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DETERMINING QUALITY OF WOMEN HEALTH CARE SERVICES IN RURAL INDIA

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ABSTRACT

That study finds out that current public health care system is fraught with many problems that are perhaps making the users lose faith in it. The results throw light on areas requiring urgent and immediate attention so that suitable strategies are employed to improve the quality of health care services in public centres in order to make them more sensitive and responsible to the needs of the rural women. This could lead to restoration of faith in public health care centres and subsequently their increased consumption. The tool employed in the current study has highlighted some of the indicators of quality such as availability of drugs, doctors, medical, equipment's; interpersonal and diagnostic aspect of care; health care delivery; proper disposal system, cleanliness; health personnel conduct. These parameters can provide valuable assistance in developing a quality assurance/ improvement programme and be employed to assess the quality of current public health care centres with a view to bringing about improvement through incorporation of user perspectives. The use of purposive sampling for selection of sampling units at the last stage of sampling may constitute a limitation for the study. As the study was confined to a single state with specific socio-cultural features generalisations for the entire nation have to be used with caution.

KEYWORDS

women health care services, rural India.

INTRODUCTION

Maxwell (1984) has asserted that quality in health care comprises a comprehensive six dimensional framework that includes accessibility, relevance, effectiveness, equity, social acceptability and efficiency. However, this framework does not represent a holistic approach to health care as some of the essential elements like structure, process and outcome (Donabedian, 1966) have not been considered. Consequently, "Wright's matrix" that combines the two models has been proposed by Maxwell (1992). Health care quality can be assessed from two viewpoints: patients and technical or professional (Institute of Medicine, 2001). The former includes assessment of service provider's ability to meet customer demand, customers' perception and satisfaction (Chatterjee and Yilmaz, 1993). Customer perception with respect to evaluation of health care quality has been supported by a number of researchers (Donabedian, 1980, 1982; Palmer, 1991; Reerink and Sauerborn, 1996). Emphasising this Peterson (1988) opines that how the patient felt is more important than the caregiver's perception of reality. Researchers observe that quality perceptions impact satisfaction; that is the service quality is the antecedent of satisfaction (Cronin and Taylor, 1992; Parasuraman et al., 1994; Storbacka et al., 1994; Heskett et al., 1997; Kasper et al., 1999) and the latter exerts strong influence on purchase intentions (Cronin and Taylor, 1992). Studies conducted in Nepal (Lafond, 1995), Vietnam (Guldner and Rifkin, 1993), Sri Lanka (Akin and Hutchison, 1999), Bangladesh (Andaleeb, 2000) and Nigeria (Uzochukwu et al., 2004) support strong relationship between patient perception and health care service utilisation. Improving quality of healthcare services apart from increasing accessibility and affordability to its population in the face of limited resources has become a major challenge for developing support strong relationship between patient perception and health care service utilisation. Improving quality of healthcare services apart from increasing major challenge for developing countries that have taken little interest in the issue of improving quality of health care until recently (Reerink and Sauerborn, 1996; Smits et al., 2002; Uzochukwu et al., 2004).

NEED FOR THE STUDY

The Indian government has made stupendous efforts through the vast institutional network and diverse human resource (Satpathy and Venkatesh, 2006), comprising Accredited Social Health Activist (ASHA) workers, ayurveda, yoga and naturopathy, unani, siddha, and homoeopathy (AYUSH) practitioners, midwives, nurses, doctors, pharmacists, community health workers, Anganwadi[1] worker, lab technicians, and pharmacists, to reduce the regional imbalances and inequities and improve the accessibility of health care services to rural areas where the majority of the Indian population resides. The National Rural Health Mission (NHRM) was set up in 2005 with the objective of providing effective, efficient and accountable health care programs to the rural population in the country with special attention being focused on those states of the country that have either weak public health indicators or weak infrastructure or both. This mission also seeks to revitalise local health traditions by bringing AYUSH (Indian systems of medicine) into the mainstream public health system.

Though a number of initiatives in the form of health programmes and setting up a vast infrastructure have been undertaken by the government, the "selective, fragmented strategies and lack of resources have made the health system unaccountable": that is, unable to "address people's growing expectations" and deliver quality services (Ministry of Health and Family Welfare, 2005; Bhandari and Dutta, 2007). Consequently, the importance of public health care centres in India has been declining due to poor quality of services (Bhandari, 2006) and their inability to meet the health outcomes (Satpathy and Venkatesh, 2006). The lopsided focus on access and affordability causing negligence to quality has been reported in other developing nations as well (Reerink and Sauerborn, 1996).

