A STUDY ON INVOLVEMENT AND REFERRAL BEHAVIOUR OF RURAL UNQUALIFIED MEDICAL PRACTITIONER (RMP) AT WESTERN DOOARS OF JALPAIGURI DISTRICT, WEST BENGAL, INDIA: THE TORCH BEARER OF HEALTH SERVICES

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ABSTRACT

The role of unqualified medical practitioner cannot be ignored by the health authorities because of health staff crisis particularly in rural India. Studies have revealed that the existing size of the health staff in India can only serve the one fourth of the population with quality service. Hence, the situation of health performance by the unqualified practitioners is an important aspect not only in terms of quality but also the home service offered by them during the point of need. The present study tries to find out the types, amounts, and quality of health services provided by the Rural Unqualified Medical practitioner (RMPs) in the Western Dooars of the Jalpaiguri district.

Keywords: Rural Unqualified Medical Practitioner, Health Providers, Poor, Ailment

INTRODUCTION

The significant presence and handling of huge health load by the unqualified medical practitioners is evident in developing countries like India. Many research studies observed the role of RMPs especially in rural healthcare markets. Bhatia and Cleland (1995) observed that, in India, a large number of private medical practitioners of both traditional and modern systems of medicine are practicing in rural and urban areas, many of whom possess no recognized medical qualifications. There are also traditional practitioners who use herbs, oils and incantations. However, they are increasingly using modern medicines and it has become difficult for the people to distinguish between a qualified and an unqualified practitioner. Campbell et. al. (2000) considered that for developing countries, the importance of these informal providers should be recognized by the health authorities. Olenja (2003) found that due to unresponsiveness of the health system with respect to basic amenities, inappropriate client–provider interaction and staff attitudes, patients especially the poor prefer to seek health care from the informal providers. Ensor and Cooper (2004) observed that in Asia, cultural factors that are prohibiting females to take maternal health assistance from publicly provided health institutions, preferred to collect care from unqualified providers at home. Chikanda (2004) observed for Zimbabwe that the skilled health professionals were always try to migrate to urban centers and as a result, the poor disadvantageous rural sectors were always suffered by the crisis of health staff and hence the people move to the unqualified practitioners, healer and untrained health staff during ailments.

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In case of India, studies found that 80% of outpatient visits and 60% of hospital admissions are in the private sector. On the whole, the absence of adequately trained health-care providers in public and private sectors is a major cause for concern. Urgent reforms are needed, particularly in human resources, to achieve universal and affordable health care in India (Selvaraj, 2009). Some studies have revealed that India has roughly 20 health workers per 10000 populations (Rao et al., 2009). Studies of Rao, Bhatnagar, and Berman (2009) found that the total health-care workforce consists of allopathic doctors (31%), nurses and midwives (30%), pharmacists (11%), practitioners of ayurveda, yoga and naturopathy, unani, siddha, and homoeopathy (9%), and others (9%). They also suggested that the number of health workers per 10000 population in urban areas (42) is more than about four times that in rural areas (11·8). The number of allopathic doctors per 10000 people is more than three times larger in urban areas (13·3) than in rural areas (3·9).

