basic facilities and social support (for inpatients).

Results: The mean age (yrs) of the study subjects is 46.078 ± 13.998 . 68.25% (273) were males. 31.75% (127) were females. 46.25% (185) were using government services and 53.75% (215) were using private services. The mean waiting time (min) in the public health facilities was 135.2 ± 111.2 which was more than private facilities, 62.4 ± 40.8 .

Conclusions: All the responsiveness domains (except confidentiality) were found to be positively associated ($p < 0.05$) with the government health services. Proportion of people rating the responsiveness domains from most important to the least important showed prompt attention (52%) and dignity (30%) as the most important domains.

Keywords: Health system, Responsiveness, Community based study, Public health services, Private health sector

INTRODUCTION

The World Health Organisation's new framework for health system performance assessment has health, responsiveness and fairness of financing as the three goals of the health system (Murray and Frenk, 1999). Inequalities in distribution may take the form of social, economic, demographic and other types of inequalities. These issues are all important. The WHO health systems performance framework considers fairness a primary goal of health systems.^{1,2} Maximising social welfare depends

on improving distribution, as well as increasing the average level of responsiveness.^{1,3}

Responsiveness in the context of a system can be defined as the outcome that can be achieved when institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals.¹

The concept of responsiveness has been consisted of eight domains according to WHO framework: (1) respect

for the dignity of persons; (2) autonomy to participate in health related decisions; (3) confidentiality and trust; (4) prompt attention; (5) adequate quality of basic amenities; (6) clear communication; (7) access to social support networks (only for inpatients); and (8) choice of health care providers (Gostin et al). The intrinsic goal of responsiveness is important because it deals with basic Human rights of individuals, reflects a positive orientation to those the system is designed to serve and holds promise to make health improvement among population.^{2,3} According to the WHO study on the Responsiveness in 2003 among key informants, the public health sector responsiveness was worse than the private sector responsiveness. The discrimination on the socio-economic and urban-rural basis was also prevalent. Among the top best performing countries with respect to responsiveness were United States of America, Switzerland, and other countries with high health expenditure per capita. The South East Asia region only had Thailand in the top quartile.⁴ According to a study by Malhotra et al, there existed socio-economic disparities in all domains of health system responsiveness in India.⁵ Prompt attention and quality of basic amenities received low score for outpatient services and the type of centres was significantly related to responsiveness.⁵ As the progress to universal health coverage (SDG 3.8) is gaining pace, the present study has attempted to study the domains of responsiveness in the government and private health services and health care providers.

Objectives

- To study the socio-demographic factors in the responsiveness of outpatient and inpatient care.
- To study the association of the responsiveness domains and utilisation of public and private health services.

METHODS

Study design

A community based cross-sectional study.

Study period

3 months (August-October, 2018).

Study population

Households in the urban field practising area.

Sampling technique

Simple random sampling was used. Assuming the prevalence of 50% and allowable error of 5%, 400 households were surveyed. KISH table method was used at household level (Figure 1).

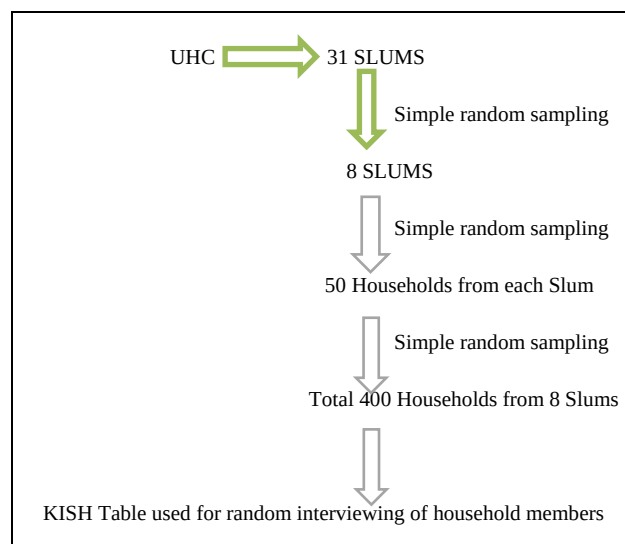


Figure 1: Flow chart showing the sampling technique employed for the study.

Study tool

World health survey responsiveness module questionnaire for the eight responsiveness domains-prompt attention, dignity, communication, autonomy, confidentiality, choice, quality of basic facilities and social support (for inpatients).

Inclusion criteria

The households which utilised the outpatient or inpatient services in the past 12 months for self or for family members. Informed consent taken from the households.

Exclusion criteria

The households who had not utilized the outpatient or inpatient health services in the past 12 months for self or for family members, non-cooperative and the households refusing to participate in the study were excluded.

The data analysis was done using Excel and EpiInfo 7.2.2.

RESULTS

The respondents were the households who utilized the outpatient or inpatient health services in the past 12 months for self or for family members. In the present study, all 400 (100%) households reported outpatient service utilization and out of them, 184 (46%) utilised inpatient services also.

