A critical analysis of individual patient factors in gaining access to healthcare

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Significance:
Impartial access to health care is the right of every human being. Even though it is the first priority of every doctor to provide the best care to their patients, often times, patients do not have equal access to health care. This research was conducted to evaluate such parameters which affected patients' experience with the healthcare system. This research would serve as the guiding principles that the doctors can adopt to remove such prejudices from their practice.

ABSTRACT

Background: Pakistan is one of the largest host of refugees. People in Pakistan have bad access to healthcare not only due to bad facilities but also due to discrimination based on their personal characteristics and possessions. The behavior not only damages the dignity of the people being targeted but also creates hindrances in further seeking professional medical help and follow-ups thus deteriorating the health status of the community as a whole. Health providers possess a moral commitment to encourage dignity and treat their patients without any kind of discrimination in their behavior. Patient experiences of discrimination result in delay in seeking healthcare, they do not stick to advice of professionals and ultimately poor health. The objective of this study is to identify sources of discrimination and its effects on patients' health status and their level of satisfaction.

Methods: This descriptive study took place in Outdoor Patient Department, Mayo Hospital, Lahore. 170 patients were selected from all the patients coming to OPD with equal male to female ratio. Each patient was given a questionnaire containing relevant questions to know whether they faced any sort of discriminatory behavior or not.

Results: 66% females and 49% males of the study sample experienced discrimination at some stage of their hospital visit.

Conclusion: Our study concluded that females experienced more discrimination than males. Therefore, gender is the most important factor when it comes to discriminatory experiences. Moreover, people with the higher income had fewer incidents of discrimination than their counterparts.

Introduction

In Pakistan, the system of health has basically been originated from the health system of British before the Independence of subcontinent. It consists of primary , secondary and tertiary healthcare that is gradually evolving with time. Discrimination means the prejudice or partiality those different categories of people face. Discriminatory behavior based on people's socioeconomic status, their sexual identities and various racial, religious or ethnic backgrounds is a ground reality globally. In a research conducted about discriminatory experiences on African American it was found that 63% felt discriminatory behavior in accessing to healthcare due to their colour and race and 58.9% felt distinctive behavior due to their low socioeconomic rank. (1) Often a visible contrast in health laws of a country and provision of health care facilities is observed. (2) Discriminatory behavior is faced by different category of people and the numbers vary in different settings. It was revealed that more than 10 percent of patients suffered some sort of distinctive behaviour in their stay at hospital, the common patient factors were age, language, nationality, these factors being negatively perceived. Skin color, sexual orientation, and income based discrimination were relatively uncommon. Any type of discrimination was associated with lesser satisfaction of the patient as compared to patients facing no discrimination. (5)

A country must possess a health system that protects the integrity and physical dignity of each individual. The individual physical dignity and integrity is recognized in international law. (3) Health providers possess a moral commitment to encourage dignity and treat their patients without any kind of discrimination in their behavior. (4) Patient experiences of discrimination result in delay in seeking healthcare, they do not stick to advice of professionals and ultimately poor health. (5) Pakistan is one of the largest host of refugees. People in Pakistan have bad access to healthcare not only due to bad facilities but also due to discrimination based on their personal characteristics and possessions. Refugees also suffer from discrimination in host country. Findings from both Canada and Sweden show decline in their health status after settling in host country. (6) Because of discrimination there is underutilization of health care consequently increase in morbidity and mortality. (7) Maintaining and assuring patients dignity must be a top

priority of healthcare providers. The ideology of dignity is clarified by its characteristics. In interviews with 102 patients Matiti (2002) 11 classes of attributes were found i.e. ,confidentiality, control, involvement in care , need for information, privacy , form of address, nurse patient communication, Independence, form of address, choice, decency, and respect. (8)

The behavior not only damages the dignity of the people being targeted but also creates hindrances in further seeking professional medical help, follow-ups and hence the deteriorating health status of the community as a whole. So, in order to prevent and rectify the problems mentioned previously and for effective steps to be taken and policies are made, there is a need for identification of the reasons that lead to a discriminatory behavior towards the general while accessing healthcare.

