

Original Research Article

A study regarding availability and utilization of services of the government health facility in village Nagkalan, district Amritsar, Punjab

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ABSTRACT

Background: Health care expenses induced impoverishment in the poverty stricken strata of rural India is a major issue. The government of India has come up with various services in public health facilities, but there are various factors which curtail the utilization of available services and people have to visit some private health facility. The present study deals with the extent of utilization of services of government health facility and the factors impeding the utilization.

Methods: The present cross sectional study was conducted in village Nagkalan, district Amritsar, where the eldest adult members present in the house at the time of the visit, and are interviewed using a semi-structured and predesigned questionnaire. A total of 1123 families were included in the final analysis. Data was compiled, analysed and valid conclusions drawn.

Results: Almost all the respondents were aware about the existence of subsidiary health centre in the village. However, out of those who were aware, 40.8% never visited the centre. Utilization was more in the lower socio economic status. Immunization services followed by treatment for common ailments constituted the top two reasons for visiting the centre. Out of those visiting the centre, 80.7% were not satisfied with the current timings of the centre; only 20.2% were attended by the doctor and 33.3% reported that the prescribed medicines were never available at the centre.

Conclusions: Regular supply of prescribed medicines, availability of the doctor and appropriate timings are critical for utilization of health care services at the government health facility.

Keywords: Availability, Utilization, Government health facility, Rural India

INTRODUCTION

Health is central to human well-being and development. It also makes an important contribution to economic progress, as healthy populations live longer and are more productive. Health has impact on development and poverty reduction, and conversely, development policies can contribute to the achievement of health goals.

Therefore, health must be prioritized in particular, to achieve social and economic development.¹ The availability, accessibility and equity in distribution of basic health services must be ensured to attain the goal of 'health for all'.

The health planners in India had visualized the primary health centres and its sub-centres as the proper

infrastructure for providing health services to the rural population and subsequently over the decades the health service organization and infrastructure underwent extensive changes and expansion in their services. The five year plans were laid down by the planning commission of India, which mainly focused on the development of primary health care sector.² The joint World Health Organization and United Nations International Conference on Primary Health Care, which was held on the twelfth of September in 1978 at Alma-Ata (USSR), highlighted that the most important worldwide social goal is the attainment of highest possible level of health, which could be achieved only when the preventive, promotive and curative services become accessible and equally distributed between all the people irrespective of their socio-economic status.³

Thereafter, the Ministry of Health and Family Welfare, government of India, evolved a national health policy in 1983 as India's first national health policy which focused on promotive, preventive and rehabilitative aspects of health care, and stressed the need of establishing comprehensive primary health care services to reach the population even in the remote areas of the country.⁴ Launch of the National Rural Health Mission (NRHM) in 2005, now under National Health Mission to address the health needs of under-served rural areas, was a major step towards the adoption of these strategies.⁵

India has since then made significant advances in improving health of its populations for over more than a decade, reducing the gaps between rural and urban areas, and between the rich and the poor. However, huge disparities still remain, and access to healthcare in rural areas continues to pose a significant challenge. There is a growing recognition that India needs to build a strong comprehensive primary healthcare system to accomplish any further advancements in the overall health status of its populations, and to reduce any disparities.⁶

According to the report of situational analysis- backdrop to national health policy 2017, there is high degree of inequity in the access to health care services and health outcomes that exists in India, between and within the states and in the vulnerable groups. Even in states where overall infant and maternal mortality are improving, marginalized communities and poorer sections of the population, continue to perform poorly. Also, over 70% of ailing population in rural areas and almost 80% in urban areas utilize private facilities, adding to their out of pocket expenditures.⁷

The present study was proposed because 68% of the total population lives in rural India; which makes it imperative to focus on the health of rural population. The extent of the utilization of government health centers in the rural parts, which may not be optimal, and the factors impeding the utilization of health care services will have to be looked into; because the only way to decrease poverty, induced by healthcare expenditures, is to

strengthen the public healthcare system by making the services available and accessible to all and by promoting the utilization of existing health services.

