A Survey on the attitudes and practices concerning cost-effectiveness in respect of UG and PG Siddha Doctors towards Patient Care Management in Chennai district

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Abstract

Background. In spite of the fact that cost-adequacy plays an acknowledged part in expansive clinical approaches, there is little awareness of how doctors integrate it into choices. Doctors see cost-viability as a suitable model while settling on treatment choices for their patients. Regardless of their help for cost-adequacy in principle, doctors seem conflicting by the way they apply it practically. Whenever cost-viability is to be utilized as an apparent standard in understanding choices, doctors and patients need to foster agreement on cycle and correspondence issues. Some medical care suppliers feel uncomfortable to lead cost correspondence. Their eagerness to talk about costs with their patients is questionable.

Objective. To identify the view of Siddha Doctors regarding their attitudes and experience towards cost-containment, cost-effectiveness and cost communication in clinical decision making in respect of patients. **Methods. S**urvey was conducted in Chennai District from January to April in 2022. Total 122 Under Graduate and Post Graduate Siddha Doctors from various Hospitals and Clinics and Institutions participated in the study. Questionnaire method was used to record the response pertaining to attitudes regarding the cost communication and data was analysed. **Result.** Most Siddha doctors see cost-viability as a fitting part of clinical choices and deliberate that the doctor and patient ought to conclude optimal cost effectiveness. Notwithstanding, doctors are partitioned on whether they bring an obligation to the table for clinical mediations with slim possibilities of advantage paying little mind to cost and they shift impressively with their patients towards the issue of cost-viability. The respondent Doctors expressed their positive attitude regarding the communication of cost issues with their patients. Maximum Doctors preferred towards explaining their Patients regarding the cost of treatment. Experienced Doctors had positive attitude towards discussing cost ($\beta = 0.214$, $P < 0.05$).

Conclusion. Discoveries support the significance of talking about treatment-related costs with patients. Siddha specialists are alright with that and want to examine the treatment-related costs. Besides, the current discoveries stress to foster instructive projects for medical care gives to work on their monetary, correspondence and the executives abilities. Despite the fact that doctors in and around the Chennai district acknowledge cost-viability as significant and proper in clinical practice, there is no consistency in how the cost-adequacy choices are carried out.

Key words: Cost effectiveness, Patient care, Attitudes and Practices, Siddha Practitioners

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Introduction

The rising expense of health care and the unequal dispersal of the resources are major social and political challenges. The people paying for their own health care are still on the high side [6] . The great capacity of biomedical science to produce new and pricey medical therapies is a major factor to cost inflation. While purchasers, such as companies and the government, are opposed to increases in health-care premiums and reimbursements, Doctors, medical groups, and health-care plans are under legal, regulatory, and societal pressure to offer all medically necessary care. Many factors influence hospitalisation costs, including the ageing population, Technological advancements and the implementation of Novel treatment modalities [7].

It's not easy to reconcile the conflict between limiting resources and ever-increasing demands. Physicians might utilise cost-effectiveness as an explicit criterion when

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creating therapeutic policies that apply to large groups of people or when examining treatment options for individual patients. Although it has long been thought that utilising cost-effectiveness criteria to construct clinical policy (e.g., drug formularies or practise guidelines) is an appropriate physician role, limiting marginally useful and costly procedures for individual patients is controversial [11]. The body of knowledge regarding the cost-effectiveness of medical therapies is rising, but less is known about how Doctors make cost-effectiveness judgments practically with Patients. Impact on patient clinical outcomes is well documented; nonetheless, its unclear how doctors influence hospitalisation expenses. Supposedly, because of bad care such as prescription errors and falling down, necessitates greater resources to compensate for damages, enhancing doctor care quality entails additional cost [8]. Every cost-related decisions requires a methodological foundation to support the monetary and clinical values [9], [10].

