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RESEARCH ARTICLE

UNQUALIFIED HEALTH CARE PROVIDERS AND RURAL PUBLIC HEALTH IN RAJASTHAN

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Abstract

There are many players for health care delivery systems like public and private providers. In between, another service delivery system exists and survived at large scale in rural India. One of them is called “Rural Medical Practitioner” or “quacks” or “Jhola Chaap (unqualified service provider)” or unethical practitioner. The term RMP is still not clear. In the lay men language, RMP stands for registered medical practitioner but only graduate in MBBS are registered by the Medical Council of India and has a valid licence to practices allopathic medicine in public health. In the medical world. In many developing countries like India, informal or rural medical practitioner provides the large-scale services to the poor and villagers. These practitioners cater a large population especially in rural India. In Rajasthan, the coverage of population by Government Public Health Services is not sufficient. This study carried out with interviewing 117 unqualified health care providers in rural area of Rajasthan. The current paper discusses about academic background, training, experience, daily patient load and practice of informal health care providers altering the unavailable health care professional for a long time. As resulted, a total of 95 (81.20%) informal health care providers have their own clinic where they attend the patients and provide services 24 x 7 without charging consultation fee, go for home visits to see the patient and refer the patients in critical situation to Government health facilities, etc. The strong presence of these so-called rural practitioners in the basket of private health care system put the rural health in very critical situations.

Introduction:-

India is second largest country worldwide in population. Better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy population. Many factors influence health status and a country's ability to provide quality health services for its people. There are many players for health care delivery systems. One of them are called unqualified healthcare practitioner (UHP). Only graduate in medical education, registered by the Medical Council of India and has a valid licence are ethically allowed to practice allopathic medicine in public health. These unethical practitioners also called rural medical

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practitioners (RMP). The most recognized definition of RMP is "the public health services providers who practice modern allopathic medicine without any formal registration/ approval or education" (Nallapu, 2017). In the medical world, these practitioners called Rural Medical Practitioners even if they are practicing in urban area too. In many developing countries like India, informal or rural medical practitioner provides the large-scale services to the poor and villagers (Bloom, Standing, Lucas, Bhuiya, Oladep, & Peters, 2011). These rural medical practitioners cater a large population especially in rural India. They are most considered, available and accessible medical service providers for local community. The preference of these providers observed in the treatment of diabetes, hyper tension, respiratory tract infection, diarrhoeal disease, Malaria and so on (Rao, 2005). There are very less evidences on the quality of care provided by informal health care providers and there is also a general perception that informal health care providers provide the substandard care (Cross & MacGregor, 2010). There are 716 million people from rural area are not getting basic health care in their habitat in India. This condition has been worsening by their lining standard (Jaysawal, 2015). The poor hygiene, health awareness, clean water, open defecation, availability and accessibility of public health services promote the expansion of several diseases in rural areas in India. In Rajasthan, the coverage of population by Government Public Health Services is not sufficient. According to the data available of 2019, the most peripheral and first point of contact between the primary health care system and the community Sub-Health Centre catering average 4,245 people, Primary Health Centre 27,547 and Community Health Centre 1,00,443 people in Rajasthan (Division, 2019). According to WHO, the workforce statistic has put the country into the "critical shortage of healthcare providers" category. Bihar, Jharkhand, Uttar Pradesh and Rajasthan are the worst hit. In this situation, these informal health care providers in rural area playing an vital role in the delivery of health services in rural Rajasthan when they are not qualified, registered and legally approved by the Government of Rajasthan. In this study, we will explore the role of these informal health care providers in rural public health, the load catered by them in rural area, expected cost of treatment, their education and experience, scope of their involvement in government schemes, their willingness to take part in any training or certification course and further increase the human resource in public health.

Method:-

Rajasthan is geographically largest state in India and having 68.6 million population in 33 administrative districts and growing relatively in every area. Three quarters of population i.e. 75.13% residing in rural area and 2.1 million families are in standing in below poverty line (Raj, 2010). In this study, the district Sri Ganganagar of Rajasthan, India selected for the survey and qualitative and quantitative survey conducted with the people who practicing allopathic, Ayurvedic and Homeopathic medicine in rural areas. A random sampling method was used for data collection with respondents (informal health care providers).

