

Community Perception And Client Satisfaction About The Primary Health Care Services In A Tribal Setting Of Gujarat - India

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Citation

H Chandwani, P Jivarajani, H Jivarajani. *Community Perception And Client Satisfaction About The Primary Health Care Services In A Tribal Setting Of Gujarat - India*. The Internet Journal of Health. 2008 Volume 9 Number 2.

Abstract

This community based cross sectional study attempts to assess the community perception and client satisfaction of primary health care services provided by Primary Health Centre (PHC) of Panchmahal district of Gujarat to assess the awareness of the community about primary health care services and its utilization in a tribal area and to assess the client satisfaction of those who have utilized the services. This study was conducted from January 2009 to March 2009. For the community survey, two blocks were randomly chosen and the interview was carried out by house visits. For exit interviews, patients were selected randomly from those attending the primary health centre. A total of 479 interviews were conducted. It was seen that 82% were aware of the availability of primary health centre but more than two-thirds preferred quacks. Approximately two-thirds to three-fourths of the clients were satisfied with the primary health care services.

INTRODUCTION

The health sector occupies an enormously important position in ensuring sustainable overall socio-economic advancement in developing countries. In the way of providing primary health care services, the Government of India has made impressive growth in terms of the establishment of primary health care institutions across rural, tribal hard-to-reach sectors. However, shortcomings in the delivery of primary health care services has resulted in lesser utilization rates. The delivery of health services for the poor people in tribal areas and disadvantaged population remains a challenge in India. All healthcare providers and programmes in our country have overwhelming emphasis on quantitative aspect of service delivered, which means that, in a quest to chase runaway targets, we neglect the concept of quality of care, which is also a right of clients (1). Healthcare providers and programmes worldwide have increasingly recognized that the quality of care they provide determines their overall success in attracting the clients and meeting their needs, and the quality improvement initiative has been started because poor quality is costly - to clients, to programmes and to the society overall. People's perception about quality of care often determines whether they seek and continue to use services (2). Being intangible in nature, the perception directly affects the quality rating in service. So, there are attempts to scale and measure this perception. Primary

health care is the window to any health system and primary health care indicates the quality care of health system reflected by patient's perception in terms of satisfaction to the services they are provided. A concern for patient satisfaction has been taken up by many health care authorities worldwide with the aim of responding to the client's needs when addressing the issue of quality improvements in primary health care services. It is easier to evaluate the patients' satisfaction towards the service than evaluate the quality of medical services that they receive. Therefore, a research on patient satisfaction can be an important tool to improve the quality of services.

While the efforts are in the right direction, the public health sector is plagued by uneven demand and perceptions of poor quality. Countrywide, the underutilization of available facilities is of significant concern. The unavailability of doctors and nurses, as well as their negative attitudes and behaviours, are major hindrances to the utilization of primary health care services. The situation is further compounded by lack of drugs, and long travel and waiting times. What is particularly disturbing is the lack of empathy of the service providers, their generally callous and casual demeanour, their aggressive pursuit of monetary gains, their poor levels of competence and, occasionally, their disregard for the suffering that patients endure without being able to

voice their concerns—all of these service failures are reported frequently in the print media. Such failures can play a powerful role in shaping patients' negative attitudes and dissatisfaction with health care service providers and health care itself (3).

Information about community perception with a thorough understanding of the needs and expectations of the community about the health care services can help in better delivery and higher utilization of health services. Scarcity of information on this aspect of health care inspired the authors to carry out the present study at the Panchmahal district of Gujarat which is a tribal district. This study attempts to assess the community perception and client satisfaction of primary health care services in the Panchmahal district with the following objectives:

To assess the awareness of the community about primary health care services and its utilization in a tribal area.

To assess the client satisfaction based on those people who have utilized the services.

MATERIAL AND METHODS

The present study was conducted in Panchmahal district of Gujarat state. Panchmahal district is a tribal district with population of 18,21,894.

