



IMPERIAL

**Missed Diagnoses, Unmet Needs: Exploring Barriers to Asthma Care
in India's Government Hospitals**

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Laidlaw Foundation Research Project Report Summer 2025

Table of Contents

ABSTRACT	3
BACKGROUND	3
METHODS	4
RESULTS	6
DISCUSSION	10
CONCLUSION	15
LIMITATIONS	16
PERSONAL REFLECTION	17
ACKNOWLEDGMENTS	18
APPENDIX	19
REFERENCES	21

Abstract

This study investigated barriers to asthma management across government and private healthcare sectors in Kolkata, Delhi, and Anantapur. Through structured interviews with 138 asthma patients (87 from government hospitals, 51 from private facilities), we examined healthcare access, diagnostic capabilities, and patient experiences. The mean age was 43 years in the government sector and 51 years in the private sector, with balanced gender distribution. Government facilities showed gaps in diagnostic equipment availability such as spirometry and forced exhaled nitric oxide (FeNO), often relying on clinical history and airway sputum analysis. Key barriers identified included financial burden, medication unavailability in government dispensaries and inadequate health education. The findings reveal that healthcare quality varies substantially between each hospital rather than strictly between government and private sectors. This research underscores the urgent need for policy interventions including expanded medication access through government dispensaries and standardized asthma education programs for the general public to ensure equitable asthma care across India's diverse healthcare landscape.

Background

India contributes 11.1% of the global asthma burden (37.8 million estimated cases), however it is also responsible for over 42% of global asthma related deathsⁱ. This large discrepancy shows that India is one of the neediest in the world in terms of improving asthma management. This is confirmed by the 'Asia-Pacific Asthma Insights and Management Study' which found that within the 9 countries surveyed, India ranked the lowestⁱⁱ. Large proportions of low-income households (20-30%)ⁱⁱⁱ often go to government funded hospitals in the nearest towns and cities or to unqualified doctors in rural parts of India^{iv}. However, these centres face many problems such as being under-staffed, lacking equipment and often being difficult to reach^v. In 2024 the World Health Organisation (WHO) called for better education, not just for patients but also healthcare professionals, to empower people living with asthma^{vi}.

India has a mixed healthcare system with both private and public services. The private services mainly include secondary and tertiary care centres along with small private

practices^{vii}. The smaller private practices are sometimes referred to as ‘local doctors’ in this paper as this is the common term used by the participants of this study. Public healthcare is managed by the central government who provide funding for these ‘government hospitals’. Here patients are treated for free including investigations, medications and doctor’s fees. Despite this provision, Indians on average spend 20% of their health expenditure out of their own pocket^{viii}. This project aims to identify barriers to asthma care and provide some solutions which can help tackle them.

Methods

Due to the scale and heterogeneity between different states in India, 3 different regions were selected for a more representative sample of the Indian population. Kolkata, Delhi and the region of Anantapur were selected to represent a spectrum of urban and economic contexts. As per September 2025, Kolkata and Delhi ranked 9th and 14th respectively on the IQAir World Air Quality Ranking^{ix}. Kolkata (West Bengal) is in Northeastern India while Delhi provides a perspective from North India. To contrast this, the region of Anantapur (Andhra Pradesh) is in South India. Although the town is an urban area, the government hospital serves rural and village residents from the surrounding area.

In Delhi and Kolkata, 3 different sites were selected to collect data from. In Delhi data was collected from 3 different hospitals: Saroj Multispecialty Hospital (Private), All India Institute of Medical Sciences Delhi – AIIMS (Government) and B.S Ambedkar Hospital – BSA (Government). In Kolkata another 3 sites were selected: Calcutta Medical Research Institute – CMRI (Private), Calcutta National Medical College – CNMC (Government) and NRS Medical College (Government). In Anantapur only one hospital site was used, Government General Hospital – GGH (Government). An equal amount of time (2 weeks) was spent in each region for data collection. The focus was to collect more data from the government sector as it was the ‘active’ arm of investigation for this research project, the private sector acting as a ‘control’ arm for comparison. To achieve this, an arbitrary ratio of 6:4 of government to private sector participants was chosen.