Considering that almost 300 million people live below the poverty line and are greatly dependent upon the almost free health services from the public sector, its role cannot be undermined or ignored. Improving service quality is one of the measures that requires to be undertaken for achieving improvements in the health care system as the patients' perception impacts the "health-seeking behavior" (Uzochukwu et al., 2004; Ministry of Health and Family Welfare, 2005). User perspectives therefore constitute valuable inputs towards effective improvement in various areas of health care quality. Considering that very little research has been done on assessing the quality of health care services from a user perceptive in rural India, this paper seeks to address that gap.

METHOD OF ANALYSIS

Numerous studies on service quality in various service sectors have been guided by the SERVQUAL framework (Parasuraman et al., 1985, 1991, 1994). Despite its extensive use it has been debated upon by the academicians with respect to statistical properties (Carman, 1990; Cronin and Taylor, 1992; Brown et al., 1993; Boltan and Drew, 1991b; Babukas and Boller, 1992; Cronin and Taylor, 1994; Van Dyke et al., 1997), measurement problem (Reidenbach and Sandifer-Smallwood, 1990; Brown et al., 1993; Andaleeb and Basu, 1994) and the number of dimensions (Carman, 1990). Realising that appropriate measurement tool (Reerink and

Sauerborn, 1996) should be employed for measuring health care quality in developing nations researchers have made some attempts in this direction. However, a number of such studies have been confined to family planning while others have not established the validity of their research instruments. On the other hand, Haddad et al. (1998) have developed and proved the reliability and validity of their 20-item scale that recorded the user's opinion about the quality of primary health care services in Guinea. Their scale comprised two subscales: health care delivery, and facilities.

The same scale has been employed for the current study. However, in order to the instrument to reflect the cultural context an exploratory study was carried out. In total, six focus group discussions and 12 in-depth interviews were conducted in two districts of the state of Tamil Nadu to identify the factors employed in evaluating the quality of health care services. A large number of items were generated that overlapped with Haddad's study indicating conceptual similarity. The generated items with eigenvalue of more than 1 were included resulting in 23 items. Each scale item comprised five opinions that ranged from a score of 22 for "very unfavourable", 21 for "unfavourable", 0 for neutral, þ1 for "favourable" and þ2 for "very favourable." The questionnaire was translated from English into Tamil, the principal language of the state of Tamil Nadu, where the study was conducted. It was pre-tested to ensure that the wording, sequencing of questions, length and range of scale was appropriate.

METHODOLOGY

A sample size of 300 was chosen keeping in mind the average size of samples (Malhotra and Dash, 2009) in similar studies (Haddad et al., 1998; Baltussen et al., 2002; Duong et al., 2004; Uzochukwu et al., 2004). Data was personally collected during the period between March-August 2015. Verbal consent was obtained from the respondent prior to administration of questionnaire.

DATA ANALYSIS

Factor analysis based on principal component extraction followed by Varimax rotation was employed to examine the structure within the 23-item scale. The KMO value and Bartlett's test of sphericity were used to examine the strength of relationship among the factors. Reliability of the scale was investigated through Cronbach's alpha coefficient. ANOVA analysis and t-test were performed to understand the differences in perceived quality across socio-demographic characteristics of the patients

RESULTS

The respondents were curious about the purpose of study and were enthusiastic in expressing their views on the overall performance of health care centres. Though they were forthcoming in airing their views, their comments were general in nature. When it came to recording their responses to the questionnaire, a number of them were hesitant. They were coaxed into completing the questionnaire but only 246 complete questionnaires could be obtained.

TABLE I: LITERACY STATUS

Independent variable	No of n Respondents	Percentage
Literate	150	60.0
Illiterate	96	40.0
Total	246	100

A total of 60.9 percent of the respondents were literate, 40.0 percent were above 30 years.

TABLE II: AGE OF RESPONDENTS

Independent variable	No of n Respondents	Percentage
<30	110	44.8
>30	136	55.2
Total	246	100

A total of 44.8 percent of the respondents were < 30, 55.2 percent were above >30 years.

TABLE III: INCOME LEVEL (RS [A])

Independent variable	No of n Respondents	Percentage
< 1,000	51	20.7
1,001-3,000	82	28.3
> 3,000	133	51.0
Total	246	100

54 percent of them earned income above Rs. 3,000 per month. Table I shows the demographic profile of the respondents.