It was a community-based cross-sectional study conducted between January 2009 and March 2009. Due to resource and time constraints, it was decided to include 400 community interviews and 100 exit interviews. For the community survey, two talukas (blocks)- Halol and Santrampur of Panchmahal district were selected randomly for inclusion into the study. Households were considered as a unit of study. The informant was the head of the household or any individual aged 15 years or older who was present during the time of the study. Verbal informed consent was obtained from the study participants. Every third household was chosen for inclusion in the study. For exit interviews, patients were selected randomly from those who attended the Primary Health Centre- Arad of Halol taluka in the morning OPD hours during the study period. It was ensured to include all days of the week and also to include special activities like immunization and antenatal clinics.

A preliminary questionnaire was first developed in English, then translated into Gujarati (vernacular dialect) and retranslated several times until it was user friendly and captured the desired constructs. The questionnaire was pre-

tested several times to arrive at appropriate wording, format, length and sequencing of the questions. Pre-test feedback was used to refine the questionnaire until it was ready for data collection. Interview questionnaires were developed for exit interviews and community surveys separately. Different sections of the interview questionnaire were demographic profile, awareness and utilization, level of satisfaction, and suggestions and expectations. Operational definitions were defined for awareness, utilization, waiting time, consultation time, and time for procurement of drugs. The level of satisfaction was assessed in two stages; first satisfied or not satisfied, then extremely or moderately in both categories.

RESULTS

A total of 479 interviews were conducted, which included 387 community interviews and 92 exit interviews. The refusal rate was approximately 4% in both categories of respondents. In the community surveys, half of the respondents were female, around three-fourths were in the age group of 20 to 59 years old, and four-fifths were married, most with either primary or no education. In the exit interviews, the demographic distribution of the respondents was similar with most of them being females in the age group of 20 to 59 years old with either primary or no education [Table 1].

Figure 1

Table1. Demographic details of study subjects

Variables	Community Surveys (%) N= 387	Exit Interviews (%) N= 92
Sex		
Male	184 (47.5)	25(27.2)
Female	203 (52.5)	67(72.8)*
Age group (Years)		
< 20	89 (23)	04(4.3)
20-59	277 (71.6)	76(82.6)
≥ 60	21 (5.4)	12(13.1)*
Marital status		
Married	332(85.8)	85(92.4)
Unmarried	55(14.2)	07(7.6)**
Education		
Illiterate	118(30.5)	28(30.4)
Primary	159(41.1)	37(40.2)
Secondary	46(11.9)	11(12.0)
Higher Secondary	27(7.0)	09(9.8)
Graduate and above	37(9.5)	07(7.6)*

* P value > 0.05= not significant, ** P value < 0.05= significant

TREATMENT PREFERENCE

In the community surveys, more than two-thirds (70.5%) of the respondents listed govt. health facility (primary health centre) as their preferred choice of health care facility in case of illness followed by the services provided by quacks (12.9%). Similarly, in exit interviews that were taken after

the respondents had availed of the services of the primary health centre, about half (48.8%) of them preferred the services of govt. health facility (primary health centre) as a first choice followed by the quacks (35.3%).

AWARENESS AND UTILIZATION OF PRIMARY HEALTH CARE SERVICES

Awareness about the services provided by primary health centre was assessed only in the community survey. About 82% of the respondents were aware of the availability of primary health centre. Despite this high awareness, only just over half (54.9%) of those who were aware of the primary health centre had ever utilized the services. Some of the major reasons for non utilization of services were more faith in quacks, inconvenient timing of the primary health centre, long queues, non availability of all drugs, and investigations.

WAITING TIME AND CONSULTATION TIME

Waiting time was recorded as reported by the respondents and captured in two categories. In addition to the waiting time, a record was made about the duration of consultation with the physician. First, waiting for consultation was defined as the time from registration to meeting with the physicians. Secondly, waiting time to procure drugs was defined as time from consultancy with the physician to procurement of drugs from the pharmacy. The average waiting time reported in both the community surveys and exit interviews was approximately 30 to 35 minutes. The consultation time was approximately 5 minutes. The waiting time for getting the drugs from the pharmacy after consultation with the physician was about 15 to 20 minutes. The ranges of waiting time and consultation time are presented in [Table 2].