NATURAL AND HUMAN FACES OF WESTERN DOOARS

Like other rural parts of West Bengal, Western Dooars reflects two faces as its common profile. One is natural face; that basically describes the geographical position, climatic conditions. The other face is human face, which is constructed with social, economical and cultural aspects of human life. Here, the study has attempted to describe both the faces and then tried to highlight some specific factors which are influencing the health behaviour specifically. Dooars is a huge bio-reserve situated in the extreme north of West Bengal and famous for its tourist’s attraction for traditional natural beauty and tea garden. The name Dooars has come from the term Duar that means ‘doors’ in Bengali, Assamese and in Nepalese language. There are 18 gateways through which Bhutanese people could communicate with the people living in these parts. The eastern part of river Tista has the most impressive greenery, i.e., the major reserve forests, like Chapramari, Jaldapara, Garumara, Chilapata, Nilpara and Buxa. The district lies between 26° 16’ and 27° 0’ North Latitude and between 88° 04’ and 89° 53’ East Longitude. A vast texture of dense forest teeming with beautiful wildlife covers the region. The area outside the reserve forest is 4455 sq. km. and 3016836 peoples are settled here as home. This is the human face of Western Dooars. People with various language and diverse religious make this place of special interest. In 1900s, diseases like malaria, cholera, smallpox, and hydrophobia were spread over this place. Death rate was enormous for these diseases during that time. The extent of poverty is severe, because 35.87 percent (2001 census report) of people living below the poverty line. Considering the demography, the SC/ST proportion of this area is 55.58 percent and the percentage of land less community is 40.6 (2001 census report). Almost 15 percent of total people working in tea gardens and live under distress and most of them do not have electric supply. Only 17.33 percent of rural houses are electrified in this area. Ironically, being surrounded by forest and hills of Bhutan, chronically suffers from lack of safe drinking water. Nearly 32 percent of peoples depend upon other than safe drinking water or river water which is flowing from Bhutan. The river of this area changes its track frequently and inhabitants build their settlements in the embankments. During monsoons, the floods cause them to collapse. In brief, Western Dooars symbolizes a world of human poverty and tragedy packaged with natural richness. Poverty here is cyclically entwined with the ecosystem. The increasing economic stress makes the people recklessly feed on forest resources. As a result, erosion of traditional source of livelihood for the poor is continued that creates more stress. The cycle of poverty has got huge strength due to pressure of population, unregulated drives towards
commercialization of natural products and poor resource management system. A glaring example of this conflicting relation is the practice of collecting timber by illegal ways from the forest. A significant proportion of forest villagers are engaged in this activity primarily to meet the demand of the local timber merchant. Moreover, the people dependent on forest are prone to occupational health hazards. This type of activity is showing serious ecological damages, like extinction of many indigenous varieties of forest species.

HEALTH PROVIDERS

The health care delivery system in the Western Dooars is built on an assortment of public and private providers. The public services, delivered through a multi-tier infrastructure, are primarily financed by public funds. The private providers may be classified into several groups based on their economic motive and qualification: (1) the qualified private providers practicing solo or at private institutions, (2) unqualified private providers or RMPs, (3) private hospitals and nursing homes with capacity to provide inpatient care, and (4) not-for-profit organizations providing preventive and curative services through different programmes and facilities, especially through mobile health units under a unique public-private partnership programme and institutional birth delivery centers. The health support from state level is provided by 38 Primary Health Centers (PHCs) with 246 beds, 14 Block Primary Health Centers (BPHCs) / Rural Hospitals (RHs) with 405 beds, 7 upper tier health facilities with 1187 beds and 4 other hospitals with 215 beds for all subdivisions of the district. The study finds concentration of beds of the PHCs highest at Jalpaiguri Sub-division (110 beds) which is also the district headquarter, whereas in Alipurduar sub-division PHCs (which have more or less same level of population like Jalpaiguri Sub-division) have less number of beds (90 beds). The quite opposite scenario is found at second tier health facilities provided by BPHCs and RHs. Here, Alipurduar Sub-division provides more beds as compared to Jalpaiguri Sub-division. But Mal Sub-division which bears 16 percent population pressure of the districts has only 9.79 percent of total available beds in the district.

MATERIALS AND METHODS

The study was conducted in three different blocks of Western Dooars. The selection of the RMPs would involve a two-stage random sampling procedure. As per the perspective of this study, the blocks were arranged in terms of high, medium and low population density and three blocks are chosen, one from each category. Now, from every block, three PSU / Villages were chosen in terms of their location (distance) from block headquarters through purposive sampling. The selection of PSU was based on their distance from the block headquarters. One PSU was selected from very remote area of block (more than 10 Km), the second one from relatively less remote area (5-10 Km) and the third one from the nearest (located within 0-5 Km) to the block headquarters. Here, it has been assumed that the highest health facilities are mainly located near block headquarter. The selected blocks for this study of Jalpaiguri districts were Alipurduar-II, Falakata and Madarihat and from these three blocks total nine villages /PSUs are selected on the basis of distance from the block head quarters. Among these nine villages, three are located close to the respective head quarters, i.e. within 0-5 Km distance, three are within the 5-10 Km distance from the block head quarters, and the last three are located more than 10 Km distance from the
respective head quarters. Now, from each PSUs on an average ten RMPs were interrogated under structured questionnaire. In total, 90 RMPs was interviewed under structured questionnaire through this process. The focus of this interview was on their back ground, background of their patients, knowledge about various diseases and treatment procedures and referral behaviour.