METHODS

This cross-sectional study was conducted in village Nagkalan, the rural field practice area of department of community medicine, Government Medical College, Amritsar, extending from the period of 1st January 2017 to 31st December 2017. The study commenced after taking permission from the institutional ethics committee, Government Medical College, Amritsar. A list of all the families residing in the village was made which came out to be 1171, out of which 29 families were not available (their houses were found to be permanently locked) and 19 families were non cooperative. These were excluded and the remaining 1123 families were interviewed and included in the final analysis.

After explaining the purpose of the study; written informed consent was obtained from the respondents. The eldest adult member of the family present in the house at the time of the visit served as the respondent and interviewed using a semi-structured and predesigned questionnaire at their place of residence, regarding availability and utilization of services of the government health facility in the village, which is a subsidiary health centre. In case if no adult member was present in the house at the time of the visit, repeat visit was made. All questions were asked in the vernacular language of the respondent. The socio-economic status of the family was assessed using the modified Kuppuswamy scale (2017).

Confidentiality of the respondents was ensured. The data thus collected was compiled and analyzed statistically by using computer and available software like Microsoft Excel. Results were drawn and chi square was used as test of significance.

RESULTS

In the present study, 530 (47.3%) of the total respondents were in the age group of 35-54 years, 201 (17.9%) in the age group of 55-64 years, 193 (17.2%) in the age group of 25-34 years, 138 (12.3%) in the age group of 65 years and above and only 60 (5.3%) in the age group of 18-24 years. Majority (77.8%) of the male respondents were above the age of 45 years whereas majorities (65.2%) of female respondents were in the age group of 35-64 years, mainly because of the availability of respondents belonging to these age groups at the time of the interview. Also, majority of the respondents were females (82.7%) and only 194 (17.3%) were males (Table 1).

Majority of the respondents (98.8%) knew about the nearest government health facility in the village. The government health facility present in village Nagkalan is the subsidiary health centre (SHC) (Table 2). Out of those who were aware about the government health centre in

the village, 657 (59.2%) responded that one or more of their family members had ever visited the centre whereas 453 families (40.8%) had never visited the health centre (Table 3). Distribution of families visiting the government health centre according to their socio-economic status revealed that the utilization of services at the centre was more in the lower socio-economic group (out of those visiting the centre, 78.1% belonged to the lower socio-economic status), which was also statistically significant (Table 4).

Table 1: Distribution of respondents according to age and sex (n=1123).

Age distribution (years)	Male (%)	Female (%)	Total (%)
18-24	7 (3.6)	53 (5.7)	60 (5.3)
25-34	14 (7.2)	179 (19.3)	193 (17.2)
35-44	22 (11.3)	259 (27.9)	281 (25.0)
45-54	42 (21.6)	208 (22.4)	250 (22.3)
55-64	57 (29.4)	144 (15.5)	201 (17.9)
≥65	52 (26.8)	86 (9.3)	138 (12.3)
Total	194 (100)	929 (100)	1123 (100)

Table 2: Distribution of respondents regarding awareness about the existence of health facility in the village (n=1123).

Response	Number	Percentage (%)
Yes	1110	98.8
No	13	1.2
Total	1123	100

Table 3: Distribution of respondents whether anyone from the family ever visited the subsidiary health centre (n=1110).

Response	Number	Percentage (%)
Yes	657	59.2
No	453	40.8
Total	1110	100

Table 4: Distribution of families regarding their visit to the subsidiary health centre according to their socio-economic status (n=1110).

Response	Lower (%)	Middle and upper (%)	Total (%)
Visit	513 (78.1)	144 (21.9)	657 (100)
Did not visit	227 (50.1)	226 (49.9)	453 (100)
Total	740	370	1110

Chi square 94.4, significant at $p < 0.05$.

Out of those who visited the centre, 97.3%, 96.8% and 82.3% were aware about the immunization, treatment of minor ailments and antenatal services respectively,

available at the subsidiary health centre. When asked about the services available by them, majority of them visited the centre for immunization services (84.0%), followed by treatment for minor ailments (39.7%) and only 31.7% utilized the antenatal services (Table 5).