Figure 2

Table 2. Waiting time and Consultation time

Variable	Community Survey (%) N=387	Exit Interview (%) N=92
Waiting time for consultancy (minutes)		
< 15	84(21.7)	11(12.0)
15-30	93(24.0)	37(40.2)
30-60	156(40.3)	26(28.3)
>60	54(14.0)	18(19.5)
Waiting time for drugs (minutes)		
<10	131(33.8)	38(41.3)
10-15	77(20.0)	22(23.9)
15-30	100(25.8)	17(18.5)
> 30	79(20.4)	15(16.3)
Consultation time (minutes)		
< 5	193(49.9)	51(55.4)
5-10	134(34.6)	34(37.0)
10-15	46(11.9)	5(5.4)
> 15	14(3.6)	2(2.2)

LEVEL OF SATISFACTION

The level of satisfaction was assessed in two stages. In the first stage, respondents were asked whether they were satisfied or dissatisfied with various aspects of the health services provided by the primary health centre. Further, they were asked to categorize their response into satisfied or very satisfied and dissatisfied or very dissatisfied, respectively into both the groups. The level of satisfaction was assessed across all the components of primary health care services using 12 items.

LEVEL OF SATISFACTION IN THE COMMUNITY SURVEYS

The domains where the satisfaction level was rated as very high included immunization services, competency of the doctor/health staff, and behavior of the doctor/health staff. There was a high level of dissatisfaction with the availability of medicines and the availability of investigations. Around one-third of the respondents were dissatisfied with the timings kept by the centre while two-fifths of the respondents were dissatisfied with the waiting time [Table 3].

Figure 3

Table 3. Level of satisfaction in community survey

Level of Satisfaction	Very satisfied (%)	Satisfied (%)	Very Dissatisfied (%)	Dissatisfied (%)
Distance from Home	93(24.0)	162(41.9)	63(16.3)	69(17.8)
Timings kept by Clinic	123(31.8)	129(33.3)	72(18.6)	63(16.3)
Waiting time	165(42.6)	60(15.5)	72(18.6)	90(23.3)
Consultation time	63(16.3)	162(41.9)	87(22.5)	75(19.3)
Behaviour of doctor/ health staff	63(16.3)	240(62.0)	66(17.0)	18(4.7)
Competence of doctor/ health staff	60(15.5)	249(64.3)	66(17.0)	12(3.2)
Health Information Provision	81(20.9)	216(55.8)	57(14.7)	33(8.6)
Physical examination	66(17.0)	192(49.6)	66(17.0)	63(16.4)
Availability of medicines	84(21.7)	126(32.6)	87(22.5)	90(23.2)
Availability of investigations	85(22.0)	105(27.1)	125(32.3)	72(18.6)
Immunization services	58(15.0)	243(62.8)	48(12.4)	38(9.8)
Relief of symptoms	106(27.4)	140(36.2)	104(26.8)	37(9.6)

LEVEL OF SATISFACTION AMONG EXIT INTERVIEWS

In the exit interviews, the level of satisfaction with the health services was quite high. The behavior of doctors/health staff and immunization services were two domains where the level of satisfaction was quite high. As in the community surveys, waiting time and availability of medicines and investigations were the domains with some level of dissatisfaction. In contrast to the community surveys, very few respondents were dissatisfied with the timings kept by the centre. [Table 4]

Figure 4

Table 4. Level of satisfaction in exit interviews

Level of Satisfaction	Very satisfied (%)	Satisfied (%)	Very Dissatisfied (%)	Dissatisfied (%)
Distance from Home	37(40.3)	38(41.3)	12(13.0)	5(5.4)
Timings kept by Clinic	35(38.0)	48(52.2)	6(6.5)	3(3.3)
Waiting time	28(30.4)	34(37.0)	26(28.3)	4(4.3)
Consultation time	44(47.8)	29(31.5)	11(12.0)	8(8.7)
Behaviour of doctor/ health staff	52(56.5)	28(30.5)	5(5.4)	7(7.6)
Competence of doctor/ health staff	49(53.3)	27(29.3)	7(7.6)	9(9.8)
Health Information Provision	35(38.0)	29(31.6)	20(21.7)	8(8.7)
Physical examination	26(28.3)	38(41.3)	19(20.7)	9(9.7)
Availability of medicines	38(41.3)	19(20.7)	29(39.5)	6(6.5)
Availability of investigations	28(30.5)	29(31.5)	20(21.7)	15(16.3)
Immunization services	46(50.0)	30(32.6)	9(9.8)	7(7.6)
Relief of symptoms	35(38.0)	42(45.7)	9(9.8)	6(6.5)