RESULTS

The overwhelming dominance of the RMPs in the Western Dooars' health care market has made it imperative to direct the policy focus towards their role as an institution. The first step towards this direction would be to develop a framework for analyzing the market structure in which the key actors especially the RMPs - play their roles. Figure 1 presents such a simple framework based on the elements of New Institutional Economics. The key market actors are (1) the RMPs, (2) government providers, (3) private qualified providers (including NGOs), and (4) medical representatives who canvass medicines to anybody who practice modern medicines. The informal or unofficial links are well established between the RMPs and medical representatives (MR) and government providers. The link with MRs is particularly interesting since the RMPs also act as medicine vendors and, hence, absorb the larger share of pharmaceutical products as the dominant actor. Their interface with MR, however, remains indiscernible to a larger extent since the RMPs are not officially or legally recognized as medical practitioners. Similar is the case with their links with government doctors, who, admittedly, often 'refer' cases to RMPs and 'receive' cases referred by RMPs at their work stations or at private clinics. The formal link is easily dwarfed by sheer strength of the parallel and informal link. The strength is derived from two forces: (1) market or price factors, and (2) institutional factors. The price factors, are more visible; evidently, people save money and time when they visit a RMP (instead of visiting a public health centre) because RMPs are available anywhere anytime. However, no less important are the 'institutional' factors, mostly arising out of the informal structure of the RMP-people connection which helps to reduce the transaction cost on both sides and wrap it with a strong bondage.

Figure-1: Rural outpatient care market in Western Dooars

The study found that out of 90 RMP, 52 percent are located in the rural area and 48 percent in the urban area. According to the study estimates, on an average, a village in the Western Dooars had
In the rural side, average number of patient’s visits is 65.34 percent. Corresponding to total population, the average population covered by one RMP is around 6306. About three-fourths of all RMPs did not have a college degree (74 percent) and almost all (81 percent) had taken it as a full time profession. The study found 82 percent of the RMPs are available in day and night. Almost all of them (96 percent) were available on-call even at mid-night although they also had been operating clinics on a normal routine. The study found that 62 percent of the RMPs (two-thirds) had past experience of working with some qualified private practitioners. This experience helps them ‘learn’ the treatment path and medicines for common diseases and develop some basic skills (such as, pushing injections, checking blood pressure, and even reading X-ray plates).

The study found 76.6 percent of the existing RMPs are practicing allopathic treatment, which is more than three times of the practicing homeopathic and AYUSH treatment process. Almost 77.7 percent of the RMPs clearly provide drugs with treatment and among them most of the RMPs (60 percent) would sell drugs on credit or at subsidized prices if the client does not have enough cash at the point of service delivery. Half of the existing RMPs procure these drugs from local pharmacies (the rest from the wholesalers and medical representatives). The operational procedures of RMPs clearly reflect a mutually beneficial agency relationship. For example, during ailments rural people tend to depend on those health care providers who would be easily accessible, understand their socio-economic constraints, respond quickly, and offer a quick medicine for their ailments at an affordable cost. The benefit of deferred payment (i.e., payments for drugs on credit basis) generates huge incentives to the buyers of services. On the other hand, the providers or the agents (RMPs) find significant market incentives in terms of clients who have no or very poor information about their own health problems or treatment procedures but always look for some packaged medicines or injections whenever they fall sick. In addition, easy access to knowledge on modern medicines (through medical representatives), good understanding of people’s social behaviour and economic constraints, and a very weak public health care system make them a formidable player in the outpatient market.

On average, one RMP treats 15-20 patients every day, about one-third of them being children below 5 years. As reported by the selected RMPs, the most common diseases treated by them are related to gastro-enteric (e.g. diarrhea) and respiratory ailments like common cough, cold, fever and asthma. However, people seek care also for relatively less common ailments; for example, about 5.56 percent of RMPs reported to have treated patients with mental health problems in the last one year. Assisting in birth delivery seems to be a common and regular part of their profession for more than half of the RMPs (71 percent). It is also a matter of concern that, even with high probability of underreporting, 15.56 percent of RMPs admitted that they provided frequent abortion services.

