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Therapeutic Perception of Access to Medicines and Health Care in Government Hospital of Union Territory of Jammu and Kashmir

MZM Nomani[1], Ajaz Afzal Lone[2], Alaa KK Alhalboosi[3], Aijaj A Raj[4], Bilal Allail[5]

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Abstract

The therapeutic perception of access to medicines and health care in government hospital of Union Territory of Jammu and Kashmir (UToJ&K) is an empirical study of Sher-i-Kashmir Institute of Medical Sciences (SKIMS), Srinagar in right based approach underpinned in *Patents (Amendment) Act*, 1970, *Patents (Amendment) Act*, 1999, *Patents (Amendment) Act,* 2002 and *Patents (Amendment) Act*, 2005, *Essential Commodities Act,* 1955 and *Drug Price Control Order*, 1995. On the other hand consumer law perspective are rooted in *Consumer Protection Act,* 1986, J&K *Consumer Protection Act,* 1987 and *Consumer Protection Act,* 2019. The broad parameters are access to medicines, health care system, health delivery services, patient satisfaction and utility and doctor – patient relationship. It is estimated that substantial section of population in Union Territories of Jammu and Kashmir is health deficient and medicine starved due to unavoidable contingency, spiraling cost shifting and inordinate health care infrastructures. The therapeutic perception needs a closer analysis of attendance and care of patients, diagonostic methods of treatment and access to medicine in the context of medico-legal profiling of SKIMS, Srinagar.

Keywords: Therapeutic perception; Access to medicines; Health care; Diagnostic methods of treatment; Doctor–Patient relationship.

Introduction

The access to medicines refers to the ability of all persons to receive the medicines necessary for the treatment of any condition afflicting them. It includes that these medicines are available, accessible, acceptable under physical, informational and economic access to vulnerable and marginalized sections of the population.[1] The access to medicine has been a key ingredient of desirable health policies however in India it is below 35% due to several barriers and aggravating circumstances.[2] Globally the subject is attended by *Universal Declaration on Human Rights,* 1948, *International Covenant on Economic, Social and Cultural Rights*, 1966. *The TRIPS Agreement*, 1995 flexibilities under the *Doha Declaration on Public Health,* 2001 and *United Nations Sustainable Development Goals* 2015–2030[3] and *United Nations Secretary-General's* High-Level Panel On Access *To Medicines: Promoting Innovation And Access To Heath Technologies Which Review And Assess The Situations of Health Technologies Report*, 2016.[4] The legal and intellectual property dimension of health and access to medicines in India is governed by the *TRIPS Agreement*, 1995 and the *Patents (Amendment) Act,* 1970, *Patents (Amendment) Act,* 1999, *Patents (Amendment) Act,* 2002 and *Patents (Amendment) Act,* 2005, *Essential Commodities Act,* 1955 and *Drug Price Control Order,* 1995.[5] The health care delivery system is guided by *Consumer Protection Act*, 1986, *Jammu and Kashmir Consumer Protection Act,* 1987 and *Consumer Protection Act,* 2019 in terms of consumer right awareness.[6] Such access is deemed to be part of the right to health and supplemented by *National IPR Policy,* 2016 and *National Health Policy,* 2017 in balancing the public interest in health

Authors Affiliation: [1]Professor, [2–5]Research Scholar, Faculty of Law, Aligarh Muslim University, Aligarh 202001 Uttar Pradesh, India.

Corresponding Author: MZM Nomani, Professor, Faculty of Law, Aligarh Muslim University, Aligarh 202001 Uttar Pradesh, India.

E-mail: zafarnomani@rediffmail.com

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care system.[7] On the ground of reality, a silent crisis is confronted by patients seeking treatment of acute and chronic diseases in India. Firstly, 40% of Indians live on less than US$1 per day and most of them pay out of pocket for using healthcare. Secondly out-of-pocket spending in India is over four times higher than public spending on healthcare. Thirdly the direct out-of pocket payments could push 2.2% of all healthcare users and one-fourth of all hospitalized patients, into poverty in a year.[8] A study has shown that patients belonging to the low income group in urban India were spending 27% of their annual income and those in rural India 34% of their annual income on diabetes care and purchase of medicines.[9] A recent study calculated the expenditure incurred on outpatient treatment of community-acquired pneumonia as a proportion of the mean per capita expenditure on food.[10] On the other hand the urban patients spent 17.6% of their mean per capita expenditure on food (rural patients spent 23.4%) on the medicines prescribed for community-acquired pneumonia.[11] The lack of access to essential medicines 348 drugs are listed in the national list of essential medicines of India give rise to unexpected illness having a catastrophic effect on the family of the ill person.[12]