In a study, Doctors created a committee of registered practitioners to investigate the acceptability of clearly including cost-effectiveness into clinical and coverage choices. Its purpose is to provide cost-effectiveness suggestions that incorporate consumer and provider values, interests, and concerns. The committee's first task was to conduct a written survey of local physicians to get their opinions on three main topics: cost containment and physicians' role in providing cost-effective care, barriers to practising cost-effective medicine, and experience with patients who insist on treatment that is not considered cost-effective [2], [3].

Methods

Members were recognized helpfully as indicated by their accessibility and qualification. The consideration rules were; medical services suppliers UG and PG doctor, clinical experience of 5 years or more, and a readiness to take part. Nonetheless, medical services suppliers who were in administrative positions were prohibited from the review. The questions were preceded by the following definition: For the purposes of this survey, a medical intervention is cost-effective when it produces benefits comparable to those of an alternative intervention but at a lower cost, or when it produces benefits greater than those of an alternative and the additional clinical benefits outweigh the additional costs.

Survey Sampling

Siddha Physicians who practise in and around Chennai District and whose primary duty is direct patient care were the target population. A total of 112 Siddha Doctors from Chennai District (India) were submitted with demographic and professional data after restricting/ eliminating the retried physicians, administrative physicians, and others specialist.

Main measures

The questionnaire used to create the information for this study were coordinated into three areas. The main tended to doctors' perspectives and convictions about the job of cost control and cost-viability utilizing 5 Likert's scale things (from unequivocally consent to differ firmly). The subsequent segment requested doctors to rate the significance from 9 potential boundaries to financially savvy practice. The third area incorporated a few inquiries regarding the doctor's involvement in patients who demand having a clinical intercession that the doctor considers either not showed or not financially savvy.

Data Collection Instruments

The segment information was gathered by a survey in regards to mature, orientation, conjugal status, long stretches of involvement, and number of meeting patient/week. A 10-thing self-detailed instrument was embraced from the investigation. This scale estimates the perspectives and commitment of medical services suppliers toward cost correspondence

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with their patients. Afterward, all interpreters back-made an interpretation of the scale to affirm the substance exactness by the two structures repeating similar reasonable implications. All things are scored on a 5-point Likert-scale from 1 (strongly disagree) to 5 (strongly agree); higher scores reflected greater commitment with cost conversations. The scale is substantial and solid with Cronbach's alpha of 0.80. The UG and PG doctors who were qualified were drawn closer by the essential specialist. A coded survey was given to every member and response were recorded.

Survey Administration

The review was regulated with the siddha specialists who works with coordinated effort on medical services issues among shoppers and medical care suppliers. The study was conducted from January 2022 and finished in April 2022. Siddha specialists answered all inquiries.

Data Analysis

Information was analysed utilizing the SPSS programming, Version 23. Information was tried for the ordinariness utilizing the Kolmogorov-Smirnov test. Moreover, frequencies and rates, means and standard deviation (SD) were determined to portray concentrate on factors including segment factors. Pearson's relationship coefficient was utilized to connect UG and PG doctors' mentalities toward cost conversations with their demographical factors. Various straight relapse examination (forward method) was utilized to foresee the variables related with medical UG and PG doctors' perspectives toward cost conversations. In the wake of changing the straight-out factors over completely to sham coded factors, the critical variables in the univariate investigation were placed into the multivariate examination. Tests with $P < 0.05$ were thought of as measurably huge.

