

The Quality of Life and Satisfaction Level among the Doctors Working in Rural Areas of India

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ABSTRACT

The study aims to measure The Quality of Life and Satisfaction Level among the Doctors Working in Rural Areas of India, the challenges faced by them and to understand the determinants of stay on the job. The sample comprised of 40 doctors from rural areas of Maharashtra using convenient sample method. The data was collected using Quality of Life(QoL): BREF (WHO, 1996) and Satisfaction with Life scale (Ed Diner, 1985) and the scores obtained were analyzed using T-test and Pearson product moment correlation and thematic analysis were used for analyzing the qualitative data obtained. It was found that there is a significant association between the satisfaction levels among doctors when compared with various domains of QoL. The satisfaction of life was significantly associated with physical, social and environmental domains. It was also significantly associated while comparing the doctors who went willingly to rural areas as compared to doctors who went unwillingly. The association was seen in the physical and psychological domain of QOL. Hence, the satisfaction level is seen to be associated with QoL. The results obtained from the present study indicated that those who choose rural service have better QoL and are more satisfied. It is, therefore, important to promote motivation among young doctors to choose to serve their country in rural areas.

BACKGROUND

Apart from all the progress achieved by India on the health-related services, India still ranks very low in the world in terms of health indices. The health system is yet to achieve full coverage in India and many remote rural and tribal parts of India face an acute shortage of health care providers. (National Health Profile, 2015), There is also a vast difference between the doctor-patient ratios among different areas. This difference is seen more in urban-rural or urban tribal context. The difference between the health facilities and workforce in various states of India is also seen. On one hand, there are states like Delhi with doctor-patient ratio of 1:470 and on the other extreme, there are states like Haryana with this ratio being 1:15000. The WHO norms for doctor-patient ratio are 1:1000. The overall doctor-patient ratio for whole India is 1:1472 which is still lower than the norms set by the WHO. Another difference in this ratio is that more than 70 % of doctors' workforce is living and providing services to the people in urban areas while the rest are working in rural India (National Health Profile, 2015). A study done on human resources for health in India shows that India faces a big deficit in Health workforce. It is around a quarter of what the WHO has proposed as a benchmark, which is 2.3/1000 population. There also appeared to be a big problem with unqualified doctors (37%). In rural areas, the problem of unqualified doctors is even more (63%). Since there is no service provider in the community; the people have no other choice (Rao, 2012).

The research study "beyond job security and money: driving factors of motivation for government doctors in India", published in 2014 found out that 70% of the doctors interviewed were unwilling to work in rural areas. The top most reason for leaving or retaining service was found to be lack of professional growth, lack of clinical experience, delays in post-graduation studies, living conditions are poor, no good schools are available, lack of job opportunities to their spouses. Some of the doctors had never experienced rural life and they didn't want to experience hardships. Infrastructure is also a reason which contributes towards the unwillingness of doctors to work in rural areas. Rural areas have no roads and transport accessibility which is again a major reason (Purohit & Bandopadhyay, 2014). It was found that fertility and family responsibilities influence a married female health workers' chance of mobility, whereas economic and labour market factors influence the mobility of married male health workers (Smith & Duncan, 1998).

There is a lack of such genuine research which had studied the QoL and level of satisfaction among doctors who once worked in the rural part of India and what are the various challenges faced by them. The answers are we need to increase our understanding towards the attitude of such doctors towards their job and might give us some clues to help solve the problem of disproportionate allotment of doctors in urban and rural India. This study also intends to find out whether the doctors who worked in rural area are still satisfied and happy with their decision to work in such places or not.

METHODOLOGY

Hypotheses of the study

1. There will be a significant relationship between satisfaction and QoL in all domains physical, psychological, social, and environmental.
2. There will be a significant difference between by choice or forced transfers on satisfaction and QoL in all domains (physical, social, psychological and environmental).

3. There will be significant difference between doctors living with family and staying alone, on satisfaction and QoL in all domains (physical, social, psychological and environmental).
4. There will be a significant difference between average socioeconomic status and high economic status on QoL in all domains (physical, social, psychological and environmental).

Research design

A mixed method of study was used as a research design using a quantitative and qualitative approach in order to generate the evidence. While taking interviews of doctors they were asked to fill three quantitative questionnaires. Thereafter, a semi-structured interview of doctors was taken and recorded. Conducting the study within the hospital settings helped the study to build strong evidence from observation and to avoid bias.

Sample and sampling method

The convenient sampling method was followed to select 40 doctors. The doctors chosen were both from government and NGO sectors who are either already working or have worked in rural parts of the state of Maharashtra. The doctors who have worked in rural areas, doctors who are going to appear for PG exams and the doctors who are working from at least last 1 year were included in the sample. Doctor’s qualification should be AYUSH, MBBS, any specialist in MD (Doctor of Medicine) or MS (Master of Surgery), Ayurveda, homoeopathy or other parallel therapists. Doctors were contacted and they gave consent for taking the interview. Permission was taken from the authorities if the doctors were working for any institution. The interview was taken by the researcher.

