

# Research Article

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## Patients' Satisfaction with Public Health Care Services in Bangladesh: Some Critical Issues

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### ABSTRACT

This paper attempts to explore the experiences of Bangladeshi patient with public health care services, clients self-perception of health, understanding their expectation and demands of health care towards government health practitioners and service providers. The study points out the issues and difficulties they faced in treatment or getting other services and presents some recommendations to improve the public hospital services. The study was undertaken using the interpretivist paradigm and based on qualitative research method with various data collection procedures, such as interview, focus group discussion (FGD), documentation survey, etc. were employed to collect necessary information. The data highlight a continuous cycle of marginalisation resulting from the interplay of health service providers and their business counterparts e.g. private pharmaceutical companies, diagnostic centres which reduce the opportunity of protecting patients' consumer rights at large scale. Therefore, the study suggests that policy makers and service providers should be more responsive to initiate effective policy measures and programmes to combat marginalisation and exclusion of that poor patient groups.

**Key words:** Patient satisfaction, Public health care, Services

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### INTRODUCTION

The recent improvement in health indicators of Bangladesh has got much recognition and is well documented (WHO, 2006, UNDP, 2009 cited in IMF, 2013). The statistical evidence show that life expectancy at birth has been raised from 44 years to 67 between the year 1970 to 2007; the infant mortality has been declined from 92 per 1000 live births to 41 by the year 1991 to 2008; Child (under five years) mortality has also been reduced from 146 per 1000 to 54 during the period of 1991 and 2008 (IMF, 2013). About 73 per cent of children aged 12- 23 months have been fully immunized from the six major diseases (BDHS, 2004). This substantial progress is happened through developing a nationwide network of medical colleges, nursing and paramedical institutes at large scale. The national health policy, plans and programmes are governed by the Ministry of Health and Family Welfare (MOHFW) through its two broad divisions- health services and family planning. The public health service delivery network has been operated through three tiers: primary care at *Upazilla* (sub- district) level, secondary care at district level and tertiary care at divisional level. However, in recent times, the Government of Bangladesh (GOB) has taken broader initiatives to deliver primary health care at the door step of grass root people through establishing Community Health Clinic (CHC) at the village level and Union Health and Family Welfare Centre (UHFWC) at the union level, specialized postgraduate hospitals are available only at the divisional level. It is shown that in 2006, the total number of hospitals in Bangladesh was 1685; among those hospitals 678 were governmental hospitals and 1005 were non-government hospital (cited in Rahman et al. 2005). Despite such progress, the health and population sector has been characterized as poorly coordinated and inefficient delivery of health care services. A major government

report, *Bangladesh: Unlocking the Potential* (2005) recognized that public health services have been rated the lowest among all types of service providers in term of user's satisfaction. It further points out that some governance issues such as staff absenteeism, pilferage of drugs and other essential services, mistreatment and negligence of clients, unauthorized and illegal payments collected from consumers etc. responsible for lower patient satisfaction. However, patient satisfaction as an important dimension for ensuring quality health care is getting priority in the developed countries (Calnan et al., 1994; Epstein, Laine, Farber, Nelson and Davidoff, 1996, cited in Ashrafun and Uddin, 2011), the concept of patient as consumer is still less emphasized and their voices are rarely heard (Hossain and Westhues, 2011). There are some qualitative studies yet to be conducted to explore the issue. Aldana et al. (2001) pointed out that provider's behaviour, especially respect and politeness are the most powerful predictor for client satisfaction with the public health care services. They further explored that there is a negative co-relation between gift culture in hospital services and client/patient satisfaction. Another study on patient satisfaction with quality of hospital services in Bangladesh showed that there is a loss of faith in public and private hospitals. The study also identified some factors such as doctors' treatment, the behaviour of nurses/boys and their services to patient are significantly influence patients' satisfaction. (Andaleeb et al.: 2007). However, these were some good attempts to point out some factors linked with client satisfaction, they gave less emphasis on accounting patients' experiences and failed to identify the gap between the expectation and reality and clarify the issue as why do people feel dissatisfied and how can better these issues to be addressed. Therefore, the proposed study was an attempt to explore the patients' expectations and perception of quality health care and experiences of receiving public health care services, their condition of satisfaction etc. For the purposes of study the following definition of key concepts were used:

**Patient satisfaction** was defined as to refer patients' self-perception, positive or negative evaluations and attitude to health and medical care services provided by government hospitals and other public health centers. Perceptions were regarded as patient's beliefs about occurrences which could reflect the degree to which patients consider specific occurrences to be desirable, expected or necessary.