The main aim of our study is to improve the healthcare utilization by assessing discriminatory culture in public health care system. The objective is to identify sources of discrimination and its effect on patients' health status and patients' level of satisfaction.

Materials and Methods

The design of our research is "Descriptive Survey". The study was conducted at Outdoor Patient Department, Mayo Hospital, Lahore. The duration of our study was 9 months from January 2019 to September 2019.The sample size of 170 patients is estimated by using 95% confidence level, 5% absolute precision with expected %age as 12.6%. The sampling technique used is Non-probability Convenient sampling. All the patients over 18 years of age coming to the Outdoor Patients Department for checkup or follow-up were included in our study. Data was collected through a pretested questionnaire. Questions were selected from Picker patient experience-15. Questions were selected according to our social settings by research team and were translated both in English and Urdu and any ambiguous question that could be misinterpreted was rephrased. Every participant was given appropriate time to complete the questionnaire and research team helped the participants in understanding the questionnaire. Data was collected using the questionnaires and was entered in SPSS-26. The variables were created related to the data which included gender, socioeconomic status, religion and discrimination out of which nominal measurements were used for gender while the other variables were measured on a scale where certain values obtained from the bio-data of patients were added for analysis. Tests of Association and Descriptive statistical analysis was performed on the data and frequency tables were obtained for each variable which reported the relative distribution of each variable separately. Graphical analysis was also performed using bar-graphs to obtain the visual correlation of different variables. Chi-Square test was performed to find out the significance of the difference between expected and observed data. The p value <0.05 was the standard set for considering the statistical significance. Cross-tabulations were structured for each variable with discrimination separately and the p value for gender was 0.03.

Results:

The analysis revealed that out of one-seventy patients 77 (45.3%) faced discriminatory behavior from the healthcare staff while the other 93 (54.7%) did not report any sort of discriminatory experiences. Gender based discrimination was the highest compared to others while patients reporting discrimination because of language or religion were rare. Discrimination was reported more frequently by women than by men, not only by younger patients but also by the very old. 56 (66%) females experienced discriminatory behavior from the healthcare staff compared to 42 (49%) males. Cross-tabs also showed a significant relationship between discrimination and gender with p value <0.05 on chi-square test since the number of females who reported discrimination was significantly greater than the expected count. Discrimination based on religious beliefs was not significant at all. One possibility of that maybe the unavailability of religious diversity in the data set. No relationship could be established between religion and discrimination.

Discrimination based on socioeconomic status was also present to some extent. 35 (20.5%) were those with income between ten and fifteen thousand rupees per month, 47 (27.6%) were those with income between fifteen and twenty thousand rupees per month, 24 (14%) had income between fifteen and twenty thousand rupees and only 5 (3%) were those with income greater than twenty thousand rupees per month. But no statistical relationship could be established using chi-square test.

Experiencing discrimination from any cause was associated with higher problem scores on the questionnaire compared with no or fewer experiences of discrimination. People with experiences of discrimination in the past were also less likely to reconsider the idea of revisiting the hospitals.

