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Qualitative interviews to uncover the quality of care for patients in India's EWS

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I. Introduction

More than 30% of the Indian population does not have access to healthcare[1]. Over the years, the Indian government has devised numerous schemes to increase access and provision of healthcare to all Indian citizens. These schemes are especially designed to benefit the people of the 'Economically Weaker Section'(EWS), which the Union Government of India defines as those who have an annual income of less than 8 lakhs INR[2]. While the true number of individuals in the EWS has been hard to estimate, the population is approximated to be 190 million individuals[3].There are several eligibility criterias that an individual must meet before officially being considered a part of EWS[4]. These are : the annual income of the family should be less than 8 lakhs INR ; the family should own agricultural land less than 5 acres ; and their residential flat should be less than 1000 sq ft. Candidates who meet the criteria can apply for a certificate which officially places them under the EWS. They can then use this certificate to access healthcare.

RashtriyaSwasthyaBima Yojana (RSBY), was one such programme launched by the Ministry of Health and Family Welfare in 2008. The program aimed to provide health insurance to people below the poverty line (BPL)[5]. In addition to this, all Indian citizens have free access to healthcare in all government facilities. Yet some have questioned if this is enough to make a difference.

There are still over 400 million people left without proper health care and treatments due to its inaccessibility[6]. Disparities also exist across geographic locations. Notably, women living in rural areas of Tamil Nadu are forced to live with almost no access to medical institutions[7], primarily because of concern about expenditure. Rural villages also lack modern means of transport to reach the medical institutions where the women can seek care. Moreover, the EWS in Kashmir, especially those living in rural areas, are deprived of requisite healthcare facilities[8]. The ramifications of this problem only intensified during the Covid-19 pandemic, as countless lives were lost simply because a hospital was not within their reach. Numerous people also lost their jobs due to the pandemic and hence weren't able to afford even basic necessities, which further caused their health to deteriorate.

Even though India is a popular destination for medical tourism due to the low costs, it accounts for 17% of global maternal deaths and 21% of deaths amongst children below 5 years of age[9]. Studies examining potential causes of this phenomenon include those which looked at rural areas of Uttar Pradesh, where access to maternal healthcare is a significant contributor to the maternal deaths as well as the infant mortality rate. Despite healthcare being free, there are no medical facilities in rural areas. There is a shortfall of 36346 Sub Health Centers, 6700 Primary Health Centers, and 2350 Community Health Centers against the specified population norm in India[10]. Even when there is access to a medical facility most families cannot afford the transportation costs to hospitals in the cities. Additionally, despite the existence of schemes such as PMJAY (another health insurance scheme), numerous people are unaware of its existence completely, and are hence left without access to health care.

Although access to medical facilities has increased tremendously, people often find themselves being subjected to biases by healthcare workers. The thick skin bias explains how people from strong financial backgrounds perceive impoverished people as being less harmed by negative experiences[11]. This common misconception invariably impacts the way people from stronger financial backgrounds treat the impoverished. In this case it highlights how doctors may subconsciously provide treatment of lower quality to people from the EWS.

The disparities in healthcare exist beyond just rural regions. For example, private hospitals in Delhi, the capital of India, have to treat 25% of patients free of cost. These patients need to be those who come under EWS or BPL. Despite this provision, there are several biases, both implicit and explicit, which impact the quality of care that this 25% receives. The main aim of this research article is to explore the question : do doctors working in the Indian healthcare system provide different care when treating patients from the economically weaker section compared to when treating patients who are not economically disadvantaged?

II. Methods

All interviews were performed between May and June 2022. A literature review was performed using the phrases "Economically weaker section," "India," and "bias." Relevant articles were identified via PubMed and Google Scholar, with relevant studies and articles selected as inclusion for review in this paper. Analyzed articles were included if they were published within the last 5 years, they discussed health disparities, or they explored quality of care in India. Results from the literature review guided the structure of the interviews. Interviews were conducted via semi-structured interviews from 25 physicians, working in private and public hospitals. Both the hospitals were in Delhi. The private hospital is partially owned by the Delhi government and hence dedicates 25% of its resources to treating patients from the EWS free of cost.

The public hospital, on the other hand, is fully funded and managed by the Indian government, thus they are required to treat all patients free of cost, regardless of their backgrounds. Although the questions asked were not fixed, they were based on a checklist which stated all topics that needed to be covered during the interview. Based on the answers that the doctors provided, follow-up questions were asked as well. Of the physicians interviewed, 10 doctors were specialists, 10 were surgeons, and 5 were primary care physicians. After the interviews, each one was analyzed and coded to develop themes consistent with thematic analysis.

Data

Data was collected from 20 doctors working in a private medical facility in New Delhi, and 5 doctors working in a government hospital in New Delhi. The physician sample consisted of 10 specialists, 10 surgeons and 5 primary care physicians. The first theme derived from the interviews was inequalities in the system. Under this most surgeons (8/10) agreed that patients from the EWS had longer waiting periods on transplant lists, including waiting periods of longer than a year. Whereas patients who were not economically disadvantaged were sometimes able to receive organs within weeks. However, the doctors largely agreed that patients had access to medicines they needed (22/25) and their ability to take time off work after the treatment did not affect the quality of care provided to the patients (23/25).