**Public health care services** were used to denote those preventive or curative treatment or any health promotion services provided by the government of Bangladesh through hospitals or health centers at local community level or district level.

## OBJECTIVES OF THE STUDY

The general aim of the study was to know the patient's satisfaction over different health care services provided by government hospitals and health centres. Therefore the specific objectives were:

- To explore clients self-perception of health, understand expectation and demands of health care towards government health practitioners and service providers;
- To know their experiences of getting health care services provided by the governmental hospitals; identify patients' satisfaction or dissatisfaction in getting those services;
- To point out the issues and difficulties they face in treatment or getting other services and finally present some recommendations to improve the public hospital services.

## LITERATURE REVIEW

The National Health Policy (2013) approved by the GOB aims to ensure good health through developing an easy and sustained availability of health services for the people. Such efforts of the government to improve its health care system require strong emphasis to the notion of quality health care. For understanding the notion of quality health care, majority of the quality assessment studies usually try to measure three types of outcomes: medical outcomes, cost and client satisfaction (Aldana, 2001). Recent studies also reveal that services or client satisfaction can significantly enhance patient's quality of life (Dagger and Sweeney, 2006) and enable service providers to determine specific problems of customers, on which correction can be taken (Oja et al., 2006). Some other studies suggest that dissatisfied clients of health services tend to complain to the establishment or seek redress from it more often to relieve cognitive dissonance and failed consumption experiences (Nyer, 1999). In addition, dissatisfaction might have serious ramifications: patients are unlikely to follow treatment regimen, may fail to show up for follow up care and in extreme cases, may resort to negative word of mouth that can dissuade others from seeking health care services from the existing system or persuade them to seek it privately or from abroad. However, in Bangladesh the government has begun to strategically integrate the health sector into its poverty reduction plan, the public health sector is plagued by uneven demand and perceptions of poor quality (Andaleeb et al. 2007). One study shows that the overall utilization rate for public health care services is as low as 30 per cent (Ricardo et al., 2004). Another study revealed that the trend of utilization of public health care services has been declining between 1999 and 2003, while the rate of utilization of private health care facilities for the same period has been increasing (CIET, 2003). The study identified the unavailability of doctors and nurses as well as their negative attitudes and behaviours including the lack of drugs, long travel and waiting times as the major factors of dissatisfaction and barriers to utilization of public hospital services.

The GOB and its development partners also make concern over the issues and point out that absenteeism of health care provider, short consulting hour (2-3 minutes) with almost no privacy are the major factors that restricts the service delivery system and satisfaction. In addition, it is confessed that a lot of posts are lying vacant at the Upazilla and below levels. Service providers are busy with private business, unavailability of drugs were identified as important reason for people's dissatisfaction about public health facilities (MOHFW, 2003; cited in Andaleeb et al., 2003). Another study conducted by Ashrafun and Uddin (2011) was done with a view to identify factors determining in-patient satisfaction in the hospital setting. The study findings reveal that toilet and bathroom condition, quality of food, long waiting hour etc. were come out as the most influential factors contributing to patient dissatisfaction in Bangladesh. The study further clarified an important issue called as bribe or gift culture where patients need to pay money to different service providers in the name of gift/ tips which is a significant factor for patient dissatisfaction. Rahman et al.'s study (2005) focusing on inequality issue pointed out that in spite of having an extensive health care infrastructure, the government services are not client focused, need based, of high quality and within the reach of the poorest. They also identified different challenges of health care services of Bangladesh which include the challenge of population growth, poverty, changes in the spectrum of disease, insufficient budget allocation, poor health knowledge etc. They also raised the question of governance issue in health care services. They identified governance crisis in the area of administrative management, crisis in personnel administration, monitoring and accountability, lack of coordination, corruption, policy incoherence etc.