Materials and Methods

The materials and methods applied for the study include analytical method of legal research by undertaking the legislative survey and scrutiny of health care laws at international, national, regional and state levels. The comparative law study of international health and consumer laws is based on established canons of statutory interpretation.[13] These laws are studied under Brint and Williams' pragmatism in law and society of Union Territories of Jammu and Kashmir.[14] While undertaking this study the behavioral approach is focused on changing risk factors and lifestyle behaviours along with the determinants approach which situates health and social problems in the broader social, structural and cultural conditions of our society and informs public health and health promotion approaches. Thus penultimately health promotion approach is the process of enabling people to increase control over, and to improve their health. The material and method reveals that health promotion work is strongly influenced by the knowledge derived from the determinants of health approach and consumer right awareness. The study partake the empirical framework of SKIMS, Srinagar a premier medical institution in the UToJ&K in terms of access to medicines, health care system, health delivery services, patient satisfaction and utility, doctor–patient relationship.

Results

The health care services in the UToJ&K are important not only for human resource development, but also for restoring the faith of the people in the institutions of governance. At present there are 5,534 health institutions (4,433 governments and 1,101 private) functional in the UToJ&K. Among these there are two notable medical colleges, namely Government Medical College, Bakshinagar, SKIMS whereas four new medical colleges have been set up in Anantnag, Baramulla, Kathua and Rajouri districts of the state.[15] (Fig. 1).

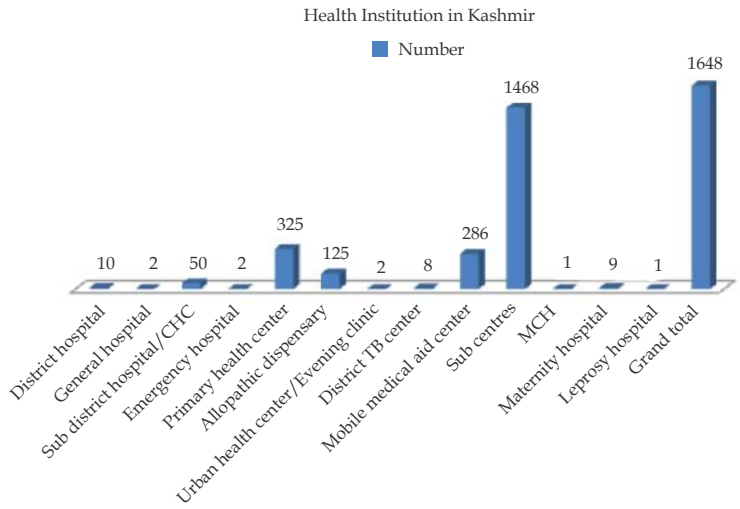
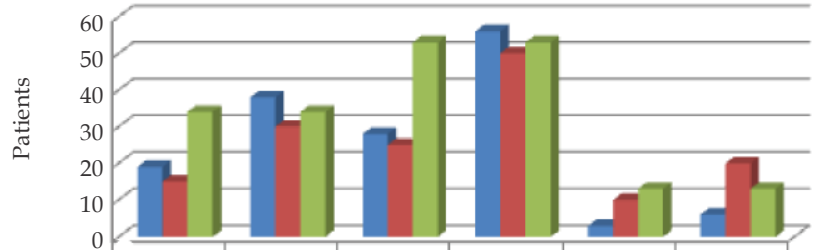


Fig. 1: Health Institution in Kashmir
Source: http://jkhealth.org/new2017/

Satisfaction towards health care delivery: To assess the health care services and patient satisfaction a survey of 100 patients admitted to SKIMS was conducted regarding by applying randomized sampling method. The following Table 1 and Chart 1 shows the responses of patients having varying degres of satisfaction towards medical care in SKIMS.

In health care services the patient satisfaction is an important and commonly used indicator for measuring the quality in health governance. The above table clearly shows that 34% respondents were quite satisfied and 53% respondents said that they are partially satisfied. When we asked patients about the medical care they received 13% respondents is oblivious of any opinion on the subject.

Table 1 & Chart 1: Satisfaction towards health care delivery



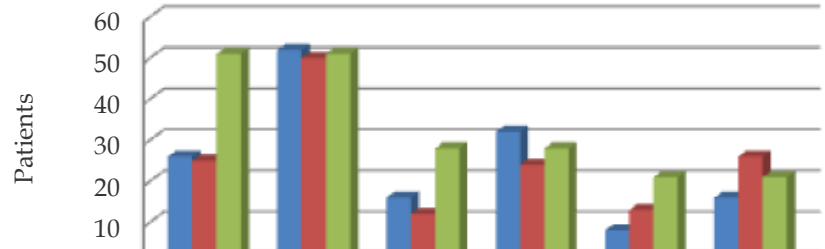
	Satisfied	%age	Partial	%age	Indifferent	%age
In Patients 50	19	38	28	56	3	6
Our Patients 50	15	30	25	50	10	20
Total 100	34	34	53	53	13	13

Source: *Field work*

Patient–Doctor relationship and health care: The attendance and attention constitutes an important segment of health care system under patient–doctor relationship.[16] The adequacy of time given to patients presumably considered indices for better for health care and staisfaction to the patients.[17] A simple question put to patients as to whether doctors devote adequate time to a patient during diagonostic treatment and therepeutic perception Table 2 and Chart 2.

