



TO STUDY THE SOCIO – ECONOMIC STATUS OF PATIENTS AND ITS IMPLICATIONS ON HEALTH CARE

Shrikant Sharma^{*}, Sunita Hemani^{**}, G.N. Saxena^{***}.

^{*}Assistant Professor , Department of medicine, S.M.S. Medical College, Jaipur.

^{**}Assistant Professor , Department of Obstetrics and Gynaecology, S.M.S. Medical College, Jaipur

^{***} Professor , Department of medicine, Mahatama Gandhi Medical College, Jaipur.

ABSTRACT

Aim: This is a prospective study to assess the socio-economic status and various problems faced by the patient and their relatives. Co-factors like education, Income and awareness of public on healthcare were also assessed.

Materials and Methods: This Study was conducted on indoor patients in department of medicine at SMS Medical College. Relatives of admitted patient well given a questionnaire in Hindi with unbiased assistance to illiterate.

Results: Most of the patients belonged to low socioeconomic status with per capita income of less than Rs 5000 per month (56.8%) . In 76.5% cases the patient was the sole earning member of the family. People used their savings to meet the expenditure (76.3%) and 58.65% used public transport to reach the tertiary centre.

Conclusion: This study showed a direct co-relation of socio-economic status with health and use of the available resources. Lack of education is a hindrance in proper treatment and utilization of facilities. Government needs to further address these areas and make policies accordingly.

INTRODUCTION

'Study of health embraces the totality of life and ways of living'.

Health and healthcare is always affected by socio economic status (SES) of patient. On the contrary role of SES on disease morbidity and mortality despite being well connected, is lesser cared off, either due to overburdened hospitals or commercialized attitude of health care providers.

We can subdivide SES in fractions which definitely interlink directly or indirectly to health; these fractions can be education, awareness of health and health schemes, regional or cultural limitations, development and economic growth and lastly income of family. SES based management of patient can help to decrease economic disparity in our country.

AIMS AND OBJECTIVES

- 1- Socio economic status (SES) assessment of patient and his family
- 2- Effect of Variables (Education, awareness, Income etc.) on health and health care.

MATERIALS & METHODS

The present cross sectional study was carried out in admitted patients in department of medicine at Sawai Man Singh Medical College, Jaipur. The study was carried out during Dec

2009 to Dec 2010. Patients and their relatives were given a questionnaire. This was developed by authors and was based on literature review^{1,2,3} and extensive discussion with sociologists⁴, economists, anthropologist and statisticians. The questionnaire was provided in Hindi language only. Most of questions were of multiple choices and assistance by unbiased person was given to illiterate ones. Statistical analysis included calculation of percentages and proportions.

Various classifications for SES have been used in India. Classification of British Registrar general based on occupation being the fore runner, followed by Prasad's classification of 1961^{5,6} based on per couple monthly income (Modified in 1968 & 1970) to more commonly used classification now a days-the Kuppuswami^{7,8} scale to measure SES. We adopted Kuppuswami scale in our study to measure the SES which is based on three variables education, occupation and income with each variable having seven point predefined scale.

RESULTS

Data regarding the economic profile, illness, sources of income, affordability and sociological assessment was extracted by the questionnaire put to the patients admitted in SMS Hospital, Department of Medicine wards.

A total of 1860 patients were studied in terms of above parameters to have a glimpse of indoor patients' status in our center.

Economic Profile

About their Economics profile it was found out that in majority of cases, patient was the sole earning member of the family (56.5%) whereas 33.5% are either females or having a family with another earning member. Also fraction of females as sole earning member was very low.

56.8 % patients had monthly income between Rs 1001-5000 and 27.9% had income in range 5000-10000 Rs. Only 9.3 % patients were having income >Rs 10000. It implies that most of the patients taking treatment in our settings belonged to lower middle class and poor sections where as people earning good enough i.e. > Rs 10,000 usually do not get admitted in our hospital. It can thus be suggested that the state support in health management should increase and we also need a more sophisticated and far better infrastructure to cater the rest-the so called good enough earning strata. Wrong/ less disclosure of income for multiple reasons cannot be denied.

If the expenditure which a patient bears before coming to a tertiary Centre like ours is taken into account, we find that 64.6 % spend <1000 Rs/-, 25.1% spend between Rs 1000 - 5000, 10% spend between Rs 5000 - Rs10,000 and a negligible 0.01% spend >10,000. A tertiary carfare was adopted late in good numbers before spending in periphery. Does it mean that there is a need to strengthen our subcentres, Primary Health Centres, Community Health Centres and District hospitals with more skilled manpower and technology for better primary care and reduce load on tertiary referrals.

In 76.3% , the source of expenditure was their savings whereas 15.5% and 2.52% took loans and sold properties. Only a minority take the advantage of insurance policies(5.59%) which means we need to make these facilities available at grass root level and simplify it .

As the savings of the family are used for treatment purposes, expenditure in other areas is affected. Main areas affected in family are education (35.64%) followed by marriage expenses (14.4%). 47.4% of relatives had capacity to bear further expenses whereas 29.19% did not have any money to bear further expenses.