A quantitative survey was done to understand the respondents’ socio-economic and other demographic indicators as well as the satisfaction level and QoL among the doctors working in rural area of India together with challenges faced by them. An in-depth interview was then conducted by the researcher to understand the issues pertinent to the topic, the objectives and the hypotheses. The interviews were taken in the month of April and May of 2017.

Study tools: In the study, there are three types of questionnaires used, first is demographic questionnaire with basic details and other details such as specialization, family composition, and family staying in the same place or outside. Satisfaction with life scale by Ed Diener was used to measure satisfaction level. The validity and reliability of the scale have been authenticated.

Data Analysis: for qualitative data thematic analysis was used and quantitative data-test was used to find the difference between two groups. Pearson’s product moment correlation was used to find out the relationship between variables. All calculations were done using statistical package for social sciences (SPSS).

RESULT

Table 1: Correlation between satisfaction and QoL (physiological)

Variable	
Satisfaction	
Physiological	$r = .49^{**}$

** Significant at .01 level

Table 2: Correlation between satisfaction and QoL (Social Relationship)

Variable	
Satisfaction	
Social relationship	$r = .46^{**}$

** Significant at .01 level

The two variables, from table 1, satisfaction and physiological QoL are moderately correlated and there is a positive correlation, $r(38) = .49, p < .01$. Hence the hypothesis that “*there will be a significant relationship between satisfaction and physical domain of QOL*” is accepted.

The two variables, from table 2, satisfaction and social relationship QoL are moderately correlated and there is a positive correlation, $r(38) = .46, p < .01$. Hence the hypothesis that “*there will be a significant relationship between satisfaction and social relationship domain of QOL*” is accepted.

Table no: 3 Correlation between satisfaction and QoL (Environmental QoL)

Variable
Satisfaction
Environmental

r = .47**

** Significant at .01level

t-test Result

The two variables, from table 3, satisfaction and Environmental QoLs moderately correlated and there is a positive correlation, $r(38) = .47, p < .01$. Hence the hypothesis that “*there will be a significant relationship between satisfaction and environmental domain of QOL*” is accepted.

Table 4: Comparison of means score between chosen doctors and transferred doctors on QoL (physiological QOL).

Variable	Sample size	Mean	SD	t	p
Willing-	16	13.33	1.63	-2.23	.03
Transferred	24	11.88	2.50		

From Table 4, it was inferred there was a significant difference on QoL (physiological) with respect to by choice or by force transferred doctors $t(df) = -2.23, p < 0.05$ with by choice having more QoL ($M=13.33, SD=1.63$) than transferred ($M=11.88, SD=2.50$). Hence the hypothesis “*There will be a significant difference between chosen doctors and transferred doctors on QoL (Physiological)*” stands accepted.

Table5: Comparison of means score between chosen doctors and transferred doctors on QoL (psychological QOL).

Variable	Sample size	Mean	SD	T	P
Willing	16	14.29	1.27	-2.09	.04
Transferred	24	13.00	2.33		

From table 5, it was inferred there was a significant difference on QoL (psychological QOL) with respect to chosen and transferred doctors $t(df) = -2.9, p < 0.05$ with chosen doctors having more QoL ($M=14.29, SD=1.27$) than transferred ($M=13.00, SD=2.33$). Hence the hypothesis “*There will be a significant difference between chosen doctors and transferred doctors on QoL (psychological QOL)*” stands accepted.

Table 6: Comparison of means score between chosen doctors and transferred doctors on QoL (Environmental QOL).

Variable	Sample size	Mean	SD	T	p
Willing	16	15.88	2.67	-2.11	.04
Transferred	24	13.75	3.69		

From table 6, it was inferred there was a significant difference on QoL (environmental QOL) with respect to chosen and transferred doctors $t(df) = -2.11, p < 0.04$ with chosen doctors having more QoL ($M=15.88, SD=2.67$) than transferred ($M=13.75, SD=3.69$). Hence the hypothesis “*There will be a significant difference between chosen doctors and transferred doctors on QoL (Environmental)*” stands accepted.