Islam and Jabbar's (2008) study on patient satisfaction of health care services provide some valuable information. This was a descriptive cross-sectional study on 299 patients visiting out-patient department (OPD) of Dhaka Medical College Hospital. The study findings revealed that majority of the patients (81 per cent) expressed satisfaction (ranging from fair to good) with respect to adequacy of space, sitting arrangement and cleanliness of waiting rooms, but were dissatisfied (75.31 per cent) with respect to toilet facilities and supply of drinking water. However, majority of the respondents were satisfied (ranging from fair to good) about the responsiveness and patience of the doctors to listen to their patients problems, half of them were dissatisfied because the treatment was not explained and/ or enough information was not given. However, there were taken some good attempts to know about the different factors responsible for patient satisfaction; majority of those studies failed to point out the issue of patients' consumer rights and clarify how the rights could be violated in the recent arena of market places and what measures could be taken for better protecting their rights and promote utilization of public services. A better understanding of the determinants of client satisfaction should help policy and decision makers to implement programmes tailored to patients' need as perceived by patients. Therefore, the current study was conducted with the aim to inform the policy makers, practitioners as well as providers of services what the general patients actually want, their condition of satisfaction as a matter of consumer right regarding public health care services, and how the quality of service provision system can be improved.

## THEORETICAL FRAMEWORK

A better understanding of the patient's health care experiences including satisfaction requires the consideration of different theoretical approaches with health care. Theoretical framework helps us with providing the explanation of human experiences in terms of a continuous interaction among cognitive, behavioural and environmental determinants. Peoples' health care experiences can be better understood on the basis of the following theoretical viewpoints: the medical approach, the behavioral approach and social determinants of health perspective. In Bio-medical approach (BMA), the major emphasis had been given to understand the epidemiological and biomedical factors related to disease with the objective to eliminate and control disease through screening and treatment. Typical medical interventions may include population wide programs such as immunization, cancer screening, and other opportunistic interventions such as cholesterol or bone density tests (Holman, 1992). Historically, the medical approach has led to a dramatic rise in health standards by controlling the spread of disease (Holman, 1992). Thus, public health efforts have been progressed from this 'survival' focus towards a more holistic emphasis on positive wellbeing and lifestyle (Crowther et al., 2002; Holman, 1992). Public health efforts now focus on changing health risk behaviour and constructing an environment that is conducive to health promoting behaviour change that is, eliminating health risk behaviour and increasing performance of healthy behaviour. According to this approach the main focus is given on the epidemiological and biomedical factors related to disease with the objective to eliminate and control disease through screening and treatment.

The behavioral approach (BA) focuses on implementing interventions to change or remove behavioral health risk factors. Interventions from this perspective target a particular behavioural risk factor associated with a particular negative health outcomes; they target a population performing the behavioural risk factor and endeavor to promote health through various strategies. These strategies may include raising awareness of health risks through health education, social marketing, and policies that support lifestyle choices. We see that there is a clear difference between the medical approach and the behavioral approach. The BMA gives on focus to improve the total health situation by controlling the spread of diseases. By contrast, the BA gives focus on to promote the health care situation by changing or removing behavioral health risk factors.

The social determinants of health (SDH) approach draws attention that human health status is not only determined by medical factors rather social factors. According to WHO, the SDH can be regarded those conditions in which people are born, grow, live, work, age including health systems. The SDH perspective focuses on the importance of material disadvantage, social inequality and describes how the social structures within which people live determine the choices people can make and the experiences they get etc. shape their wellbeing (Kirby, 2002, cited in Hossen, and Westhues, 2011). Therefore, the SDH framework supports a policy shift from illness based discourses to wellness based discourses that emphasize prevention of illness and chronic diseases as well as people's positive social experiences of better health outcomes. The current study was guided by SDH approach as it was thought more suitable for a better understanding and exploring the people's perception and attitude, their expectation to health service providers; their real experiences of getting health services; their feelings of satisfaction or dissatisfaction etc.

## RESEARCH DESIGN AND METHODOLOGY

### RESEARCH QUESTIONS

The central research question of the study was as follows:

What is the condition of patients' satisfaction in getting health care services provided by the government hospitals?

Therefore, the specific research questions were as follows:

- What are the different kinds of health care services people do receive from government hospitals?
- What are the patient expectations and experience in getting health care services provided by government hospitals? Do they face any difficulties in getting those services?
- What is the situation of patients' satisfaction with public health care services?
- What are the patients' recommendations to improve public hospital services?