Table 5: Distribution of respondents regarding awareness about the services available and their utilization at the subsidiary health centre (multiple response permitted) (n=657).

Services available	Number	%
Immunization	639	97.3
Treatment for common ailments	636	96.8
Antenatal	541	82.3
Postnatal	81	12.3
Any other	31	4.7
Immunization	552	84.0
Treatment for common ailments	261	39.7
Antenatal	208	31.7
Postnatal	57	8.7
Any other	18	2.7

In 133 respondents (20.2%), out of 657 who ever visited the centre; reported that they were attended by the doctor upon their visit to the centre while 79.8% were attended either by the multipurpose health worker (female) or the pharmacist (Table 6). Also, out of those who visited the centre, majority (80.7%) were not satisfied regarding the timings of the centre, which was from 8 am to 2 pm and therefore its services were not available to them during the evening hours (Figure 1). It was further observed that out of those who visited, 33.3% reported that the prescribed medicines were never available at the centre while 66.7% reported that they were sometimes available. However none of them reported that the medicines were always available (Table 7).

Table 6: Distribution of families according to health personnel attending them (n=657).

Response	Number	Percentage
Doctor	133	20.2
Health worker	524	79.8
Total	657	100

Table 7: Distribution on the basis of availability of prescribed medicines at the centre (n=657).

Response	Number	Percentage
Sometimes available	438	66.7
Never	219	33.3
Total	657	100

About 283 (43.0%) and 234 (35.6%) responded that they were explained about the doses of the prescribed medicines and diagnosis respectively. However 556 (84.6%) of those visiting the centre responded that they

were not explained about the side effects of the treatment and 606 (92.2%) said that their queries were left unanswered or unattended (Figure 2).

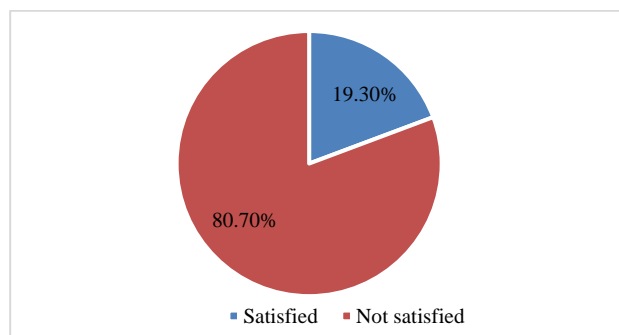


Figure 1: Distribution of respondents on the basis of satisfaction regarding the OPD timings (n=657).

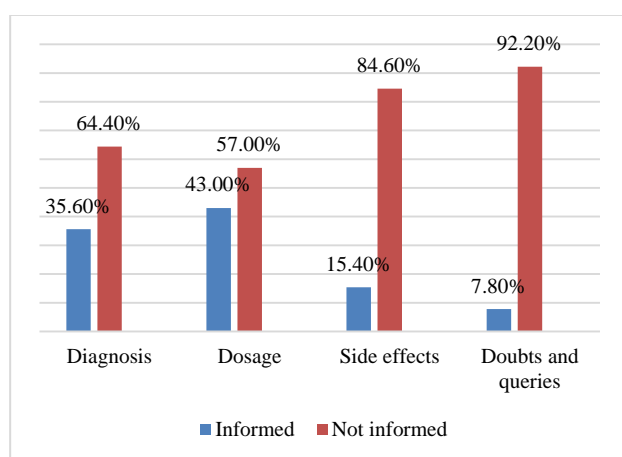


Figure 2: Distribution of respondents about information given by the health personnel regarding the various issues related to disease and medicine (n=657).

Out of total 1123 respondents, 30.3% preferred going to some kind of private health facility only while another 35.5% preferred private health facility but occasionally visited the government health facility (subsidiary health centre) mainly for immunization services or minor ailments. Only 23.2% preferred the government health facility for treatment purposes exclusively and 11.2% did not feel the need of going to any health facility and took medication directly from the chemist (Table 8).

Table 8: Distribution of respondents according to their preference for the health facility (n=1123).