Pertinent question arises, how safe is MCH at the hands of RMPs? Do they have adequate knowledge on how to diagnose and how to treat in a particular situation? Do they practice the proven safe methods in birth deliveries or in treating a child with diarrhea? In the study on the RMP, the process of knowledge, attitude and practice (KAP) is implemented on selected RMPs, which reveals a mixed picture. The study found, many of them have basic knowledge about the
diagnosis and primary purpose of modern medicines related to common diseases; on the other, the practices (or treatment) often reflect lack of judgement regarding rational use of drugs. For example, pushing Oxytocin during labor pain (for induction of labor) is found to be a popular part of assisting in birth deliveries by a large section of RMPs even though unmonitored intra partum use of Oxytocin has been found to have several adverse outcomes. Similarly, despite having knowledge about importance of ORS in diarrhea treatment, 64.4 percent of RMPs indicated use of IV fluids as the first line treatment of children's diarrhoea. Data on the RMPs preferred line of treatment also indicate rampant use of antibacterial / antibiotic drugs (e.g., Ciprofloxacin and Metronidazole for normal diarrhea, Cefalexin for common respiratory troubles). Given no data on the degree of irrationality in the use of these drugs it is, however, difficult to assess the harmful impact of these practices.

Despite uncertainties about health impact in case of non-surgical treatments, the potential harm can be captured in a more concrete way in three other related RMP practices: (1) the increasing engagement of RMPs in surgical intervention, (2) their gradual penetration in the inpatient market (i.e., clinics with beds), and (3) their pool referral practices. Available data indicate that an alarming trend of surgical interventions including major surgeries - by RMPs. About three-fourth of the RMPs interviewed during survey indicated that occasional or frequent tryst with surgical equipment. The surgical cases ranged from female sterilization to operating on 'liver abscesses'. There is virtually no barrier to be a surgeon which also induces an established RMP to venture into hospital 'business', i.e., running a clinic with inpatient facilities. Clearly, in a poorly unregulated environment, RMPs penetration into inpatient market implies a sizeable risk to their clients.

The referral behaviour of RMPs also manifests the risk. The basic question regarding the referral behaviour of RMPs asked that whether they refer potentially or actual complicated cases to public facilities or qualified private doctors. The study suggested that, on average 1251 patients were referred by the RMPs in last months, which is actually 40.75 percent of the patients who visited their clinic. Low referral rate reconfirms that they refer only when cases go completely out of their control. The scenario is, however less discouraging in the complicated birth delivery cases; for example most of the RMPs, according to their responses, would refer to the government hospitals (45.48%) or private nursing homes (30.54%) in case a woman comes with obstructed labor, or bleeding before delivery, or eclampsia. Discussion with the villagers revealed that most of the RMPs have good working relation with private nursing homes which popped up over the years at the periphery of the Western Dooars. Few of them work as linkmen to particular private nursing homes and refer cases whenever they have to. This finding is corroborated with the household survey estimates that two-third of all RMP-referred cases were advised to visits particular private clinics or institutions.

CONCLUSION

RMPs are an integral and vital part of the Western Dooars' health care structure. They have a strong grip over the health care market, much stronger than the public health care system. From the policy perspective, there is an inherent dilemma acknowledging this fact and taking a clear stand on this issue. On one hand, RMPs dominance is too obvious to ignore, while on the other,
the legal and technical barriers are too strong to formally acknowledge RMPs and redirect their market power in a controlled and guided manner. Study found that major proportion of the unqualified providers was from the rural middle-class families and they had supplementary income-earning activities, mainly in agriculture. The treatment behaviour of the RMPs are found most common regarding the irrational use of drugs such as over prescribing, multi-drug prescribing, use of unnecessary expensive drugs and overuse of antibiotics and injections. Aggressive marketing strategies by the pharmaceutical companies through medical representatives in Western Dooars as well as free availability of ‘prescription only’ drugs in the unlicensed and unregulated drug retail outlets may be responsible for such kind of drug using policies by the RMPs. Studies on different Asian countries shows that it is possible to improve the knowledge and practice of these RMPs, if they receive appropriate formal training to fulfil their public health role in rational use of drugs, including prevention of resistance and misuse of antibiotics. Thus, with the remarkable shortage of supply of qualified health care professionals in rural India, the importance of these unqualified practitioners as major providers of health care to the poor should be recognized by the public sector. Thus any effort to increase their capacity development in a planned way so as to ensure that the poor and the disadvantaged get an acceptable level of care, at least in the short-term, should be kept in mind.

REFERENCES