Results

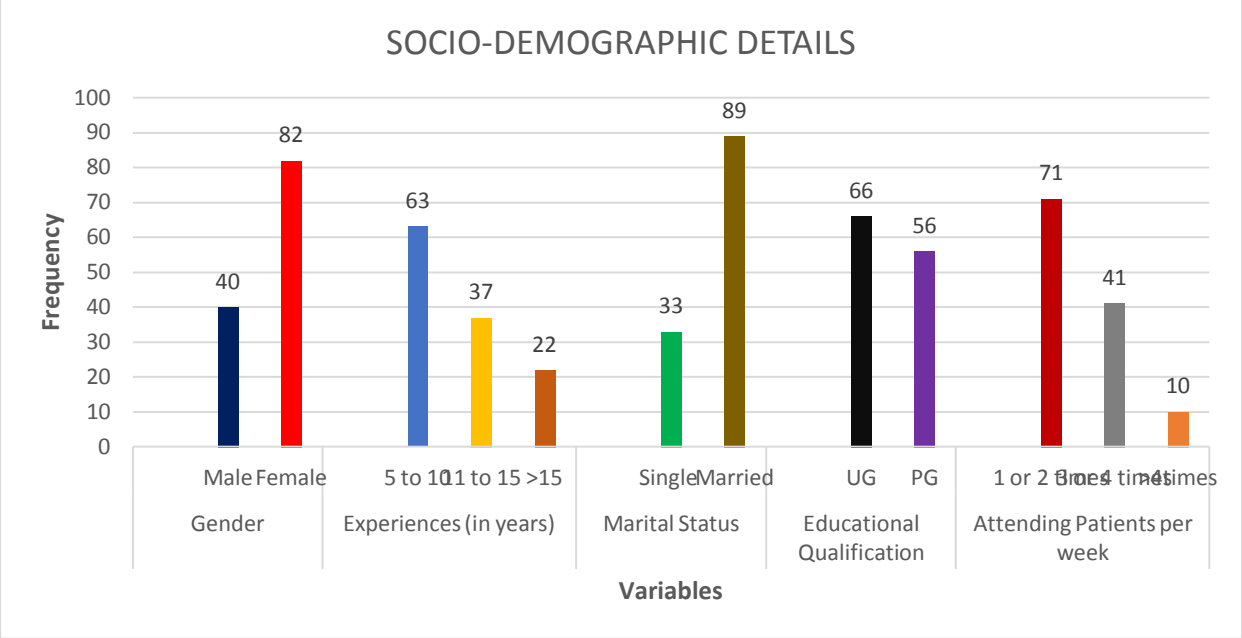
Attitudes about Cost-effectiveness

Siddha doctors agreed that there is a legitimate need for cost containment and that individual physicians should help in containing costs.

Table 1: The sociodemographic characteristics of respondents (n=122)

Variable		Frequency (%)
Gender		
	Male	40 (32.78)
	Female	82 (67.21)
Experiences (in years)		
	5 to 10	63 (51.63)
	11 to 15	37 (30.30)
	>15	22 (18.03)
Marital Status		
	Single	33 (27.04)
	Married	89 (72.92)
Educational Qualification		
	UG	66 (54.09)
	PG	56 (45.90)
Attending Patients per week		
	1 or 2 times	71 (58.19)
	3 or 4 times	41 (33.60)
	>4times	10 (8.19)

Figure 1. Socio-Demographic Details



The study conducted with 122 siddha doctors. Majority of siddha doctors were females (67.21%) had 5-10 experiences (51.63%), and married (72.95%). Most of the siddha doctor participated in the study were UG educational qualification (54.09%). The age of the siddha doctors ranged from 28 – 52 years, mean of the age is 39.72 and Standard Deviation is 6.64. The siddha doctors visited patient 1 or 2 times per week is 58.19% (Table1).

Table 2: Attitudes towards cost discussions

Variables	UG			PG		
	SA/A	N	DA/SDA	SA/A	N	DA/SDA
Doctors should explain patients regarding the cost of treatment	67.98	10.25	21.77	68.56	8.23	23.31
Doctors should explain patients regarding cost payable by the government for the treatment	47.67	10.78	41.55	31.44	32.77	35.79
Doctor should consider the cost for choosing new treatment for the patients	22.54	5.2	72.26	16.17	12.41	71.42
Doctor should consider the cost applicable to the insurance company for choosing new treatment	20.62	7.12	72.26	15.81	9.54	74.65
Doctor should be prepared for discussing the cost effectiveness of their recommended treatments	44.51	11.8	43.69	51.33	13.2	35.47
Doctor should have easy access for quality resources assisting in cost discussions with patients	36.97	14.36	48.67	43.36	11.41	45.23
Doctor should prescribe the cheaper	45.27	10.22	44.51	36.69	8.54	54.77