Qualitative data was collected in the form of structured interviews directly from asthma patients. The questionnaire involved asking the participants about their experience of the investigations, diagnosis and management of their condition [Appendix A]. It also asked for their perspectives on any barriers they may have faced (access, costs and education). The questionnaire was used as a framework to help guide the interview with some pre-written follow-up questions, but extra questions were sometimes asked based on answers given by the participants. The questionnaire was translated into the major languages of each area (Hindi, Bengali and Telugu).

Participants were selected in an opportunistic fashion after they had been seen by a doctor in the respiratory outpatient department (OPD) at the hospital. The doctors would assist in identifying asthma patients and then an interview was taken from the patient following consent.

Inclusion criteria involved participants who have been consented to answer the questionnaire. Patient participants had a 'confirmed' or 'suspected' diagnosis of asthma. Participants that were excluded are those who are under the age of 18 and any with significant cognitive impairment as they must be able to consent.

The interviews were audio-recorded to assist in data analysis later. The help of interpreters was used in Kolkata and Delhi due to language barriers between the interviewer (this author) and the participants. The interpreters were asked to translate as accurately as possible and to speak in first-person when doing so (from the perspective of the patient). These audio files were then transcribed into text using AI software (ElevenLabs Speech to Text). Some corrections were made manually to these transcripts due to errors during the transcription process.

The completed transcripts were used for data analysis which involved carefully reading each transcript and noting key reflections and pieces of information relevant to 'barriers to asthma care'. During this process, any comments or reflections which shared common themes across different participants were grouped under a common 'code'. This process was repeated 2 times for all transcripts. The qualitative 'codes' from the government sector was collated into a mind map. The qualitative analysis

method was inspired by the Braun and Clarke method of reflexive thematic analysis^x. Although it does not follow the Braun and Clarke method exactly it seemed like the best approach for the qualitative part of this study. The quantitative data was used for comparison between the private and government sector.

Results

City/Region	Hospital Name	Total no. participants	Total
Kolkata			60
	CMRI Hospital	33	
	NRS Medical College	3	
	Calcutta National Medical College	24	
Delhi			62
	Saroj Multispecialty Hospital	18	
	AIIMS	20	
	B.S Ambedkar Hospital	24	
Anantapur			16
	Government General Hospital	16	
Overall			138

Figure 1: Number of participants from each hospital and region

In total 138 participants were interviewed, of which 87 (63%) were from government hospitals and 51 (37%) from private hospitals. This was close to the target ratio of 6:4. Data collection was split well between the larger cities of Kolkata and Delhi, however much less data was collected from the region of Anantapur. This is due to the smaller population in the area which is only serviced by a single government hospital. From observation the volume of patients per day in the OPD was much less when compared to the other cities.

Data Point	Government	Private
Total no. participants	87	51
Average Age	43	51
Average Age at Diagnosis	34	44
M:F	33 to 54	21 to 30

Figure 2: Average demographic data between government and private sector participants including age, age at diagnosis, male : female ratio

The average age of participants from the government sector was 43 years (range: 18 to 87), 8 years higher than the private sector which was 51 years (range: 20 to 88). The average age at the time of diagnosis was also lower in the government sector participants (34 years) compared to private (44 years) by 10 years. In both sectors there were more female participants than male, however a chi-squared test of independence showed there was no statistically significant difference in sex ratio, $\chi^2(2, N=138) = 0.14, p = .71$.