Response	Number	(%)
Private only	340	30.3
Private mostly, sometimes government	396	35.3
Government only	261	23.2
Chemist alone	126	11.2
Total	1123	100

DISCUSSION

According to a study on utilization of primary health centre facilities in rural Pondicherry by Prasad et al, more than 80% of the respondents were aware about the government health centre and its location.⁸ A study done by Logaraj et al regarding the effective utilization of primary health centre in rural Tamil Nadu, showed that majority (85.5%) were aware of the primary health centre and its location.⁹ Similar results were found in the present study. According to a study regarding utilization of primary health centre services amongst rural population of Northern India by Rajpurohit et al, only 36.3% utilized the services.¹⁰ A study done among the rural population of a coastal area in South India regarding determinants of health care seeking behavior showed that 56.4% were visiting the nearest government health facility, which is similar to the results of the present study.¹¹

In a study conducted in Bihar, Gujarat and Kerala by Khan and Prasad, it was observed that 81.5% in Bihar, 99.1% in Gujarat and 80.5% in Kerala were aware about immunization services respectively while 50.5%, 85.4% and 83.7% were aware about antenatal services in Bihar, Gujarat and Kerala respectively, which is consistent with the results of the present study as well.¹² When asked about the services availed in our study, majority of the families visited the centre for immunization services (84.0%), followed by 39.7% for treatment for minor ailments and only 31.7% for antenatal services. According to NFHS 4, 86.0% of the children in Amritsar district of Punjab received most vaccinations in a public health facility.¹³ Present study also showed similar results. According to a study done in West Bengal by Ray et al, only 25.59% population utilized the government health facility; and 99% out of those, chose government health facilities mainly for immunization.¹⁴

In the present study, only 20.2% of those visiting the centre, reported that they were attended by the doctor upon their visit to the subsidiary health centre while majority of them were attended either by the MPHWH (F) or the pharmacist. According to a study by Ray, 50.4% of them reported that the non-availability of doctors (specially female doctors) at health centre to look after female patients was the major factor that affected the utilization of services.¹⁴ A study conducted by Kumar et al in three districts of Punjab, showed that supply of medicines was irregular and most of the medicines were in short supply, which was also observed in the present study.¹⁵

Most of the respondents reported that they were not explained about the side effects of the treatment and that their queries were left unanswered or unattended. The probable reason for dissatisfaction in the present study could be the fact that majority of the time, patients were either attended by the pharmacist or the MPHWH (F) (in the absence of the doctor), who could only deal with minor ailments, without explaining much regarding the

diagnosis, treatment; and possible adverse effects or other queries of the patients.

In the present study, 30.3% preferred going to some kind of private health facility only while another 35.5% preferred private health facility but occasionally visited the government health facility mainly for minor ailments or immunization services. Only 23.2% preferred a government health facility for treatment purposes exclusively and 11.2% did not feel the need of going to any health facility and took medication directly from the chemist. A study done on availability and utilization pattern of public and private health services in Mumbai region (2012) revealed that 27% of the respondents primarily relied on the medicines prescribed by the local chemist while 41% consulted the private health facility (traditional faith healers, local clinics) for treatment on falling sick.¹⁶ According to NFHS-4, the private health sector is the main source of health care for about seven in ten households in the state of Punjab (73% of urban and 71% of rural households).¹³

CONCLUSION

Although majority of the respondents were aware regarding the availability of the government health facility in the village, only 59.2% had ever visited the centre. The utilization of the government health facility in the village was mostly for immunization purposes followed by treatment for minor ailments and very few utilizing the antenatal services. The utilization was more in families belonging to the lower socio-economic status. The main reasons cited for the dissatisfaction among the population were the timings of the centre, due to which its services were not available to them during the evening hours of the day; the irregular supply of prescribed medicines; and the non-availability of the doctor due to which they were hardly given any information regarding the diagnosis or the dosage, and their doubts and queries remain unanswered most of the times. Therefore it is important to strengthen the provision of basic health services at the primary health care level for their effective utilization, for improving the health of the people.

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