### RESEARCH METHODS

This study was conducted following the interpretivist paradigm to explore the experiences of individuals who get health care services from govt. hospitals and their satisfaction and attitude to the services. The study was based on qualitative research method with various data collection procedures, such as interview, focus group discussion (FGD), documentation survey, etc. were employed to collect necessary information. Although the study was based on primary data, a number of secondary sources, such as policy documents, journal articles, academic books, official documents, etc. were used to conduct the study. The semi-structured interview strategy was used to generate sufficient primary data to address the research questions and study objectives by capturing the meaning of experiences of the participants in their own words (Marshall et al., 1999). In addition, two focus group discussions (FGD) were arranged for participants with having direct experiences of getting services from govt. hospitals for the last three years.

### SAMPLING PROCEDURE: ACCESS AND RECRUITMENT

Both purposive and snowball sampling method were used to access the data necessary to address the research objectives. A multi-stage sampling technique was employed to collect appropriate samples to generate sufficient primary data. The Sylhet City Corporation (SCC) area of the Sylhet district, *Jagannathpur Poursaba* (JP) of the *Sunamgonj* District, *Nabiganj Pouroshoba* (NP) from *Habigonj* district and *Maulvi Bazar Pouroshoba* (MBP) of the *Moulavi Bazar* district were selected purposively for conducting the study. A total number of thirty samples (30) taking minimum nine (07) informants from each city or *Pouroshoba* area were selected purposively for in-depth interviewing. In addition, three (03) focus groups discussions (FGDs) were arranged in the SCC, NP and JP areas. Each FGD was constructed with six to eight participants for collecting sufficient empirical data to substantiate with those primary data collected from individual interviews. The inclusion criteria were to become Bangladeshi citizen with having direct experience of getting in- patient services from govt. hospitals for minimum three days. The access to participants was gained through City Corporation or *Pourasaba* officials, local voluntary organisations and other local gate keepers in research. A letter, outlining the study as well as inviting participation, was sent to the potential informants.

### ETHICAL CONSIDERATIONS

The research process and design was guided by the Ethical Guidelines of the Social Research Association. Participation in the study was entirely voluntary and relied on the ethical principle of consent. At the start of interview and FG discussion, the study purpose and nature was explained. Therefore, written or verbal consent was taken from them. Moreover, as part of the consent process, ground rules were negotiated regarding the confidentiality of the proceedings with respect to protecting the right to anonymity of individual participants. It was further explained that while the anonymity of individual participants was preserved, their verbatim might be published, although action would be taken to prevent them being identified.



## DATA COLLECTION

Most of the interviews were taken in the official places, such as local voluntary organisation, hospital premises and permission was obtained as necessary. The respondent's home was also used with their consent. The semi-structured interviews were taken for duration of approximately one and half hour for each interview, whereas the focus group interview was longer, i.e. minimum two hours duration. Interviews and FGDs were undertaken in Local Sylheti dialect of Bengali language, as most of the people in Sylhet region speak in this dialect. A full transcription i.e. verbatim method was followed and the audio- recorded interviews were first hand-written in Sylheti dialect of Bengali language and then translated and typed into English. The main focus was on retaining conceptual consistency (Atkin and Chatto, 2006) and in some cases transliteration of significant word/s was carried out in order to avoid the loss of meaning. To facilitate the larger number of participants, the FGD data were managed and analysed through the adaptation of strategies suggested by Bulmer (1998). All responses were recorded on flip-chart paper and together with the group using grounded theory techniques of open coding and theme analysis (Strauss and Corbin, 1990) to sort the data and generate categories. The researcher led the group through a series of questions; however a facilitator also facilitated the group and took handwritten notes. Interviews and focus groups were audio- recorded with the permission of the participants.

## DATA ANALYSIS

Qualitative analysis of data requires an interpretive approach concerned with understanding the meanings which people attach to phenomena (actions, decisions, beliefs, values etc.) within their social worlds (Denzin and Lincoln, 2003). Therefore, a general inductive analytic approach was undertaken as informed by the work of Bryman and Burgess (1994), Miles and Huberman (1994), Thomas (2003). The recorded interviews and FG discussions were transcribed in full and the accuracy was checked against the original audio recordings by the researcher. The transcripts were analysed using thematic analysis, derived deductively from the research questions or as in vivo codes emerging inductively from meanings or actual phrases used by the participants. The trustworthiness of data analysis process was enhanced by method triangulation in addition to comparing with available literature. In this study triangulation of the data was ensured by using semi-structured interview and focus group in a complimentary fashion as well as comprehensive manner. The same questionnaire or topical guidelines were used to generate sufficient information and tackle the inconsistencies and tensions within the data.