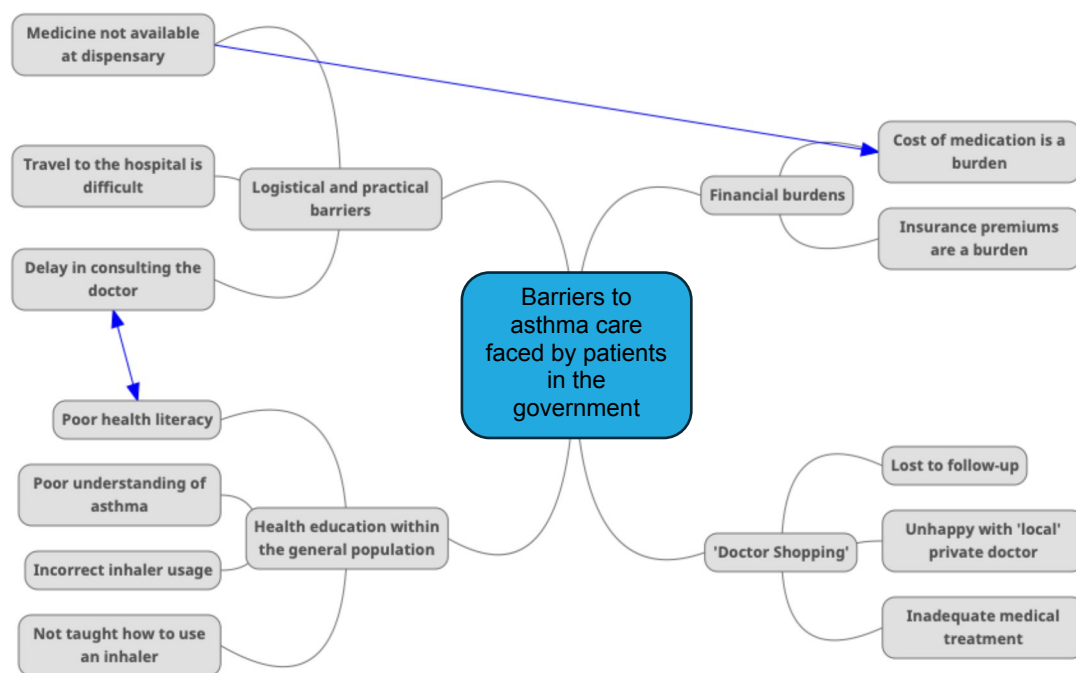


Figure 3: Mind map of key 'themes' drawn from the interview data of government sector participants. Blue lines show connections between different components between themes

On analysis of the government sector data, 4 main 'themes' were found through the coding process. Each theme consisted of different observations and experiences that the participants expressed in their interview. These 4 themes are: Logistical and practical barriers, Financial burdens, Health education within the general population, 'Doctor Shopping'. These 4 themes are quite closely related and often there are direct links (as shown by the blue arrows).

During the coding process participants were coded as having a 'poor understanding of asthma' if they were unable to answer the question "What is your understanding of asthma?" or demonstrated a degree of misinformation and misunderstanding of the condition such as inappropriate/underuse of inhalers and expectation of a 'cure' from asthma. Amongst the government sector participants, 54% (47) were classed as having a 'poor understanding of asthma'. It was lower in the private sector at 25% (13). 'Poor health literacy' (11% in the government sector, 6% in the private sector) was coded when participants expressed less awareness about when to seek help and which type of doctor to visit. 'Incorrect inhaler usage' at 14% (12) and 'Not taught how to use an inhaler' at 3% (3) was seen in the government sector, however these were not seen at all amongst private sector patients.

25% (22) participants in the government sector reported that the medicines they were prescribed were not available at the free government dispensary at the hospital. 7% (6) of government sector participants said that travel was a barrier which affected their ability to visit the hospital compared to 4% (2) in the private sector. Participants in both government and private sectors reported leaving symptoms for some time before visiting the doctor. A 'delay in consulting the doctor' was classified as a time gap of 2 months or more from onset of symptoms. This was 14% (12) in the government sector and 16% (8) in the private sector which was similar.

38% (33) of government sector participants reported that the cost of medication was a burden. In the private sector patients must pay for investigations and doctor fees if they do not have insurance, as well as medications so 27% (14) have been counted as 'medical costs are a burden'. 8% (4) of private sector participants described paying annual insurance premiums was a burden. Surprisingly 3% (3) of the government sector participants also mentioned that paying for insurance was a burden.

In the government sector 23% (20) said that they were unhappy with the care they received after visiting private doctors who practice independently. In the private sector this was lower at 14% (7) however there were more varied answers as 2 participants expressed dissatisfaction with a government hospital and 1 participant with a different private hospital. 12% (6) of private participants also described examples of improper asthma care when talking about treatments they have had from previous doctors.

Examples include “treated by ENT doctor” and being prescribed “injectables only”. A reliable value could not be calculated for the government sector for ‘poor medical management of asthma’. In the government sector, 7% (6) in the government sector reported that they abruptly stopped visiting a doctor ‘lost to follow-up’ and changed to a different doctor/hospital, which was similar at 6% (3) in the private sector.