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medicine						
Patients should pay for treatments that improve survival	28.58	10.36	61.06	25.35	11.51	63.14
For effective treatment of Patients, Cost should not be a criteria	69.05	3.21	27.74	70.82	4.62	24.56
Cost effectiveness of the treatment is to be considered before commencement of treatment	55.49	4.48	40.03	62.44	6.35	31.21

The siddha doctors' attitudes towards cost discussions with patients are represented in the Table 2 with the proportions. The overall result of the attitude towards cost discussion were positive and preferred most to communicate about cost. More than half of the UG and PG siddha doctors were strongly disagreeing to keep in mind about the costs to the patient or insurance company before starting a new treatment. Nearly 68% of the UG and PG siddha doctors are strongly agreeing to explain the costs to the patients how much they have to pay for the treatment. About 70% of siddha doctors were strongly agree that every patient should have access to best treatments regardless of the cost. Total 33% of PG Siddha doctors neither agreed nor disagreed with the factor "doctor should explain the patients the costs Government will have to pay for the patients treatment." Only 14% of UG siddha doctors were neutral with the factors "Doctor should have easy access for quality resources assisting in cost discussions with patients."

Table 3: Correlation coefficients between Siddha Doctors attitudes toward cost discussions with their demographical variables

Variables	Attitudes toward cost discussions	Age	Years of experiences	Marital Status	Educational Qualification	Attending patient per week
Age (in years)	0.217^{x}	1				
Experiences (in years)	0.621^{y}	0.532^{x}	1			
Marital status	-0.024	-0.154	0.351^{x}	1		
Educational Qualification	0.374	0.269	0.241^{x}	-0.234	1	
Attending patient per week	0.641^{x}	0.415^{z}	0.584^{y}	0.265	0.482^{x}	1

^{x}p<0.05,^{y}p<0.01, ^{z}p<0.001

Table 4: Predictors of siddha doctors' attitudes toward cost discussions from their demographics

Variables	Perception toward cost analysis (n=122)		
	beta	standard error	beta
Age (in years	0.214	0.102	0.192^{x}
Experience (in years)	0.274	0.087	0.214^{x}
Marital status	0.041	0.062	0.055
Attending patient per week	0.175	0.104	0.158^{y}
Educational Qualification	0.225	0.13	0.182
R^2			0.433^{z}

^{x}p<0.05, ^{y}p<0.01, ^{z}p<0.001

To identify the correlations between sample's sociodemographic and siddha doctors, positive attitude toward cost discussions [Table 3] and [Table 4], the following variables (age, experiences, marital status, educational qualification, attending patient per week) were selected and after ensuring that there are no problems with multicollinearity, their positive attitudes to discuss cost is increased when their age, experience and attending the patients per week are increased. However, none of these correlations was very high (above 0.70). The regression model explained 43.3% of the variance and that the model was a significant predictor of siddha doctors' experiences, $F(5,116) = 0.433$, $P < 0.001$. It was found that years of experiences significantly predicted siddha doctors' attitudes ($\beta = 0.214$, $P < 0.05$), as did meeting patient/week and major specialty ($\beta = 0.182$, $P < 0.01$); $\beta = 0.158$, $P < 0.01$) respectively, while age and marital status did not.

Discussions:

The ongoing review is viewed as the first that directed in attitude and practices to portray siddha doctors' mentalities toward cost correspondence with their patients. It is observed that a larger part of the example felt agreeable to talk about cost issues with their patients; additionally, medical care suppliers appeared to focus on therapy benefit no matter what the monetary expense. In examination with global investigations, this result is steady with large numbers of them. Different examples of medical services suppliers showed moderate to elevated degrees of involvement with talking about cost issues with their patients [4], [5]. However, this outcome is going against to the investigations led in and around Chennai district which observed that most siddha doctors were not starting conversations about cost issues, drug costs explicitly, with their patients. These disparities perhaps in view of the distinctions in health care coverage frameworks and utilizing unique, estimation technique, plan, information assortment system, or target bunch.

