Sir,

Once considered a disease of rich, diabetes has silently deepened its roots among urban slums of megacities\(^1\) where the provision of good quality basic health services is highly questionable\(^2\) and so are services for diabetes, one of the most expensive diseases.\(^3\) In India, significant proportions of individuals, seek treatment from private health facilities in both urban and rural setup.\(^6\)

The present study is an effort to find out a preferred place for health-care utilization among diabetes patients in an urban resettlement colony, Kalyanpuri, Delhi. All the diabetes patients aged more than 25 years and who were a permanent resident of Kalyanpuri, attending the Diabetic Clinic of a tertiary care hospital for 2 months (November–December 2014) were enrolled.

Approval from Institutional Ethical Committee of the hospital was taken for this study. Informed written consent from all the enrolled patients was taken. Patients of gestational diabetes and those who did not give consent for the study were excluded from the study. Thus, we included 153 patients in our study. We conducted multiple house-to-house visits among all the selected patients at a regular interval of 3 months for 1 year, i.e., January–December 2015. The follow-up visits were made to minimize the recall bias in remembering all the treatment details major and minor related to health-care utilization.

Here, in each visit, we enquired about a visit to the doctor for consultations, availing of medications and investigations, and all details related to hospitalizations for diabetes care. In the first visit, we also requested them to keep a record for all the above-mentioned things as far as possible.

Out of 153 individuals, one patient died and two migrated out, so finally, data of 150 patients were analyzed. Majority individuals were female (105 [70%]), aged between 35–65 years (95 [63.5%]) and belonged to upper lower (73 [48.7%]) and middle (71 [47.3%]) socioeconomic class.

Despite being enrolled in diabetic clinic of a government hospital, 33 (22%) subjects had to visit private health facility for routine follow-up visits. Various reasons for private consultations were nonsatisfaction with treatment (60.6%), long waiting hours outside OPD (45.5%), and being covered with medical insurance (15%).

Another major finding in our study was that a large proportion (89.3%) of individuals had to buy medicines from the private pharmacy, which is much more than patients who visited private doctor for consultations. This shows a significant proportion of subjects had to buy medicines from the private pharmacy, despite being followed up at diabetic clinic of the government hospital. Nonavailability of medicines in the government hospital dispensary (70.9%), long queue at dispensary counter (35.8%), and side effects after taking medicines from the government (25.4%) were the common reasons.

Similarly, majority (83.3%) patients had to visit the private laboratory for investigations; reasons being long waiting hours for investigation in the hospital laboratory (72.7%), nonavailability of some investigations (10.4%), medical insurance (4%), and poor staff behavior (1.6%).

Four individuals stopped visiting any doctors and started purchasing medicines from private medical stores and getting their blood sugar test done from private laboratory without any further consultations.

For inpatient services, out of total 41 individuals who got hospitalized during the study for diabetes-related complications, 18 (43.9%) individuals got admitted to private hospitals. The main reasons reported were overcrowded wards, poor satisfaction with the treatment given in health-care facilities and nonavailability of beds in 77.8%, 16.7%, and 5.5%, respectively.

This is first of its kind of study on utilization of health-care services among diabetes patient in economically underprivileged community. Despite being enrolled in the diabetes clinic of a tertiary care hospital, patients preferred private facilities for various aspects of diabetes care. To avail these services from private, the majority had to spend either from their pocket or take credits from relatives as only 11 (7.3%) individuals were medically insured in our study. Moreover, the health services are mainly provided by untrained private practitioners, in such areas which could lead to poor management of diabetes and henceforth complications.

Hence, we conclude that the government health sector is not adequately equipped to meet the demands of the growing diabetes population, which force people to utilize private sector and bear out of pocket expenditure (OOPE). The strengthening of government health sector is required, especially in terms of laboratory services and drug availability. Along with it, steps to increase coverage of health insurance, especially among poorer sections to decrease OOPE on health and quality control of both private and government health sectors need to be taken. We hope that addressing above-mentioned issues will help diabetic patients in a great way and in achieving the WHO theme of Universal Health Coverage.
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Archana Thakur, Tapas Kumar Ray, Manish Kumar Goel
Department of Community Medicine, Lady Hardinge Medical College,
New Delhi, India

Address for correspondence: Dr. Archana Thakur,
D93a Pratap Garden, Uttam Nagar, New Delhi - 110 059, India.
E-mail: archanat786@gmail.com

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