Comparison of codes: Comparing government and private sectors

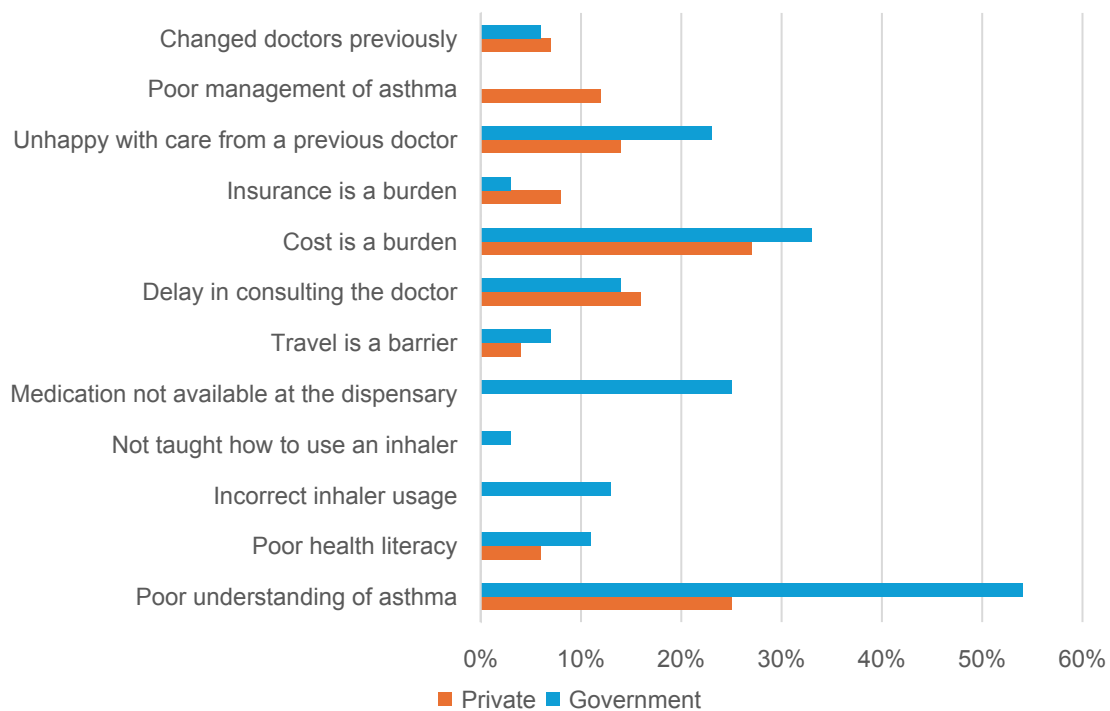


Figure 4: A bar graph showing the comparison between the codes in government and private sectors.

Discussion

The results show some of the similarities and differences between private and government care in India. The contextual information around the data will be discussed which will help in drawing conclusions. Data was only collected from asthma patients, however many differences were noted on how different hospitals were able to operate. Both private hospitals (CMRI and Saroj) had access to spirometry and forced exhalation nitric oxide (FeNO), which are key investigatory tools for the diagnosis and

monitoring of asthma^{xi}. While AIIMS (which is a large outlier in the government sector) and B.S Ambedkar Hospital had access to spirometry as well, the other 2 government sites (GGH and BSA) did not have access to spirometry or FeNO investigations. In those 2 hospitals it was observed that the diagnosis of asthma was made purely based on clinical history and some basic investigations such as airway sputum analysis (to rule out tuberculosis) and a chest radiograph. In fact at GGH hospital, spirometry equipment had been sent to the hospital in early 2025 but the company was yet to dispatch a technician for installation and teaching of staff on how to use it, with no indication of when they might do so. The lack of this equipment can make diagnosis slightly less accurate as it is a very useful confirmatory tool^{xii}.

AIIMS Delhi as an outlier

Despite being a government hospital and providing free care to all patients, AIIMS Delhi has an excellent reputation as the best medical teaching college in India^{xiii}. Due to its standing it tends to attract patients from many different socio-economic backgrounds as people seek the best possible care. Because of this the data collected from AIIMS Delhi often looks more comparable to a private sector hospital than the other government sector hospitals that were analysed in this project. For example, only 30% of participants from AIIMS (6 out of 20) were classed as having a 'poor understanding of asthma' which is 24% lower than the government sector average. With the prestige that the hospital holds it also attracts patients from outside the city, even surrounding states. Of the 6 participants in the government sector that were coded as 'travel to the hospital is difficult', 4 of them were from AIIMS Delhi (67%). Participant 81 stated "the travelling costs are more than [my] medications costs". It shows that some are willing to pay more for the travel to be treated properly. Something that helps to facilitate this is that patients can claim medications for free or for subsidised prices which reduces the burden that the cost of medications brings, although the hospital only provides 1 month supply and many follow-up consultations occur every 3 months.