## THE FINDINGS

The data generated in the interview schedules and the focus group discussions illustrate the experiences of patients with the public health care services in the Sylhet region and the condition of their satisfaction with services they receive from different government hospitals. These are presented below:

### PATIENT'S CURRENT HEALTH STATUS AND EXPECTATION

Before knowing the patient's satisfaction with public health care services provided by the govt. hospitals, there was an attempt to investigate their physical health status. The study reveals that majority of the participants have experienced some of the chronic diseases like diabetes, hypertension, stroke, cardiovascular diseases, arthritis etc. Some of them were experienced road accident, burning etc. They have been suffering from one or more of the above diseases which seriously affect their physical and mental wellbeing. The initial response was clarified by their statement of the physical condition which can be better described in the following narratives of the participants:

*I've been suffering from many types of diseases for the last seven years. These are headache, gastric, arthritis, throat pain, skin burning etc. The diseases are working like a chained process; one reduces then another one is started. All the diseases are equally painful. My sleep is hampered at night. At day time it seems intolerable to hear noises of the children and look after them. (IV, Female)*

Another participant narrates his physical condition:

*Actually most time, I feel severe pain at my leg. Sometimes feel dizzy, skipping head very strongly, see green and blue in the eye etc. The body is so weak! It does not work in a balanced way. (IV, Male)*

The data also show that most of the participants had experienced deteriorated health condition which required treatment in the hospital. The following extract clarifies the vulnerability of a patient:

*Last time I was admitted to hospital and the doctor advised to do Angiogram for diagnosis. They told the treatment package will cost TK. 25000.00. However, I stayed some days in hospital; I did not take the said treatment due to financial incapacity. (IV, Female)*

Another patient also expresses her condition in the following way:

*I was admitted into the hospital for delivery of pregnancy. The doctors did surgery and cut my uterus without any consent of me or my husband. The services were poor the condition of toilet and bathroom was rubbish! (IV, Female)*

The study reveals that majority patients who come to the govt. hospitals for health care services are poor and belong to lower income groups. Their expectation may vary from a wide range of services. The common expectations of patients are to get immediate relief or cure from diseases, health advice and all types of treatment facilities e.g. cost of medicine and diagnostic examinations, food etc. to be provided by the hospital authority. There are some poor patients who face difficulties to bear the transport, food and other costs e.g. staying of their attendants. The following extracts clarify the different types of expectations of patients:

*We have come to govt. hospital to get all types treatment at free of cost. Since we are poor, we do not avail the expense of private health care. That's why we are here in long queue to visit the doctor. (IV, Female)*

*I know the govt. is spending lots of money for our services. So I hope the medicines will be provided by the hospital authority. (IV, Male)*

*I expect doctors and nurses will be sympathetic to us. They should allow some times to hear our sufferings. They should give dignity as a human being and pay due attention. Sometimes nurses, doctors and other behave harshly! It is not expectable. (IV, Female)*

*I want services will be provided promptly and service providers will strictly follow their professional guidelines. They will give sufficient time to provide reliable treatment. The management authority will monitor and evaluate the activities and performance of doctor, nurses and others working in the hospitals. (IV, Male)*

## EXPERIENCES OF PUBLIC HEALTH CARE SERVICES AND SATISFACTION

### Delivery of health services and behavior pattern of service providers

Despite some positive experiences, majority participants opine that they are less satisfied with the ways the services are operated and delivered to them. The situation of dissatisfaction arises due to many factors which include access to health care, delivery of free medicine, the cost of medicine, behaviour pattern of service providers, responsibility of doctors and nurses etc. Some participants raise the issue of accessibility:

*Getting admission is not a problem; the problem is to get a bed. I had a terrible pain in my body. Following the advice of doctor I took admission in the hospital, but did not get a bed in the ward. I had to stay one day in the floor. Then the authority gave a bed in the ward which was payable. (IV, Female)*

*For in-patient services the tough thing is to get an appointment of surgery. It may take 10 to 15 days and depend on doctor's will. Then they give a long list to buy materials which are very expensive. The other big task is to manage blood. All these things are very troublesome. (IV, Male)*