SCALE PROPERTIES

On the basis of item analysis, 23 items were selected (Table IV,V,VI). The factor analysis of the items based on the basis of principal component extraction by using Varimax rotation resulted in five homogeneous sub-scales with the eigenvalues of 4.1, 3.8, 3.8, 2.8 and 2.4. All the items had factor loading above 0.45 and the total variance explained after rotation was 74.22 percent with communalities after extraction ranging from 0.59 to 0.83. Appropriateness of factor analysis was assessed by examining sampling adequacy. The KMO measure of sampling adequacy of 0.92 and the significant Bartlett's test of sphericity clearly demonstrated that the factors were related.

TABLE IV

Items	Components / factors		Communalities after extraction
	1	2	
HEALTH CARE DELIVERY			
Adequate availability of doctors	0.49	--	0.66
Good diagnosis	0.54	--	0.83
Satisfaction over prescriptions	0.64	--	0.72
Quality of drugs	0.60	--	0.79
Recovery / cure	0.78	--	0.82
Sufficient time to patients	0.78	--	0.78
Payment arrangements	0.60	--	0.80
FACILITY			
Adequacy of rooms Proper	--	0.62	0.63
Adequate availability of doctors lady	--	0.63	0.80
Neat and clean hospital premises	--	0.73	0.67
Clean appearance of staff	--	0.56	0.59
Proper Disposal of waste	--	0.76	0.78
	17.95	16.51	

The facility, included five items: adequacy of rooms, adequate availability of doctors for women, neat and clean hospital premises, clean appearance of staff, and proper disposal of waste.
Refer Appendix Table 1
Refer Appendix Table 2

DISCUSSION

The paper seeks to understand the quality of services in women health care centres in rural India by using a reliable tool. The psychometric properties of the Indian version of the scale show good internal consistency and construct validity. Two factor were indentified from the factor analysis: "health care delivery system", "facility". The mean score was high for "health care delivery system". Earlier studies have reported a tendency among the respondents to judge favourably the various aspects of service quality (Haddad et al., 1998; Newman et al., 1998). However, contrary to these researches the current study does not report a favourable opinion of the respondents towards health care quality. This finding is similar to that in Burkina Faso (Baltussen et al., 2002). However, there has been a consistent higher rating given by females on several aspects of quality as opposed to that reported in Burkina Faso (Baltussen et al., 2002). There could be two possible reasons for higher scores among females on major issues: (1) The relative lower level of expectations among women owing to the social complications. (2) Most of the women's healthcare issues, especially those related to maternity, are covered under national programmes which get an extra push from the state government.

The overall mean score for the subscale Faculty was very low (0.10), revealing the scope of tremendous improvement in this component. Negative scores were obtained with regard to availability of adequate medical equipment. An earlier study has also pointed out the lack of equipment, improper functioning and poor repair facility (Bhandari and Dutta, 2007). Similar findings have been reported in other nations as well (Baltussen et al., 2002; Duong et al., 2004). Patients may not be able to assess the technical procedures involved in the diagnosis but human behaviour as well as the availability of machines does impact their perception of quality.

Unavailability of doctors especially for women is another item that has obtained a negative score as in case of Nigeria and Vietnam (Uzochukwu et al., 2004; Duong et al., 2004). Poor involvement of health care employees and high rate of absenteeism has been reported by earlier studies (Banerjee et al., 2004; Chaudhury et al., 2006). Researchers (Majumder and Upadhyay, 2002) have reported that the elasticity coefficient of paramedical staff is higher than that of medical staff thereby implying that the former are easily available. Lack of facilities such as proper schools for educating their children, regular supply of electricity, recreational facilities etc. are responsible for failure of health care centres to attract or retain doctors in these underdeveloped areas.

CONCLUSIONS

To conclude, it can be said that the current public health care system is fraught with many problems that are perhaps making the users lose faith in it. The results throw light on areas requiring urgent and immediate attention so that suitable strategies are employed to improve the quality of health care services in public centres in order to make them more sensitive and responsible to the needs of the rural women. This could lead to restoration of faith in public health care centres and subsequently their increased consumption. The tool employed in the current study has highlighted some of the indicators of quality such as availability of drugs, doctors, medical, equipments; interpersonal and diagnostic aspect of care; health care delivery; proper disposal system, cleanliness; health personnel conduct. These parameters can provide valuable assistance in developing a quality assurance/ improvement programme and be employed to assess the quality of current public health care centres with a view to bringing about improvement through incorporation of user perspectives. The use of purposive sampling for selection of sampling units at the last stage of sampling may constitute a limitation for the study. As the study was confined to a single state with specific socio-cultural features generalisations for the entire nation have to be used with caution.