Health education within the general population

A key difference between patients in the private and government sector was the knowledge of asthma and general health literacy. Health literacy is defined as the

knowledge and ability to access information to promote health and wellbeing^{xiv}. While some participants were able to identify some of the symptoms commonly seen in asthma such as shortness of breath and cough, many were unable to express their understanding effectively or simply stated that they did not know anything.

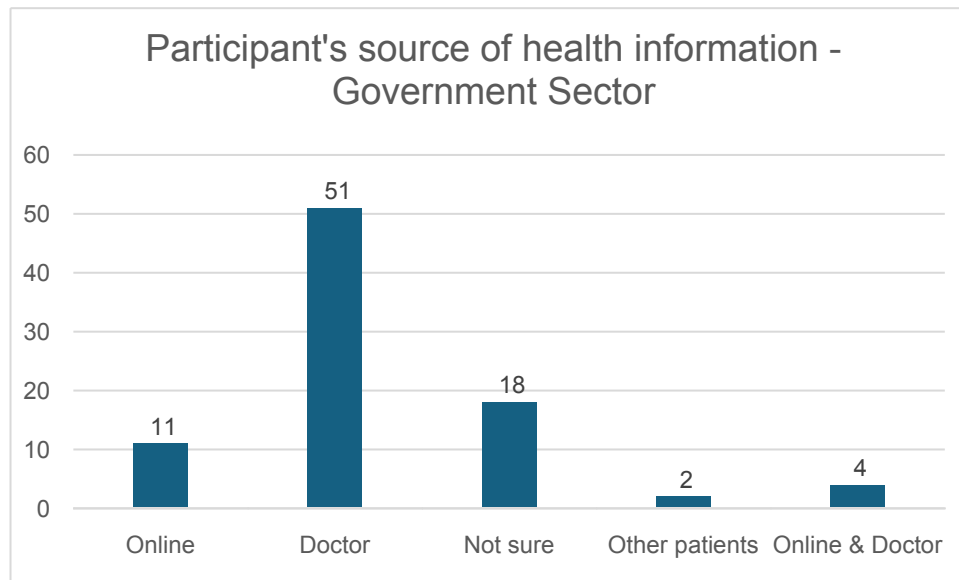


Figure 5: Graph showing what information source participants from the government sector would use to find out more information about asthma

Figure 5 shows that 59% of participants would ask the doctor if they wanted to know more about asthma. However, they are not getting enough information or being signposted correctly to learn more about their condition. Participant 13 said “[I] need some more time to interact with the doctors”. In the busy OPD clinics doctors are focussed on seeing as many patients as they can. A study showed that 75% of doctors do not routinely ask their patients about their current knowledge regarding the disease^{xv}. So, while patients would like to come to doctors to learn more, doctors may not always have the time or the intention to give more information to the patient. In a more extreme example, participant 131 from GGH gave this statement
“The doctors need to change. They should nicely ask what is wrong and check the patient properly. Instead they ask us to sit on a chair on the far side of the room while they are behind the desk”.

This was confirmed from direct observation by the researcher. This environment makes the patient feel uncomfortable and unwelcome and they do not feel cared for. This may lead to some confusion resulting in misuse of the inhaler.

Participants also often do not know what type of doctor they should go to when they identify their symptoms. Many will visit a private physician in the community initially but may not be treated correctly. Participant 60 stated that her private physician did not conduct any investigations and would only give her nebulised medications and send her home. Other participants expressed that they may have visited the wrong doctor initially but were then not referred correctly. Participant 8, who is a private sector patient, had previously been under the care of an ENT specialist who attempted to treat the asthma. The ENT doctor made no effort to refer this patient and eventually the participant themselves decided to seek help elsewhere as they saw there was no improvement over a few months. The mishandling of patients by independent physicians can delay proper diagnosis and lead to negative health outcomes^{xvi}.