Telephonic interview conducted with informal health care providers practicing in the district and list of the practitioners obtained from a local practitioner's union. Total 219 practitioners have been approached for interview where 117 practitioners have completed the interview. The response rate was 53%. The questionnaire consisted of a set of closed and open ended questions which pertaining the operational activities, medicine uses, treating diseases, public opinions, cost of treatment. Before starting the interview, a pilot testing of questionnaire was conducted to assess the language of questions, relevance, and content of tool, for which 5 practitioners were interviewed.

Results and Analysis:-

The study population are unqualified medical practitioners from a district of Rajasthan state. The found that majority of people involved in this informal health care belongs to above 30 years of age. Maximum (32.48%) number of providers found from the age group of 41-50 years whereas minimum (8.55%) number is from the age group of more than 50 years. Interestingly, it was found that almost 14 percent new practitioners involved belong to 18-24 years age group.

Academic education wise classification

It was found that majority (67.52 percent) of unqualified health care providers in the district have not educated beyond the higher secondary school education. Data correlated with The Health Workforce in India, Human Resources for Health Observer Series no. 16, 2016 proves that 62.8% traditional or faith healers were passed higher secondary schooling. Out of total 117 respondents, 21 respondents passed their GNM course and they are also practicing in rural area.

Table 1:- Academic education of informal health care providers.

Academic education	No. of Respondents	Percentage
Upper Primary	2	1.71
Matriculation	15	12.82
Higher Secondary	62	52.99
Graduation	20	17.09
Post Graduation	18	15.38

Training under qualified medical doctors

Out of total 117 respondents, only 5 respondents reported that they never worked or had training under the specialist. The remaining 112 respondents reported that they had been trained under a qualified doctor as assistant or compounder. The maximum training period reported 1-5 years under a qualified medical doctor by 53.85% people. Only 12.82% had been worked 16-20 years under the guidance of qualified medical doctor or still connected with private and qualified medical professional.

Experience of practicing in field

This table provides an insight of years of practice by informal health care providers. It was noted that more than 85% of providers have been practicing in rural area for more than ten years and this is significant time to establish their rapport and acceptance in the local community.

Table 2:- Years of practicing in field.

Years of Practice	Number of Informal Health Care Provider	Percentage
0-5 Years	17	14.53
6-10 Years	33	28.20
11-15 Years	22	18.80
16-20 Years	14	11.97
21-25 Years	22	18.80
>25 Years	9	7.69

Population coverage:

It was found that total 117 respondents covering 478 villages or wards in rural area and providing their services. These results show their acceptance and hold in the community.

Table 3:- Population coverage wise distribution.

Population Coverage	Village/Ward Covering	No. of Practitioners
1-1000	92	27
1001-5000	163	63
5001-10000	92	12
>10001	131	15
Total	478	117

Clients catered by unqualified health care providers:

The study found that majority of respondents attending more than 20 patients in a day. Also, more than 95% of providers maintain their own setup as clinic for outdoor services. It was found that time spending with the patient by a provider having a significant impact on the patient turnout as well as quality and cost of the treatment.

Table 6:- Client load per day.

Average Client load/ day	No. of Practitioners
1-10 Patient	22
11-20 Patient	4
21-30 Patient	16
31-40 Patient	28
41-50 Patient	29
>50 Patient	17