Illness Status

When illness status of admitted patients was studied, it was found that 21.1% have another family member suffering from chronic illness which indirectly suggests the prevalence of infection, environmental factors and genetic susceptibility.

Most of the patients approach tertiary hospital within 7 days (53.1%) whereas 24.03 % take up to a month. 21.2% patients take treatment for 1 year either in the form of alternative therapy, therapy at local hospital or no therapy. It indirectly says that acutely infected serious patients approach a tertiary Centre more than chronic disease patients. It also indicates that infections are still taking a major toll in terms of mortality and morbidity. Only 31.4% of patients take first consultation at the onset of disease. 7.9% report within 7 days. 56.6% of patients reported in the 7 days- 1 month period. Only 3.9% patients reported after one month.

Majority of patients relatives have mental stress because of underlying illness (92.8%) which indicates the underlying frustration and depression associated with disease, social and economic concerns of patient which stresses the patient.

SOURCES AFFORDABILITY

The attendants of ill person usually take shelter in lodges (53.7%) and a good number (39.5%) stay in hospital only during patient's indoor treatment. Minority have their own houses and even smaller section stay with their relatives. This suggests that most patients are from outside especially rural areas and face scarcity of resources. Most of the patients (58.65%) are taken to hospital in public vehicles and 32.09% came in hired vehicles and 9.24% only came in their own vehicles suggesting once again the limited self-owned resources of our patients.

Patients initially ignored their illness because of financial constraints (45.32%), unavailability of transportation (2.25%) and other causes like family function, alternative therapy etc. (40.8%)

DISCUSSION

Social, cultural, psychological, behavioral factors are important variables in etiology, prevalence and distribution of disease^{9,10,11}. Similarly living standard, habits, values and customs has always affected community health and social etiology of health^{12,13}.

We concentrated our study on family (reproduction nucleus of society) and funds available (economic nucleus of society) with interaction of both to (1) educational status, (2) social background and (3) awareness among people.

Education consists of knowledge and attitude with application of both by individual. Educational status is major factor responsible for socio economic growth potentials. Different states and selected areas within the state with different educational level may affect the scenario either way.

Educational reforms should be started at primary levels so as to join everyone inspite of their background or economic status to a common pool in which people are aware of their rights and healthcare schemes. Not only education improves sanitary habits but also earning ability which in turn reduces chronic disease burden. Social Class is determined by various parameters, mainly education, occupation and income. These three in turn affects the level of health and health care of person. We can divide population in various classes like upper, upper middle, middle, upper lower and lower using Kuppuwany's scale. Social inequality

especially in our society, which is diverse, multicultural, overpopulated and undergoing rapid but unequal economic growth is detrimental to the health of our society.

Awareness of population is conventionally expressed in terms of various health programs of Government & their utilization by them. Lack of awareness has always resulted in poorer health care.

CONCLUSION

The progress of a country depends of the health status of its people which in turn depends on various factors like education, dietary habits, economic status and availability of medical facilities. Studies like this one can help in identifying problems faced by the people regarding health sector and policies can be formulated accordingly to benefit the masses.

ECONOMIC PROFILE

Patient is sole earning member	Yes	1237 (76.5%)
	No.	623 (33.5%)
Per Capita income (monthly)	< 1000	420 (27.9%)
	1001-5000	1058 (56.8%)
	5001-10000	209 (11.2%)
	>10000	173(9.3%)
Previous medical expenditure (month)	< 1000	1203(64.6%)
	1001 – 5000	468(25.1%)
	5001 – 10000	187(10%)
	>10000	2(0.001%)
Present source of expenditure	Loan	289(15.5%)
	Savings	1420(76.3%)
	Property sale/lease	47(2.5%)
	Insurance	104(5.5%)
Work effected due to illness expenditure	Education	180(35.6%)
	Marriage	73(14.4%)
	Routine expenditure	54(10.6%)
Capacity to bear further expenditure	Yes	879(47.2%)
	No	543(29.1%)
	No reply	438(23.5%)

SOURCES AFFORDABILITY

Transportation of Patient during illness	Own Vehicle	172(9.2%)
	Hired Vehicle	597(32.09%)
	Public Transport	1091(58.6%)
Stay of Care takers	Hospital Campus	736(39.5%)
	Own House	78(4.1%)
	Lodge	999(53.7%)
	Relative's /Rented House	47(2.5%)
Cause of Ignorance of illness	Family Support	216(11.6%)
	Finance	843(45.3%)
	Transportation	42(2.2%)
	Others (alternative therapy, family function etc.)	759(40.8%)

ILLNESS STATUS

Any other family member suffering from chronic illness	Yes	393 (21.1%)
	No	1467 (69.9%)
Duration of Present illness	<7 days	988 (53.1%)
	7 days - 1 month	447 (24.03%)
	1 month - 1 year	396 (21.2%)
	>1 year	29 (1.5%)
Duration of onset of illness and 1st consultation	Disease Onset	585 (31.4%)
	<7 days	148(7.9%)
	7 days - 1 month	1054(56.6%)
	>1 month	73(3.9%)
Mental stress because of illness	Yes	1727(92.8%)
	Mp	54(2.9%)
	No reply	79(4.2%)

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