From the qualitative result, it appears that the doctors who are working in rural areas they need *family support*, it is very important at the same time an understanding partner is also important. *Acceptance* about the doctor’s life from the partner is the main thing. At the same time, doctors have spoken about how they are not able to spend time with their children because of their busy schedule. They want to manage their work and life in such a way that they can get enough time with their children. All doctors aspire for a good professional career, but in some hospitals, the scenario is they do not get *staff cooperation* (alcoholic attendant and addicted staff) and lack of medical facilities like medicine, equipment, the diagnostic facilities and laboratories and source they have to refer a patient to other hospitals. This caused a greater degree of frustration, especially among newly appointed doctors as they tried to work with patients but did not have the material support with them in primary health centers and this demotivated many of them. The housing

was provided by the hospitals but the condition of quarters was not good, lacked basic amenities. Very few were satisfied with housing facilities. Telephone and Communication network was an issue both professional purposes and personal use. *Transport* is another issue at the hospital level. Almost all the hospitals are in the hilly area and interior part of rural areas. Only half of the respondents were satisfied with transportation facilities. So the majority of the doctors used their own vehicles to travel and also for hospital use. Doctors who are staying in rural areas responded that the *availability of daily amenities* was not present at their respective places. Respondents did not get time to go to the market due to a busy work schedule. On the economic front, almost all doctors responded that salary was inadequate. The sources of stress were varied for the doctors. Lack of staff cooperation or the doctor is the only staff at the hospital, led to stress. Non-clinical work was a major source of stress. None of them reported personal health problems. Very few doctors reported that *finance* related things were causing them stress. Work-related stress was the main cause among almost all doctors. Doctors suggested that there should be a distribution of working hours and work is needed. The doctors stressed the importance of self- growth and learning. Sanitization facilities should be good in living facilities and hospital. Doctors also *suggested* that periodic and supervisory training is important. Doctors who had a *positive attitude* towards work were those who had chosen to serve in rural areas. To the doctors who had a positive attitude, the facilities and challenges did not matter much and they were happy doing their work in any given condition.

DISCUSSION

From the two sets of the quantitative result it appears that life satisfaction is associated with environmental, physiological, and social relationship aspects of life. This reiterates that only if all these aspects of life is satisfied, doctors would choose to practice in rural settings. From the qualitative results appears that while working in rural areas *acceptance* of the partner and supporting a family is very important, because lack of time for family and unavailability during emergencies led to family conflicts. *Cooperation* from the staff is a positive factor to work in the community and provide good health services in rural areas and also it helps with the doctors' mental wellbeing. Basic amenities were important for doctors to encourage them to choose rural areas. The network and connectivity are critical and the doctors faced a huge problem with communication. Working in a rural area is always challenging for doctors because of transport issues, not only for their personal travel but also for hospital facilities. Due to these problems, most doctors choose to not bring their families to the rural area and also choose to work in an urban setting. While serving in a rural area the main concern was that they should get an *adequate salary*. Delays in payment of the salary of government employees make life difficult. Manpower is also important for doctors, lack of manpower leaves them frustrated. Lack of appreciation by superiors and interference by politicians are also important things that should be addressed. The *working hours should be distributed* properly to avoid the stress that it will help the doctors to be at work with a fresh mind. The doctors in rural areas are used for administrative work and they do not get enough exposure and stunts their professional growth. Some of them suggested that doctors should have supervisory training while working in rural areas. They are saying they should get *academic incentives, schooling for their kids, good leisure facilities*. The doctors prefer to work in their own villages rather than other villages.

SUMMARY AND CONCLUSION

India still suffers from the poor doctor-to-patient ratio. The doctors are again concentrated in urban areas. The large part of India is rural. The need for doctors and efficient health services in rural India is high. But the current scenario shows that very few doctors are actually present in the rural area. And they are sent to work there against their will.

Satisfaction level and QoL of doctors working in the rural area depend on various determinants. Very few doctors are actually willing to serve in the rural area. So, to know those determinants and work on them is the pressing need on the time being. This can help manage the problem of vacancies of doctors in the rural area. So this study has been conducted to understand the determinants of doctor's satisfaction level and QoL in a rural area.

So the satisfaction level is seen to be associated with QoL. And the determinants for it are the willingness to join rural service or not. So, it is needed to make doctors more sensitized about the health needs of rural India and not just force them to do the job which they are reluctant of. This will help the health sector in the long run.

In conclusion, the importance of rural health in rural India where the majority of the people live cannot be underestimated. This study pointed out that those who chose rural service have a better QoL and are satisfied it is

important therefore to promote motivation among young doctors to choose to serve their country in the rural areas. As society and government, we learnt from the study that providing better pay, facilities, equipment and educational support for the doctors and their families will help in the retention of doctors in the rural area. “*Healthy people make the healthy nation*”

LIMITATION OF THE STUDY

The sampling was convenient sampling, hence the complete representation was not ensured. The sample frame of 40 doctors is less. All the determinants of retention and leaving of health staff were not studied. The semi-structured interview could catch the perception of health workers working in a remote area, but not that of policymakers and higher officials. The study focused on Maharashtra state only.

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