The patients interviewed while undergoing the treatment in SKIMS reveals that the majority of respondents 51% agree that doctors devote adequate time to a patient during the treatment and 28% opined that the doctors donot give their adequate time while treating patients. However 21% respondents are not very circumspect to doctors diligence.

Table 2 & Chart 2: Patient–Doctor relationship and health care



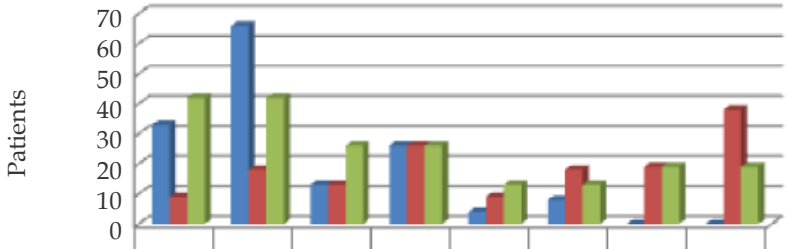
	Yes	%age	No	%age	Indiff-erent	%age
In patients 50	26	52	16	32	8	16
Our patients 50	25	50	12	24	13	26
Total 100	51	51	28	28	21	21

Source: *Field work*

Disease burden and doctors circumspection: The disease burden, appointment and availability with doctors represents uneven ratio in the hospitals. The enormity of outpatient department receiving medical services at appropriate time happens to be the central inquiry while getting treatment in SKIMS Table 3 and Chart 3.

Nobody disagrees to the proposition that the time and health are two precious assets that we don't recognize and appreciate until they have been depleted. The survey on this count reveals that 42% said that they had to wait for 2 hours for getting admitted in hospital to avail medical services, 26% respondents said that they waited for 2 to 4 hours for availing medical services, and 13% respondents waited for 4–6 hours. However, 19% respondents were waiting for more than 6 hr while receiving medical services in hospital.

Table 3 & Chart 3: Disease burden and doctors circumspection



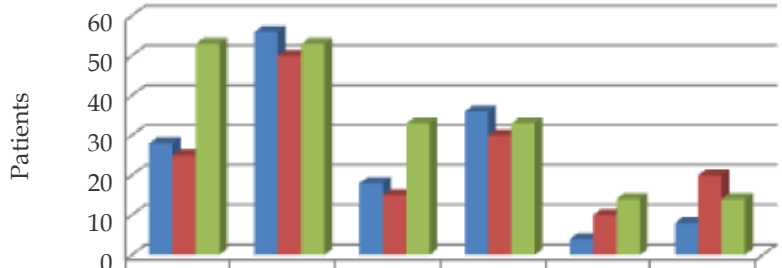
	0-2 hr	%age	2-4 hr	%age	4-6 hr	%age	6 hr or more	%age
In patients 50	33	66	13	26	4	8	0	0
Our patients 50	9	18	13	26	9	18	19	38
Total 100	42	42	26	26	13	13	19	19

Source: *Field work*

Diagnostic and prognostic line of treatment: The enhancement of the accuracy of the diagnosis and prognosis are the key determinants of doctor–patient relationship. The patient's knowledge about the disease and medical tests are to be done in holistic health care framework. The simple question as to whether doctors are good in explaining the reason for conducting medical tests in auguring medication and treatment in their diagnosis and prognosis Table 4 and Chart 4.

The patient interviewed regarding their response to medical tests revealed that the majority of respondents 53% are pretty satisfied with the doctors explaining the reason for conducting medical tests and 33% shows that the doctors don't explain reasons for medical tests. 14% respondents are either ignorant or indifferent about doctors explaining reasons for medical tests.