The qualitative interviews also categorized physician thoughts towards people in the EWS receiving advanced treatments. Most doctors(23/25) agreed that patients from the EWS should receive these treatments despite the fact that they don't pay for it. Nevertheless, when asked about the access to these treatments, the majority of doctors from the public hospital (3/5) believed that these treatments were not accessible for most EWS patients. Adding on, the majority of surgeons(8/10) also believed that these treatments should not be provided without the proper after care, which includes taking medication, follow up check ups, rest, rehabilitation etc.

Furthermore, the doctors also spoke of the quality of resources during the interviews. Most doctors expressed their agreement with this point. The quality of infrastructure in terms of the technology, machines etc used was considered to be lower for EWS patients. All 5 of the doctors agreed with this point, with one of them also pointing out "old technology is still being used." Moreover, there was a general consensus over the quality of medical staff being worse off as well. All 5 of the public hospital doctors agreed that patients from the EWS received care from less qualified workers than their non-EWS counterparts. Specifically, doctors 22 and 24 shared the quality of care amongst those in the EWS suffers because doctors treating them are overworked whilst being paid low salaries. Three doctors from the private hospital also said that although all the doctors were excellent, there were fewer doctors dedicated to EWS than the rest of the hospital.

III. Discussion

The results from the interviews showed that there's a consensus amongst most physicians that people from EWS should be provided with the same quality care as those who are from stronger financial backgrounds. However, not all of them are receiving this treatment due to the flaws in the system. These include not only the lack of funding and inequalities in the system but also the biases, both implicit and explicit, that are displayed by doctors.

This research reveals some of the existing flaws in the Indian healthcare system. A large section of India's population is not receiving adequate medical care, contributing to significant health disparities. This paper helps establish the specific areas in which the system is failing to support patients from the EWS with an insufficient number of doctors providing care in both private and public hospitals. The thematic analysis was consistent with previous reports of private hospitals failing to treat enough patients from the EWS, leaving public hospitals over burdened and without proper staffing and available appointments. Despite the government's efforts to increase access to medical facilities for people from the EWS, several of them are unable to receive cromulent treatment.

Results from this thematic analysis uncover why the system is currently failing to provide for its people. There are several ways in which this situation can be improved. Firstly, more doctors can be dedicated towards treating patients from the EWS. Moreover, the government can increase their spending on the

healthcare system to improve the current technology and increase access to more cutting - edge treatments, ensuring that those from the EWS are able to access those treatments in the same manner as their more financially stable counterparts. In the year 2021-22, the Indian government spent 2.1% of the GDP on healthcare, which although is an improvement of 73%[12] from the pre-pandemic years[13],it's still insufficient on account of the vast population of India. During the interviews, doctor 22 also mentioned a shortage of supplies such as vaccines during the pandemic. Another doctor revealed that one problem inhibiting the expansion of care for the EWS is that some people commit fraud. Government officials can prevent this by using methods to ensure that people are not misusing EWS certifications.

This study has both strengths and limitations which determine its reliability. To begin with, this study used data triangulation as data was collected from both a literature review, as well as through semi - structured interviews. The data was obtained from a mix of doctors from public and private hospitals. The cohort of doctors included a mix of specialists and generalists. Moreover, both the interviewing process and the construction of themes and codes were unbiased and objective. The results of this study were also supported as similar results were also found in other studies, increasing the generalizability of the results obtained.

Nevertheless, this study has several limitations. During the data collection, purposive opportunity sampling was used, hence the sample was not random. Moreover, the sample size was small (n=25), and all the participants were from two hospitals in New Delhi, thus they are not an accurate representation of all the doctors in India. A significant contributor to health disparities is the lack of resources in rural areas, which was unable to be assessed in this study given the location of hospitals.This may impact the generalizability of the study. Additionally, the study neither used researcher triangulation nor peer-review to eliminate researcher bias.

Following this research, future studies can focus on ways to improve the system to help more people gain access to good quality healthcare. They can explore ways in which doctor - patient relationships can be improved and how the gap between the EWS in India and people from stronger financial backgrounds can be bridged. They can also look at ways to reduce implicit and explicit biases that healthcare workers present which hinders the treatment that they provide. Seminars and informative sessions could be one possible way to make physicians more self - aware about the implicit biases which stem from treating patients from different financial backgrounds. In addition, researchers could investigate how increased healthcare spending in isolated rural areas, where people have little access to medical facilities, could improve the health and wellbeing of those from financially disadvantaged backgrounds.

IV. Conclusion

In conclusion, there are millions of people from the EWS in India who are forced to face the adverse effects of biases and inequalities in the healthcare system on a daily basis. Through a literature review and interviews with physicians these biases and their impact became evident and made the need for improvement apparent. Although the Indian government has immensely increased access to healthcare across the country, there's still a long way to go until those from financially disadvantaged backgrounds receive truly equitable healthcare.

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