Logistical and practical barriers

Within this theme were factors which could prevent a patient from seeing the doctor or receiving care in a timely manner. The most common problem that was found was that patients often wait a long time before going to the doctor. The most common reason given by participants were that they thought their symptoms were not serious at first. Participant 32 only came to the hospital when his symptoms were so bad he described them as “I get so tired, I feel that I will die” and he could no longer work. This extreme example highlights a common theme often seen in the lower socio-economic communities and rural farmers where they do not seek medical help unless it begins to seriously impact their ability to work. Unfortunately, many don't understand that receiving treatment early could have prevented serious exacerbations and so further education about health seeking behaviours would be needed.

A practical challenge that many government sector patients face is the availability of drugs at the hospital dispensary. Because medicines are provided for free, many people choose to visit government hospitals and there is great load on the dispensary to provide medications. Most commonly participants described that inhalers were often not available at the government dispensary^{xvii}. This was the worst at B.S Ambedkar hospital where 50% of participants reported that they could not get medication from the dispensary. AIIMS Delhi had the best availability with only 1 participant reporting they could not get their medication.

Financial burden

Inhalers are also some of the most expensive asthma medications to buy which can be a great burden for a low-income family (buying just one each of salbutamol and beclomethasone inhalers can cost between 1.6 and 2.3 days worth of wages from the lowest paid government employee^{xvii}). This was more evident in the rural setting of Anantapur. Participant 129, who is past the age of retirement, often must pick up work for a few days to afford his medications. The Mahatma Gandhi National Rural Employment Guarantee Act (NREGA) scheme allows rural, non-skilled workers to be guaranteed work for at least 100 days in the financial year^{xviii}. Participant 129 reports that he would get 200 rupees per day (£1.68).

Participant 135 further exemplifies the harsh reality of the struggles that many people living in rural India face in accessing healthcare. She said that “there are no men in the house to help me” and despite being prescribed inhalers she is unable to get them. A combination of unavailability at the government hospital dispensary, the large financial burden of inhalers and poor family support means that she cannot afford them and so she is not using them. “To buy from outside [privately] you need money, I don’t have the money”.

An interesting note was that 3 of the government sector participants stated that they were currently paying for private insurance but still choose to attend a government hospital. When asked about this all 3 stated the reason was that they were able to get medication for free which they said saved them more money overall. Typically they said that they have private insurance to get investigations and tests at a private clinic for convenience.

‘Doctor Shopping’

The term ‘Doctor Shopping’ was first introduced to the author by a researcher at CMRI Hospitals. In some contexts, this term refers to the act of a patient visiting multiple doctors to obtain multiple prescriptions, often to obtain large amounts of controlled substances illicitly^{xix}. However, research shows that there are other explanations for this phenomenon, and this is shared by the scope of this research project^{xx}. In this

context, 'Doctor Shopping' refers to the act of changing doctors multiple times in the search of satisfactory care in the eyes of the patient.

Participants changing doctors often was seen in both private and government sectors for differing reasons. It is very difficult to identify any patterns between private and government sector patients changing doctors as they seem to be switching between many different types of doctors (private physician, private hospitals, government hospitals and alternative medicine practitioners such as Ayurvedic medicine). A common reason in both sectors is that the participants felt that their symptoms were not improving. There were challenges in finding out if this was because of improper management on the clinician side, incorrect usage of medications from the participant or any other reasons. The questionnaire was more general and so specific information to answer these questions was not asked.

Despite the ambiguity around the reasoning why patients go 'Doctor Shopping' it was clear that this phenomenon is something which happens a lot in India where patients can freely move between government and private sectors. It leads to fragmented care where the patient can receive conflicting advice, duplicate prescriptions (as was the case with Participant 71 at Saroj Multispecialty who was taking a double dose of formoterol budesonide inhaler due to two prescriptions from two doctors) and the cost of time and effort for both patients and physicians.

The rural problem

One particular case (participant 132) contains many of the factors that have been discussed above. A 70-year-old female interviewed at GGH hospital in Anantapur had been diagnosed with asthma 20 years ago and was being treated by a private physician. For 20 years she had not been prescribed inhalers and was being treated solely with salbutamol tablets. She reports that she was happy with this as it reduces her symptoms enough for her to do some farming work. However, "during the [last] three years, it's become more serious... She is unable to do this work". It was only at this point that she came to GGH and was prescribed inhalers. Now with the use of inhalers she can continue working.