DISCUSSION

An increased emphasis on client satisfaction is driven by the perceived need for the democratization of primary health care. Patient satisfaction as a measure of health care is an important outcome measure. It is useful in assessing consultations and patterns of communications. If used systematically, feedback enables a choice between alternatives in organizing or providing health care (3).

The efficacy of medical treatment is enhanced by greater patient satisfaction. It can also be taken as the proxy measure for the quality of health care. Our study is restricted to the views of the users of the health services and it identifies various impediments in the delivery of health care services that may be important to the users of the healthcare services but may appear trivial to healthcare personnel. Incorporating the views of the users in the management of the health services will lead to fewer unsatisfied users.

This study attempts to assess client satisfaction in two distinct settings: community surveys and exit interviews.

Though these two settings are inherently different, they point towards the same trend. Most of the respondents were females, which can be explained by the fact that the interviews were conducted during working hours and most of the males were away at work. Most of the respondents were either illiterate or educated up to the primary level. These factors could have affected the level of satisfaction; because of illiteracy and ignorance, the awareness and accessibility about other health facilities is limited among the respondents; therefore they probably would not have other options with which to compare. A study conducted in Egypt reported that the level of patient satisfaction with primary health care services is not affected by gender and educational level (4); however, in this setting it may not be applicable.

In community surveys, though the awareness about the primary health centre was quite high, only about half of the respondents who were aware had ever utilized the services of the primary health centre. The reasons cited for the non utilization were more faith in quacks, inconvenient timing of the primary health centre, long queues, unavailability of drugs and investigations, and the distance from homes. More faith in quacks could be due to ready availability in case of need as the primary health centre runs for only 3 hours in the morning

The mean waiting time was similar in the community surveys and in exit interviews, which was about 30 minutes. The waiting time correlates well with the average waiting time in similar settings (5,6,7,8). It also emerges as one of the major areas of dissatisfaction with the health services as well as the cause of non utilization. A reduction in the waiting time could improve patient satisfaction and enhance the utilization of health services provided by the primary health centre. The average consultation time in community surveys was more than 5 minutes while it was reported to be less than 5 minutes in exit interviews. However, this was twice as high as that reported from another study in similar settings (9). This could be the explanation for the higher level of satisfaction with the physician-related domains vs. the behavior of doctors/health staffs, competence of doctors, provision of information, and physical examination. Non availability of certain drugs and investigations emerged as major areas of client dissatisfaction. This correlates with the findings of the other studies (10,11,12,13). This is due to the general perception that being a government organization, the primary health centre should provide all the medicines and

investigations free of cost.

LIMITATIONS

Data collection was carried out by the undergraduate medical students, which might have introduced a bias. Secondly, the waiting time and consultation time were self-reported so recall bias might have been introduced.

CONCLUSION

One of the measures of the quality of health care is by assessing client satisfaction. In this study, we have attempted to assess the level of satisfaction of the users of the primary health care services and the reasons for non utilization. In India, there is a gross disparity in the distribution of health services. While there are multiple agencies that provide health care, there is inequity in the way the services are distributed. The tribal poor still need to depend on services provided by quacks for basic health care. Therefore, as we are providing facilities for preventive and curative health care delivered at the doorstep of the people, it is important to ascertain the level of utilization and reasons for non utilization. These have to be addressed and looked into in order to improve utilization. In resource-constrained set-ups like in all developing countries, all efforts should be undertaken to bring about the maximum efficiency of health care delivery.

ACKNOWLEDGEMENT

The authors wish to express their sincere thanks to all the study participants for their support and co-operation without them, this study would not have been possible.

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