The study showed that out of 400 households, 185 (46.25%) utilized the government health facilities and 215 (53.75%) utilized the private health facilities (Table 1). Among those households utilizing public health services, 100 (54%) were using urban primary health care

(UHC) and 85 (46%) were using tertiary health care facilities (Figure 2).

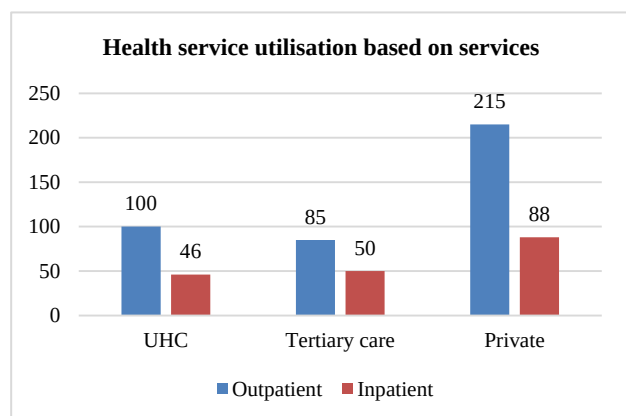


Figure 2: Bar diagram for the representation of health care utilization based on outpatient and inpatient services (n=400).

Table 1: Sociodemographic factors and the health care utilization (n=400).

Demographics	Total (%)	UHC (%)	Tertiary centre (%)	Private facility (%)
Gender				
Males	273 (68.3)	68 (24.9)	55 (20.2)	150 (54.9)
Females	127 (31.7)	32 (25)	30 (24)	65 (51)
Age group (yrs)				
21-30	76 (19)	10 (13.2)	26 (34.2)	40 (52.6)
31-40	90 (22.5)	32 (36)	10 (11)	48 (53)
41-50	102 (25.5)	30 (29.3)	17 (16.7)	55 (54)
51-60	74 (18.5)	18 (24.3)	18 (24.3)	38 (51.4)
>60	58 (14.5)	10 (17)	14 (24)	34 (59)
SES (Modified Kuppaswamy)				
Upper middle	16 (4)	3 (19)	2 (12.5)	11 (68.5)
Lower middle	170 (42.5)	43 (25)	30 (18)	97 (57)
Upper lower	176 (44)	42 (24)	44 (25)	90 (51)
Lower	38 (9.5)	12 (32)	9 (24)	17 (45)
Total family members				
1-5	256 (63.5)	69 (27)	46 (18)	141 (55)
6-10	118 (30)	27 (23)	29 (24)	62 (53)
>10	26 (6.5)	4 (15.4)	10 (38.5)	12 (46.1)
Literacy status				
Illiterate	78 (19.5)	16 (21)	23 (29)	39 (50)
Literate	322 (80.5)	84 (26)	62 (19.3)	176 (54.7)

The mean waiting time (min) in the public health facilities was 135.2 ± 111.2 which was more than private facilities, 62.4 ± 40.8 . The mean waiting time (min) in the UHC was 63.8 ± 48.3 and in the tertiary health centre was 217.6 ± 105.1 .

A binary variable for the domains of responsiveness was used as “good” and “bad” and Chi-square test was done and compared the socio-demographic characteristics of the respondents such as age group, gender, literacy status, socio-economic status and total family members. No

273 (68.3%) were males and 127 (31.7%) were females. The mean age (yrs) of males is 46.08 ± 13.9 and in females is 45.9 ± 13.9 .

123 (45%) of males were utilizing public health services and 150 (55%) males were using private services. Among females, 62 (49%) were using public health services and 65 (51%) were using private facilities.

Among the households, 16 (4%) were upper middle class, 170 (42.5%) belonged to lower middle class, 176 (44%) to upper lower class and 38 (9.5%) to lower class, according to modified Kuppaswamy classification.⁶ (Table 2). The study showed that 28 (7%) could not utilize the health services despite they felt the need to see the health care providers as they could not afford.

No discrimination was reported by the households while seeking healthcare.

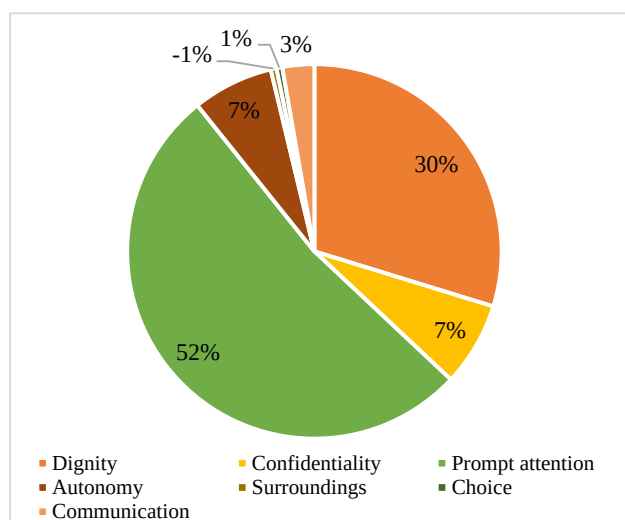
significance was found in socio-demographic factors and responsiveness domains.