The study reveals that sometimes the behaviour pattern of health providers e.g. the doctors and nurses and other workers in the hospital causes a feeling of dissatisfaction and sense of grievances among the patients and their carers. They identified rude behavior, lack of proper attention about hearing their condition, less caring attitude to the patient etc. as the major reasons of dissatisfaction. The following narratives echo the issue:

*One day I went to visit the doctor with my six years old girl child. She took her hands on the table when I was talking with my health problems. The female doctor became angry and behaved very rudely. I felt shame and disgraceful. (IV, Female)*

*My skin was burnt and I got admitted into the hospital at surgery unit. At first, the doctors and nurses were sympathetic and very caring; they observed me many times. But after few days their behaviour was changed and did not give proper attention. Even a nurse rudely behaved with my husband. (IV, Female)*

*I was admitted in the hospital with a small tumor in my leg. Many days had been passed but they did not give proper attention to me. After waiting long time, the doctor gave an appointment date for surgery which could be done in the following month. Now I am waiting and the nurses do not take care properly. ((IV, Male)*

Sometimes the doctors do not give much attention to the poor patients for giving advice and free medicine. When they go with other person who has some connectivity (e.g. relation as kinship or friendship or face value i.e. educated person, govt. officials or businessman etc.) with doctors and other persons working in the hospital, then they can avail the opportunity of public health care services very positively. One participant narrates his situation in the following way:

*I do not have satisfaction with public health care services e.g. govt. hospitals. I think the ordinary people do not get proper health care services. It may be possible if somebody's brother is army officer or he has a big brother who is a leader of Awami League or Bangladesh Nationalist Party. (IV, Male)*

*My experience is positive. I went to the hospital with my uncle. He had a friend working in the hospital. He (doctor) helped me very much. My wife is a patient of mental disorder. The doctor gave me a slip and I got all medicine by showing that slip. (IV, Carer, Male)*

Majority of the findings show that poor people think there are no alternative ways available to them without going to public hospitals. But the services are not up to their expectation. They hope that they will get most of the services free. But in reality they need to pay for attaining most of the services. One participant points out the issue in the following way:

*We are poor people and we have come here to get free services. But I have had to pay for almost everything except the doctor's consultation charge. I am paying for diagnosis, medicine. I am not able to bear the expenses. (IV, Female)*

Another participant shares his experiences:

*I have taken my sister here for better treatment. The doctor advised for some diagnostic test and treatment which require huge money. I told them the amount is not affordable to me. Then they replied that nothing they can do. ((IV, Female)*

However, in most cases people perceive that the quality of doctor in govt. hospital is good, the issue of dissatisfaction arise when they are less attentive at the time of working in the hospitals. This is evident when there found some cases of wrong treatment occurred by the doctor. One participant shares his experience:

*First I admitted into the govt. hospital. They had done a surgery; but the situation was getting worse. Then I was bound to take release from them and went to private clinic. There the doctor took another x-ray and other diagnostic tests which revealed that previous treatment was wrong, although they took TK 5000 from me. Thus I was exploited by them. (IV, Male)*

Another participant echoes the issue:

*I don't like to go to Govt. hospital but bound to come for financial limitation. Because the doctors and other people working here do not behave with us in a cordial manner. But this would be changed when you visit their private chamber. There their behavior is polite. Brother money work as tonic! (IV, Male)*

*The doctors are now running for money; patient you may go to Hell or Heaven but pay their money. You know some days ago one surgeon did operation of my wife telling his abdominal pain was due to appendicitis which required quick surgical operation. But after the operation it was not cured. When we go to another doctor, he told it was another health problem. But it was painful for me because that operation was costly. (IV, Male).*

### **Cost of medicine and availability of free medicine**

The study explores that cost of medicine and the issue of availability of free medicine work as decisive factor for satisfaction of some patients. Majority of the poor patients perceive that the cost of medicine is very high and expect that treatment and cost of medicine should be borne by the hospital authority. But in reality their expectation are very rarely met and eventually most of them remain dissatisfied. The study found that only cheaper medicines are provided by the hospital and most of medicines are needed to buy from outside in the private market. One respondent echoes the issue:

*We do not get free medicine here, except the Paracetamol, Histacin or very low cost medicine etc. Most of the medicine and diagnostic tests are required to take from outside the hospital. (IV, Female)*

Another participant describes:

*I came to the hospital with expectation of receiving all type of help to become fully cured. I had been suffering from skin diseases for two months. I thought that full courses of medicine will be given free. But I found that only cheap medicines were given from the hospitals and expensive medicines were required to from outside. I was totally frustrated about that. (IV, Male)*

The study explore that people's perception about the scarcity of medicine is not the only reason for which medicines are not available to them. According to their opinion, corruption is also responsible for that situation. There are some organized groups who steal public medicine and sell it in the private market. For example, one participant clarifies the issue:

*Corruption is one reason, I think behind the crisis of medicine in public hospitals. Because, it was found in the last caretaker govt. some people were guilty and punished for selling public drugs in the private markets. There are some dalals (intermediate person) who work with nurse, brother and some other persons for dealing with illegal trade of Govt. medicine marked as 'not for sale'. (IV, Female)*

The FG participants also discussed the issue and concerned that the cost of medicine is increasing. It does not keep pace with people's income. One participant points out the issue:

*I need to buy Avolac suspension for the last seven (07) years. The price was Taka 75 per bottle, now it is Taka 125; In this way the price of every medicine is increased, so we did not avail proper medicine. (IV, Male)*

*We the poor people become helpless when we are sick. We do not mange food for surviving then how will take treatment and buy medicine. The cost of medicine is very high. In that circumstance we have to make a choice either buy medicine or stay starves. (IV, Female)*

### **PATIENTS' CONSUMER RIGHTS AND CHALLENGES**

The study reveals that patients are less organized and facing challenges of privatization of the health sector. There are problems within health sector management that reduce the opportunities to provide adequate care of poor vulnerable patients. The study uncovers some real challenges which reduce their consumer rights and make them subject to financial and emotional exploitation which are described below:

### Private business of government health officials

The GOB has tried to ensure the availability of health care services through recruitment of doctors and nurses, health technicians at the *Upazilla* level. But majority of the participants in the *Upazilla* level expressed their deep concern about the uncontrolled involvement with private business. It is found that there are some doctors who are running their private business even at the time of government working hour. One participant echoes the issue:

*Sometimes I go to the Upazilla health complex for visiting the doctor. The doctor is rarely found in his office premises. He has rented a room near the health complex where he visits patients. There he visits patient in exchange of money. (Interview, Female)*

*Doctors or health technicians are not available in hospital area at the office time. They are present from morning to evening in their office record; but in practice they are available for two to three hours. They are busy with expanding their private businesses. They are not happy to welcome us at hospital premises, rather to invite us in their private enterprises. (FG, Male)*

*I think working in the Govt. hospital is a signboard for them to collect patients. Their main business lies in the private sector. In the last Caretaker Govt. period when there were some concerted actions taken to shift some doctors from Sylhet, they took early pension and left the job. Later they joined in the private medical colleges. So Govt. will not control their business. (FG, Male)*

### Mal- practices of diagnostic centres

Some other issues identified by FG Members that work as barriers to obtain better services and violate their consumer rights include the malpractices of diagnostic centres. However, they recognized the necessity of diagnosis for better treatment, they pointed out the malpractices done by health traders e.g. the administrators and owner of diagnostic companies by providing commission to doctors which ultimately reduces patients' consumer rights who actually bear the burden of commission on their own shoulders. The following narratives echo the issue:

*Now it has become a type of business for some doctors. They are referring for diagnosis for getting commission from Diagnostic Companies. We have heard that they get 20 per cent money of each diagnosis test. However they are getting from diagnostic companies; the companies are taking money from us. So we the poor people are getting looser. (FG, Male)*

*The mushroom growth of diagnostic centres is another problem. I think there is no hard and fast rules strictly followed to operate those centres. We the ordinary people do not understand which centres are maintaining good standard. When we go to one doctor he suggest to go this diagnostic centres; if you need to go another doctor he does not take it as reliable so tell us you better go that diagnostic centres. So it's a big puzzle! (FG, Male)*

*Visiting Physician is not a simple thing. If you visit a doctor, they will give you a slip of several diagnostic tests and recommend for going to their diagnostic centres. The receptionist of that centre will record the doctors' name and automatically send 20 per cent of total diagnostic charges to that doctor. However, there are some good doctors who do not take commission from diagnostic centres, their number is rare. (FG, Male)*