She reported that she does not know about asthma and could not say where she would go to look for more information about asthma if she wanted to learn more. Despite her symptoms her only concern was in being able to work. Only when her symptoms completely prevented her from working did she look to seek further help. It is examples of this short-term health seeking behaviour which can lead to greater long-term problems which often happens in rural, low-income settings.

Conclusion

The data shows 4 key areas which hold potential for solutions to target better asthma care in India: health education, financial burdens, practical barriers and the culture of 'doctor shopping'. The financial burdens and practical barriers are interlinked as the leading cause of financial burden was the cost of buying medications privately, which is a direct result of medication not being available in the free government dispensaries. A solution would require speaking with the Ministry of Health and Family Welfare (MoHFW), who regulate overall policy of the state^{xxi}. Health education would be incredibly important to change existing beliefs about asthma. A previous education programme by Grover, C et al. had been performed on a small scale to assess for feasibility. It focussed on childhood asthma and educating parents and children. It showed a significant increase in quality of life and self-management skills^{xxii}. However, a large scale, nationwide attempt could not be found. Health education could greatly improve the ability of the general population to identify asthma symptoms, know where to go and which doctors to see and to understand treatment options and the importance of inhaler use. It can be executed in the form of online videos and posters which are translated into all the common local languages spoken in India. As per the Indian Ministry of Communications, 95% of villages in India have internet access^{xxiii} (3G/4G) and so this solution would be able to target the people who would benefit from this education the most. With better education the hope is that patients will be able to better select doctors and will not feel the need to change doctors as often, which tackles the final challenge of 'Doctor Shopping'. In the light of this research project, we believe that even more solutions and programmes can be devised and we would like to encourage further investigation and thinking to find more solutions to the problem of asthma care in India. A WHO and ERS report highlights chronic respiratory

disease (CRDs) as a priority for global health and its impact is often underestimated^{xxiv}. By bringing this information forwards at the government level we can drive positive change for respiratory health in India where political backing can lead to large-scale change.

Limitations

This research project was an exploratory study into barriers of asthma. To achieve this the questionnaire was designed to cover many different aspects of the participants experience with asthma diagnosis and management. While this allowed a wide range of topics to covered in a short interview, it meant that often there was not a lot of detail to gain deeper insights into certain aspects of the participant story.

In terms of communication the interpreters were vital to the success of this project. There would be some variability between translation as different interpreters were used across each hospital, city and even within a single hospital due to challenges with scheduling. However, all interviews were conducted by one person, myself. The nature of the qualitative analysis method involves researcher bias due to personal interpretations of some of the comments made during the interviews. The nature of coding is often subjective and so different people may code things in a slightly different way^{xxv}. Nevertheless, the general ideas would remain similar and so conclusions can still be drawn from this data.

This research was conducted in the months of June, July and August of 2025. This is reported to be the months with the lowest prevalence and so the number of participants that were obtained may have been lower than if this project was undertaken in early spring or in the winter months^{xxvi}. Furthermore, there were challenges in finding hospitals to allow research to be undertaken in the region of Anantapur. At GGH the respiratory OPD had a much lower volume of patients compared to the hospitals visited in Delhi and Kolkata, which limited the number of participants who could be found in the region of Anantapur.

Personal Reflection

This was my first experience in conducting a research project and so my choice to do it abroad and in a topic that is more exploratory was a daunting one. Although I have been to India many times it had always been confined to the cities and towns where my family live in the south of India. In a country as large and populous as India it is almost like travelling to a different country when moving between states as people speak different languages. I chose Kolkata and Delhi not only because it is relevant to this area of research but also to push myself out of my comfort zone. Staying in 2 cities that I had never visited before and needed to travel, communicate and adapt when I didn't know Hindi or Bengali. It was a great experience overall and I learnt a lot about myself as well as the country of my origin.

In terms of technical skills, I managed to develop an idea based on the research of my supervisors and mentors (Professor Usmani and Dr Dhar) and with their help it was refined into a practical project that I could carry out myself. During the 6 weeks of data collection, I had to adapt and change my questions and methods to fit the challenges that were presented to me. Using my aunt on the phone as an interpreter for a day when I couldn't find any other help or subtly changing my question phrasing every day as I learnt what different people were able to understand.