Domains of responsiveness and type of health facilities showed significance ($p < 0.05$) in all domains except confidentiality (Table 3).

Proportion of people rating the responsiveness domains from most important to the least important showed prompt attention (52%) and dignity (30%) as the most important domains (Figure 3).

Table 2: Health system responsiveness domains and health care facilities (n=400).

Health system responsiveness domains	Prompt attention (%)		Dignity (%)		Communication (%)		Autonomy (%)	
Type of health facility	Good	Bad	Good	Bad	Good	Bad	Good	Bad
Government	81 (44)	104 (56)	81 (44)	104 (56)	125 (68)	60 (32)	133 (72)	52 (28)
Private	171 (80)	44 (20)	171 (80)	44 (20)	206 (96)	9 (4)	210 (98)	5 (2)
P value	<0.000001		<0.000001		<0.0000001		<0.0000001	
Chi square	54.52		54.52		55.58		54.09	
Urban health centre	68 (68)	32 (32)	80 (80)	20 (20)	79 (79)	21 (21)	82 (82)	18 (18)
Tertiary health centre	13 (15)	72 (85)	47 (55)	38 (45)	46 (54)	39 (46)	51 (60)	34 (40)
P value; Chi square	<0.0000001; 51.85		<0.0002; 13.03		<0.00016; 12.98		<0.0009; 11.00	
Health system responsiveness domains	Choice (%)		Quality of basic amenities (%)		Confidentiality (%)		Social support (%) (only for in-patient, n=184)	
Type of health facility	Good	Bad	Good	Bad	Good	Bad	Good	Bad
Government	150 (81)	35 (19)	97 (52)	88 (48)	173 (93.5)	12 (6.5)	64 (67)	32 (33)
Private	210 (98)	5 (2)	191 (89)	24 (11)	213 (99)	1 (1)	77 (88)	11 (12)
P value	<0.0000001		<0.0000001				<0.0008	
Chi square	30.42		65.37				11.13	
Urban health centre	93 (93)	7 (7)	66 (66)	34 (34)	96 (96)	4 (4)	29 (63)	17 (37)
Tertiary health centre	57 (67)	28 (33)	31 (36)	54 (64)	77 (91)	8 (9)	35 (70)	15 (30)
P value; Chi square	<0.000008; 20.16		<0.00003; 16.06		P=insignificant		P=insignificant	

**Figure 3: Pie-diagram showing the proportion of people rated responsiveness domains as most to least important.**

DISCUSSION

Except for one article on socio-economic disparities in the health system responsiveness in 2012 in India⁵, there were no such studies conducted on the health system responsiveness in India. The importance of responsiveness is implicated in the utilisation of the public health facilities, reduced out of pocket expenditure, reduced financial burden on poor or average income households and return to the universal health coverage.

According to the WHO multi-country survey study of Health and Health system responsiveness in 2001, 10% (n=803) of surveyed population were not able to utilize health services because of non-affordability.⁴ The present study showed that 28 (7%) could not utilize the health services despite they felt the need to see the health care providers as they could not afford. As health is human right, the non-affordability of the health services should be given importance by improving the facilities at the public health services and by the social security measures.

The study by Malhotra et al concluded that socio-economic disparities exist in the health system responsiveness in India, irrespective of the type of health facility used.⁵ The same finding was reported in a study by Maria et al.⁷ No significance was found in socio-demographic factors and responsiveness domains in the present study. This is in accordance with the study by Rashidan et al.² The reason might be the improvement in the public health services' responsiveness and improved access to health services. The other reason might be the usage of the nearby health services by the people which accounted for the easy accessibility in terms of time, money and distance.

The significance in responsiveness domains in the public health services compared to private health services is a welcoming sign. But at the same time, it is to be taken care of that the urban health centre performance is significant than the tertiary care facility.

The improvement of health manpower at the tertiary hospitals meeting the patients's needs can upgrade the public facilities.

Prompt attention and dignity were considered the most important components of responsiveness in the present study. This is in harmony with the study by Rashidan et al.² The study of Bazzaz et al also showed the same findings.⁸

The main strength of the study is that it is a community based cross-sectional study at the household level and is providing a basic view of how the responsiveness components are in the public and private facilities.

Limitations

- The limitation of the study include that it didn't see the duration and chronicity of the illness for which the individuals attended the health facilities.
- It took only the binary component (good or bad) for the responsiveness domains.
- The present study considered all the health providers that the individual came in contact, not only physicians.

CONCLUSION

Health system responsiveness is a very important goal of the health system. It needs to be emphasized by the health system. The good behaviour of the health care providers, the decreased long queues for consultation and laboratory tests, the interaction with the patients and their attenders can all be improved by increasing the health care staff and thereby decreasing their workload.

ACKNOWLEDGEMENTS

The study would not be done without thanking the respondent households of the urban field practicing area for their generous and patient cooperation.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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Cite this article as: Vemuri JLN, Kiranmai B, Cheedarla V, Laxmi SB. A community based cross-sectional study on the health system responsiveness in the urban field practicing area of tertiary health care centre, Hyderabad. Int J Community Med Public Health 2019;6:860-4.