Table 4 & Chart 4: Diagnostic and prognostic line of treatment



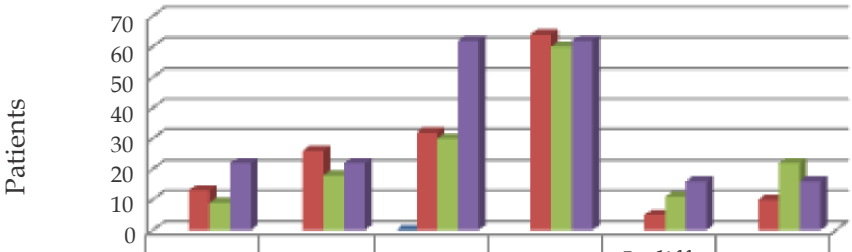
	Yes	%age	No	%age	Indiff-erent	%age
In patients 50	28	56	18	36	4	8
Our patients 50	25	50	15	30	10	20
Total 100	53	53	33	33	14	14

Source: *Field work*

Access and availability of medicines: In the entire process of health care system, the access to medicine is pivotal to health and well being of people. The medicines provided by government hospitals on subsidized rates to needy and poor people are an important benchmark. The aim and objective of medicine delivery on subsidized rates to poor patients is all the more important for health right and equity because the exorbitant rates of medicine and diagnostic treatment often pushes them into destitution and misery Table 5 and Chart 5.

The question related to access to medicine by patients at subsidized rates at government hospitals revealed that 22% respondents received medicines on subsidized rates whereas bulk of respondents 62% said that they are deprived of access to such medicines. However, 16% respondents are either ignorant or indifferent about their entitlement and access to medicines.

Table & Chart 5: Access and availability of medicines



	Yes	%age	Some	%age	Indiff-erent	%age
In patients 50	13	26	32	64	5	10
Our patients 50	9	18	30	60	11	22
Total 100	22	22	62	62	16	16

Source: *Field work*

Discussion

The therapeutic perception of access to medicine and health care UToJ&K discerns multiple approaches and perspectives namely the biological approach, biomedical approach, primary health care approach and public health approach in advancing equity, access, empowerment and preventing epidemiology and biostatistics to health protection.

Access to medicines in J&K: According to the World Health Organization (WHO), an estimated 649 million people in India do not have regular access to essential medicines. The median availability of 30 essential medicines in six states in India varied between 0 and 30%. Therefore, patients are forced to buy medicines from the private market despite ill affordability and sharing burdens of sickness and healthcare costs.[18] The study has also documented that of the rising out-of-pocket expenditures on healthcare, which pushes an estimated 32–39 million people below the poverty line annually more than 70% of expenditure was incurred on purchase of medicines. Every year, UToJ&K consumes medicines worth ₹. 600 cr, of which ₹ 400 cr is spent in Kashmir alone. 63% of J&K's population do not have purchasing power for medicines. 90.39% purchase drugs through out-of-pocket payments.[19] The study has shown that out-of-pocket costs were lowered significantly among patients who were prescribed generic medicines compared to patients who were given branded drugs.

Jammu & Kashmir drug policy: It is under this backdrop, the UToJ&K framed a policy to provide free medicines in all government health facilities. The State Administrative Council (SAC) formulated the *Free Drug Policy*, 2012 mandating all government hospitals to provide essential and generic medicines free of cost to patients based on prescriptions by government doctors.[20] The procurement of quality drugs and timely supply by Health and Medical Education Department and Drug and Food Control Organization promote equitable, affordable and quality health care. However constraints of capacity and commitment need to be revamped because of persistent disturbances and unrest since 1989.[21]

Health care delivery system: The health care delivery system is one of the worst hit services. The exodus of health care professionals from the valley created a vacuum during early 1990s adversely affecting the basic health services. The inadequate

health infrastructure, exodus of health care professionals coupled with lack of good governance has led to collapse of health care delivery systems.[22] The emergency care including trauma and disaster management service is available only in Srinagar and Jammu cities. Towns and rural areas have hardly any such facility and have to transport the patients to long distances which many times results in avoidable deaths on the way. The golden hour is lost in these long distances. Thus the improper implementations of national health programmes are highly discouraging because of accessibility of remote areas for communities like Gujjars and Bakarwals.[23]

Conclusion

The objectives of health for all enunciated the *National Health Policy* in 1983 in the context of UToJ&K thrust upon preventive and rehabilitative health care services at primary, secondary and tertiary level. The constraints in the improvement of health status of the people included lack of financial resources, dearth of technical staff, and inadequate health infrastructure. Recently the abrogation of Articles 370 and 35A of the *Constitution of India*, 1950 and Constitution of Jammu & Kashmir, respectively opened new vistas by for setting up of two medicities in Jammu and Kashmir. The facilities expected in the medicities includes medical colleges and hospitals, super specialty centres of excellence, nursing, pharmaceuticals, hospital management and dental colleges, ayurvedic colleges and hospitals and medical education hubs, AYUSH centers, research centers with residential areas, staff quarters and guest houses, etc. under these circumstances the private sector presence will increase manifold and patients will be forced to overpriced medicines. This makes public health system in UToJ&K more daunting in the context of health equity and governance. This is more glaring evidence of poor budgetary provision, lack of a comprehensive policy, and feeble regulatory framework to access to medicines and health care delivery in UToJ&K.

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