Data analysis was a unique experience. In school and university, a lot of analysis teaching focusses on quantitative data with hypotheses, statistical testing and logical conclusions. In choosing to take qualitative data in the setting to explore and define barriers I had to learn new ways to look at my data. Rather than relying on the comfortable Boolean results that maths can bring, I had to come to my own conclusions and draw together numerous contextual clues to build a complete picture of government sector healthcare in India.

Acknowledgments

I would like to say a special thank you to Professor Omar Usmani and Dr Raja Dhar. Professor Usmani's guidance and advice helped to refine my ideas and keep me

focussed. Dr Dhar was instrumental in connecting me to hospitals and doctors in Kolkata and Delhi. Dr Adithya Chawla and Dr Rakesh Chawla were incredibly welcoming during my time in Delhi and helped me in finding my second government hospital location in Delhi.

Thank you to the Laidlaw Foundation for facilitating this research project. I am very grateful for the opportunity, and I hope that there can be some great positive change because of this project.

Appendix

Participant Questionnaire
प्रतिभागी प्रश्नावली

Hindi

- What is your gender?
- आपका लिंग क्या है?

- What is your age?
- आपकी उम्र क्या है?

- Have you been given a diagnosis of asthma?
- क्या आपको अस्थमा (दमा) का निदान दिया गया है?
 - o If yes, when was this? (Year & Month)
 - o अगर हाँ, तो यह कब हुआ था? (साल और महीना)
 - o What questions/tests were conducted before the doctor gave the diagnosis? What is the cost of diagnosis? Has it been a financial burden or caused any personal challenges (such as impact on daily life) for you?
 - o निदान करने से पहले डॉक्टर ने क्या प्रश्न/परीक्षण किए? निदान में कितना खर्च आया? क्या यह आपके लिए वित्तीय बोझ था या इससे आपको कोई व्यक्तिगत चुनौती (जैसे दैनिक जीवन पर प्रभाव) हुई?
 - o What medications are you taking/have taken in the past?
 - o आप कौन सी दवाएँ ले रहे हैं या पहले ले चुके हैं?
 - o Are you buying the medications yourself, how much of a burden is this cost?
 - o क्या आप खुद ही दवाएँ खरीद रहे हैं? यह खर्च आपके लिए कितना बोझ है?
 - o Have you been given follow-up consultations? What is the follow-up frequency?
 - o क्या आप अपने निदान के बाद दोबारा डॉक्टर के पास गए हैं? यह कितनी बार (दोहराव) होता है?

- What symptoms did you experience that prompted you to seek medical help?
 - आपको कौन-कौन से लक्षण महसूस हुए जिनकी वजह से आपने चिकित्सा सहायता ली?
 - o How long did you have these symptoms for before seeking help?
 - o सहायता लेने से पहले ये लक्षण कितने समय तक थे?
 - o What prompted you to seek help?
 - o आपको सहायता लेने के लिए किसने या किस बात ने प्रेरित किया?
 - o What was stopping you from seeking help earlier (social, family, work-related, travel)?
 - o पहले सहायता लेने से आपको क्या रोक रहा था (सामाजिक, पारिवारिक, कार्य संबंधी, यात्रा)?
 - Have you currently got any insurance or government assistance for healthcare? Does this insurance require you paying up front? Is it a burden?
 - क्या आपके पास वर्तमान में स्वास्थ्य सेवा के लिए कोई बीमा या सरकारी सहायता है? क्या इस बीमा के लिए आपको पहले भुगतान करना पड़ता है? क्या यह आपके लिए भार/बोझ है?
 - In your own words can you tell me what asthma is and how it causes the typical symptoms you feel
 - आपके अपने शब्दों में अस्थमा (दमा) क्या है, और क्या आप बता सकते हैं कि यह आपके लक्षणों का कारण कैसे बनता है?
 - o If you have looked for information about your condition, how did you go about it? If you have not, how would you go about finding out more?
 - o यदि आपने अपनी स्थिति (बीमारी) के बारे में अधिक जानकारी प्राप्त की है, तो आपने ऐसा कैसे किया? यदि आपने ऐसा नहीं किया है, तो आप और अधिक जानकारी कैसे प्राप्त करेंगे?
 - What would you want to change?(about your diagnosis, management and experience with physicians during the consultations)
 - आप क्या बदलना चाहेंगे? (निदान, प्रबंधन और परामर्श के दौरान डॉक्टरों के साथ अपने अनुभव के बारे में)
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