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APPENDIX

TABLE 1: HEALTH CARE DELIVERY

S.NO	ITEM	AGE						EDUCATION								INCOME					
		<30yrs (n=110) Mean SD		>30yrs (n=136) Mean SD		"t"	"p"	Illiterate (n=96) Mean SD		(n=150) Mean SD		"F"	"p"	<Rs1000 (n=31) Mean SD		1000-3000 (n=82) Mean SD		>3000 (n=113) Mean SD		"F"	"p"
HEALTH CARE DELIVERY																					
1	Adequate availability of doctor	0.26	1.02	0.12	0.98	1.59	0.116	0.41	0.88	-0.47	1.04	30.51	0	0.08	1.08	0.08	0.92	0.21	1.00	1.023	0.292
2	Good diagnosis	0.36	0.96	0.27	1.03	0.96	0.323	0.61	0.86	-0.5	0.94	53.18	0	0.39	1.26	0.48	0.93	0.19	0.97	1.97	0.063
3	Satisfaction over prescriptions	0.39	0.99	0.53	1.012	-1.59	0.112	0.65	0.92	0.00	1.07	5.13	0	0.42	1.08	0.62	0.88	0.39	1.03	1.97	0.141
4	Quality of drugs	0.23	1.09	0.28	1.19	-0.23	0.651	0.63	1.00	-0.59	1.03	49.75	0	0.32	1.18	0.37	1.09	0.19	1.21	1.35	0.189
5	Recovery/cure	0.32	0.93	0.52	1.10	-1.91	0.057	0.72	0.92	-0.16	1.07	29.80	0	0.29	1.22	0.65	1.02	0.37	0.96	3.59	0.029
6	Sufficienttime to patients	0.49	1.01	0.79	1.05	-2.36	0.006	0.85	0.98	0.28	1.04	13.6	0	0.54	1.05	0.81	1.07	0.58	1.02	2.21	0.111
7	Payment arrangements	0.83	1.01	1.04	1.03	-2.04	0.042	1.19	1.01	0.47	0.87	19.82	0	0.67	1.03	1.03	1.06	1.00	1.00	3.35	0.036

TABLE 2: FACILITY

S.NO	ITEM	AGE						EDUCATION UP TO MIDDLE								INCOME					
		<30yrs (n=110) Mean SD		>30yrs (n=136) Mean SD		"t"	"p"	Illiterate (n=96) Mean SD		Above middle (n=138) Mean SD		"F"	"P"	<Rs1000 (n=71) Mean SD		1000-3000 (n=111) Mean SD		>3000 (n=214) Mean SD		"F"	"P"
FACILITY																					
1	Adequacy of rooms	0.02	1.16	0.19	.02	-1.15	0.133	0.44	0.98	-0.59	0.83	41.657	0	0.46	1.13	0.1	0.56	-0.01	1.02	5.824	0.003
2	Adequate availability of doctors for women	0.13	.08	0.13	1.14	2.23	0.252	0.20	1.03	-0.81	1.14	36.77	0	0.14	1.13	0.01	1.03	-0.05	1.18	0.13	0.693
3	Neat and clean hospital premises	0.32	0.96	0.62	0.93	0.35	0.727	0.46	0.86	-0.16	0.94	17.85	0	0.58	1.16	0.22	0.85	0.29	0.90	3.66	0.027
4	Clean appearance of staff	0.46	0.91	0.29	0.90	1.96	0.089	0.57	0.87	-0.19	0.81	27.11	0	0.59	1.08	0.53	0.93	0.32	0.95	3.63	0.031
5	Proper disposa lof waste	0.24	0.9	0.07	0.93	1.60	0.109	0.35	0.96	-0.34	0.78	19.86	0	0.43	1.08	0.15	0.93	0.03	0.89	5.29	0.013

	Health care delivery system	Facility	Total Score
No. of. item	7	5	12
Possible mean Range	-2to+2	-2to+2	-4to+4
Mean	0.41	0.16	1.78
Median	0.57	0.30	2.77
Cronbach alpha	0.92	0.85	0.96

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