General Practices of Informal health Care Providers

The data reflected that total 95 (81.20%) informal health care providers have their own clinic where they attend the patients. Total 91 (71.78%) providers available 24 hours and providing their services. Another important factor is consultancy fees. It was found that almost 26% providers charging consultation fees in between 10-50 rupees. The remained 74% health care providers not charged any consultation fees. As it was found that 97.50% unqualified health care providers visiting homes and nearby villages and interestingly they are not charging home visit fees. These practitioners having good relation with people. So, they avoid charging consultation fees or home visit fees most of the time. It was also found that informal providers preferred to refer the patients in critical situation at Government health facilities i.e. Community Health Centre and District Hospital. They refer the patients in private hospitals as well but not to prefer. It is indicating that there is no big issue of commission from private hospitals with these unqualified health care providers in the district. It was found that most of time people from rural area prefer these informal health care providers due to low cost treatment as the treatment costs maximum 200 rupees for 3-5 days medication in normal viral infections or non-serious, short term medication. The cost effectiveness of the treatment attracts people towards these providers. Also, it was asked from the providers that all the medication and testing is free in Government Institutions, then why people come to you. They shared the multiple reasons i.e. faith, distance between village to health facility, availability of medical doctor, long queue, immediate need of care in emergency, waiting time, conveyance to travel to health facility, not suitable timing of nearest CHC and PHC, labour loss of patient and attendant because they need to spend a day to access the treatment from CHC or district hospital, they feel okay with treatment of informal health care providers, 24 hours availability without any extra cost, no need to pay immediately after taking medication and so on. The informal health care providers faced some problems as well i.e. unavailability of pathology testing, health consciousness, don't pay money on time (sometimes pay after 6 months or a years), less medical shops in rural area.

Discussion:-

One of the common problems with Government health facilities in rural India is unavailability of healthcare providers such as doctors and nurses at Primary and Community Health Centers. The district Ganganagar having 1.97 Million population and 72.18% people living in rural area. The average population covered by Sub Centre 3,727, Primary Health Centre 28,153 and Community Health Centre 54,313 in Sri Ganganagar. The district has the total 47 Sub Centre, 24 Primary Health Centre and 12 Community Health Centers. Out of total 47 Sub Centers, only 48.7% have ANMs available in the field. There is huge gap between provisions and availability of human resource in primary health care services in Sri Ganganagar only 54.2% Medical Officers and 7.7% Lady Medical officers available against the provisioned positions at 24 Primary Health Centers (Welfare, 2012-13). This gap in human resources increases the scope for these informal health care providers. This human resource gap in public health care facility adversely affects the service uptake in rural areas. Moreover, informal health care providers available round the clock for local community and have build good rapport and community preferred to access the services provided by them.

The National Rural Health Mission (NRHM) was launched in 2005 for implementation of countries large scale program to strengthen the rural health care service delivery system. But it seems not much sufficient to serve the large population states like Rajasthan and lack of human resource at the public health facilities create another challenge in service delivery. The informal health care providers make home visits without any extra cost and spend more time with their patients. The data reflected that only 14.54% practitioners have a load of more than 50 clients per day. On the other hand, at Primary and Community Health Centers, medical officers have to cater large number of patients due to lack of other medical doctors and nurses. These all the reason gives the overwhelming reason to rural community and practitioners to come together.

It was found that majority of informal health care providers practicing allopathic medicines and they were not formally trained or qualified for that. Some of them have earned Ayurvedic diploma or certificates but practicing allopathic. It was evident that these unqualified practitioners are the first contact for any type common illness issues in rural area. It is suggested that AYUSH, Ayurvedic, Homeopathic practitioners can fill the gaps where allopathic medical professionals are not available. Also, as per the study findings, most of rural population preferred to consult and treated by these unqualified practitioners and reasons mentioned in previously discussions. People access the health care services from these practitioners forgetting the end results which can be more expensive and threatened. Planning to trained the unqualified practitioners can be short term solution but it will be a good idea in sustainable model of health care. Any type of a approach to fill the gap between health care service delivery through qualified and unqualified providers will not works but multidisciplinary method can be adopted like increase the number of

trained health care providers at public health facilities, increase in number of public health centers, utilize Ayush, Ayurvedic and Homeopathic practitioners in rural area in allopathic practitioners, special courses for trained and educated ANMs and GNMs which can be deputed in rural area, awareness among public towards public health, enforcement of law and verification of private clinics and medical shops.

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