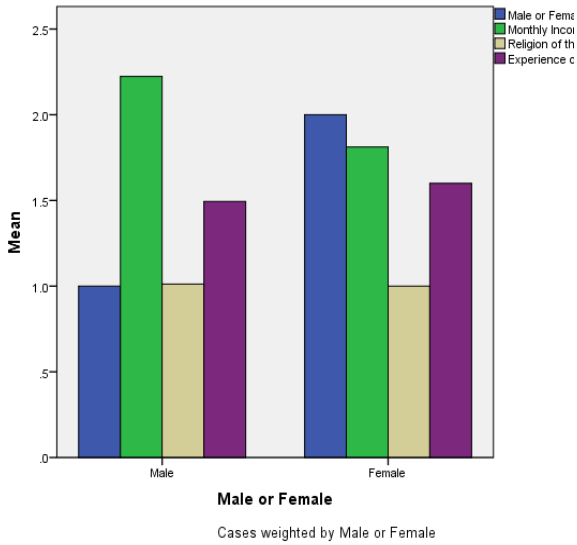

Figure 1- Bar graph plotting means of different variables weighed by Gender

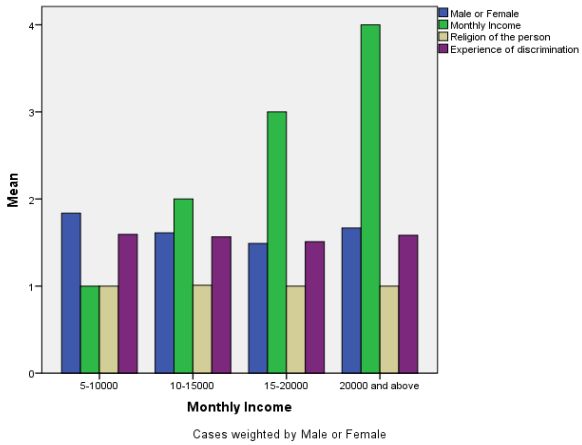

Figure 2- Bar graph representing the association of variables weighed by Monthly Income.

Discussion

Prevalence Our study was focused on the patients visiting the tertiary care hospitals for checkup and analyzed different possible causes of discrimination that included socioeconomic status, gender and religion. Regarding socioeconomic status our data suggests that higher family income decreases likelihood of individuals reporting perception of discrimination in healthcare. Consequently, people with lower family incomes had to face some discrimination while accessing healthcare. However, gender was the most significant source of discriminatory experiences as females had to face more discrimination compared to males. Religion was not found to be related to discrimination possibly because of lack of diversity in the data set so there is a need for the conductance of further studies regarding that variable with more diversity in the sample.

According to UNDP's human development report (1996) gender equality measures (GEM) for South Asia shows the lowest value (0.235) among all the regions of the world. Furthermore, as per gender development index (GDI) Pakistan has been rated the poorest (0.179) among south Asian countries, where the average index is 0.226. (10)

All this data strengthens our research finding that female gender suffers from discrimination while seeking healthcare opportunities. However, the magnitude of discrimination based on gender was quite low in our study which makes us think that there must be some other factor responsible for discrimination in healthcare access.

Pakistan's population is increasing exponentially which obviously demands a widened and more equipped public healthcare system to cope with the medical necessities of the people. The WHO reports the density of physicians (per 10,000 populations) to be 7.8%. (11) These statistics clearly indicate that resources and consumers are not balanced to an appreciable extent. Therefore, a small portion of socially privileged individuals have easy access to healthcare. This is in line with our finding that socio-economic status is an important factor while assessing discriminatory experiences in patients. This is consistent with previous research that indicates that those with multiple disadvantaged status experience more discrimination than those with privileged social status. (12, 13, 14, 15, 16)

A research conducted in USA indicated that African Americans and Hispanics believed they would've received better medical care if they were different race while this was not the problem in case of White Americans. (9) We also considered the racial factor while investigating discrimination in healthcare access in our study but no significant data was found in this regard.

Members of different socioeconomic classes were more likely to perceive discrimination when in worse health. Therefore, it is important to check "frustration effect" i.e. when individual feels poorly there is tendency to feel that health professionals are not attentive towards them. (9) This feeling of frustration may lead to perception of discrimination even among high income group members and those with other social advantages. However, our study could not check this effect.

Together, these findings underscore the significance of clinical quality of clinical encounters and the need to appreciate patients' past as well as present experiences with inequality. Taking in consideration the results of this study, healthcare providers must ensure that no

patient is treated differently because of his/ her gender so the generalized health of the community is improved.

Conclusion

Discriminatory behavior was observed especially in case of females and low-income level individuals. So, gender and socioeconomic status are the two factors that impact patients' overall experiences while utilizing the healthcare facilities. We could not access racially and religiously diverse data because of lack of availability of the diversity in our data set or study settings. A larger sample size or different study settings may be needed for that purpose.

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Human/Animal Rights: No human or animal rights are violated during this study.

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