An overview of doctors uncovered that 90% of concurred doctors had an obligation to contain costs in their discussions.[12] this review demonstrated that doctors feel much the same way, on the grounds that most of them, around 69%, concurred that it is their obligation to consider cash-based expenses for patients. In any case, there is less arrangement that it is the specialist's job to make sense of the cost's Government should pay for the patient's treatment; just 31% of our studied doctors concurred with that assertion.

This could be made sense of on the grounds that the medical services suppliers in the ongoing review were chosen from the hospitals, private clinic in and around Chennai district, which patients in these hospitals and clinic were under the umbrella of administrative protection (they didn't pay for medical care). Subsequently, medical services suppliers didn't want to talk about the expenses with their patients.

Albeit most of overviewed UG and PG Siddha doctors feel great to start cost conversations, we found that a significant number of them felt that there had restricted quality assets which could help them in cost conversations. Not exactly 50% of the overviewed UG and PG doctors (36% and 43%, separately) concurred that they had sufficient assets to examine costs, and that implies that more noteworthy endeavours toward teaching medical services suppliers about expenses of care might be fundamental.

Explicit factors including age, experiences, and number of attending patients per week were fundamentally connected with the encounters of talking about cost issues among the review test. This result was somewhat predictable with that of a past report led in the Chennai District, and found that doctor's extended period of involvement related with their mentality toward examining costs with patients, while,

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different factors, for example, negligence claims, disciplinary activity, and the size of the gathering wherein the doctor rehearses had no really great explanations connected with the kind of the protection and the clinic, as well as the huge number of patients can be one of the time hindrances that limit conversation of expenses. Moreover, the long periods of involvement were altogether anticipated and connected with medical services suppliers' conversation about costs. It is normal that absence of encounters reflected into more costly care. That is, more experienced medical services suppliers might be more recognizable about cost issues, along these lines, more agreeable to discuss the money issues.

The quantity of gathering patients/week was corresponded unequivocally with medical care suppliers' conversation about costs, as 15.8% of the difference in the information could be made sense of by this indicator. This outcome is steady with the finding of a past writing that the quantity of openness among patients and medical services suppliers is related with conversations about costs. A more noteworthy issue with the feeling that visits medical care suppliers are excessively quick and the degree of communication is excessively little to make considerable discussions and certainty. Consequently, increment the quantity of gathering patients constructs significant discussion and trust.

Limitations of the Study

The restrictions of this study are; little example, utilizing of accommodation testing strategy, and selecting medical services suppliers from the administrative emergency clinic in Chennai; every one of these cut off the generalizability of the ongoing review to all Chennai in and around medical care suppliers. Another restriction is that the enlightening plan, which restricts our capacity to lay out a causal relationship. Likewise, the effect of social allure is conceivable, which occurred for the information were gathered through self-announcing apparatuses.

Conclusion:

Medical services suppliers in and around Chennai district have exhibited an uplifting outlook toward discussing cost issues with their patients. Likewise, UG and PG siddha doctors with additional long stretches of involvement were feeling more sure and able toward starting such conversations. Notwithstanding, apparently in the fledgling medical services suppliers this present circumstance is unique.

This study exhibited the significance of getting medical care suppliers and patients to discuss costs issues. In any case, studies with bigger examples and from various settings are enthusiastically suggested. Medical services suppliers, partners, and policymakers are welcome to utilize the discoveries of this review to lay out projects and strategy to lessen this issue. Such projects can be expandable for different fields like nursing understudies, and medical caretaker administrators. This might assist purchaser with costing sharing levels preferably to support the clinically fitting utilization of medical care administrations.

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