### Drug business of private pharmaceutical companies

The study reveals that patients and their carers shows a feeling of dissatisfaction and make concern that government should take necessary steps to regulate the business; otherwise it will seriously hamper consumer's right. The FG data point out that representatives of private companies are attracting doctors and other small traders through gifts (medicine samples and other products) to gain good position in market competition. The Pharmaceutical Companies are producing 10 to 20 per cent of their products as physician sample which are mentioned 'not for sale'. But in the market the medicines are sold. Therefore, some people think that the ultimate burden of those medicines also goes to the shoulders of patients and they rationalize that it might be one of the important reasons of increasing the price of medicine.

*In our country the companies are increasing the price of medicine as much they wishes. Govt. is doing nothing for controlling it. You know private companies are busy to please the doctors through gifts. But the costs of gifts are not paying from the pocket of companies; In fact, we people are paying when we are buying medicine under the instruction of doctors. (FG, Male)*

*It is disgusting! When I see the medical representatives are seating at the hospital to see our prescription. They see it for knowing whether their products are recommended or not. They want to know it because they provide doctors lot of gifts. The doctors therefore, write some medicines from low grade companies. Thus our patient's consumer rights are neglected and we are financially exploited. (FG, Male)*

*There are some doctors who are happy to provide lots of medicines. They provide much stronger types of medicines for common diseases and if you count it will be four or five types of medicine. Sometimes they write the medicines of those companies who provide them many gifts. (IV, Male)*



## DISCUSSION

The interviews demonstrate that majority of the patients have experienced of one or more of major diseases, such as diabetes, hypertension, stroke, cardiovascular diseases, arthritis, eye cataract etc. which seriously affect their physical and mental wellbeing. The evidence further reveals that most of the participants also have had experience of facing deteriorated health condition which was followed to take treatment in the hospital. The study points out that majority of the patients who generally come to the government hospitals for health care services are poor and from lower income groups. Their expectation may vary from a wide range of services. The common expectations of patients are to get immediate relief or cure from diseases, health advice and all types of treatment facilities e.g. cost of medicine and diagnostic examinations, food etc. to be provided by the hospital authority. This study is consistent with Aldana et al. (2001) in demonstrating how the majority of Bangladeshi patients expect positive attitude and behaviour of health service providers, particularly respect and politeness, privacy, short waiting time etc. in using public health services. They give much importance on those issues than even the providers' technical competences including physical examination and explain the nature of the problem etc. Their study points out that care that meets all medical needs may fail to meet client's emotional or social needs due to ignoring the cultural background of patients and suggest for more culture specific in-depth studies. My study recommends that understanding peoples' expectation and their socio- economic and cultural background is important ingredient of quality health care and better patient satisfaction. Therefore, it is recommended that culturally competent services are needed to be provided through training of the service providers about the notion of customer care. In addition, it is shown that most people with chronic illness are also suffering from economic hardship and they feel their medical needs should be fulfilled with greater support from the hospital authority.

## PATIENTS' SATISFACTION AND HEALTH SERVICES EXPERIENCES

The study findings reveal that patients are facing some challenges which inhibit proper access to health service facilities. The interviews and FG demonstrate that district level hospitals lack adequate in- patient department (IPD) facilities e.g. lack of bed in hospital according to the demand of patients; appointment of surgical operations etc.. However, there are some services available to poor people, e.g. getting cheap medicine, food for patient, some diagnosis opportunity at reduce cost etc. but those facilities are not enough to meet the demand of the vast majority of people. The study echoes similar findings of other studies which show that majority of the patients are not satisfied with the facilities available to them. They face the same problem in hospital settings e.g. long waiting hour, long queue, cost of medicine, lack of the availability of medicine etc. (Hossen and Westhues, 2011). The FG findings also clarify that getting admission is available immediately in the hospital, but to get an appointment for surgery is difficult as it usually take one to two weeks. They draw attention to the fact that cost of medicine and diagnostic services are major hindrance to satisfaction of the poor patients. In addition behaviour of the physicians and nurses should be more patient focused so that they feel valued not ignored. My study findings resonate with another study which identified the unavailability of doctors and nurses as well as their negative attitudes and behaviours including the lack of drugs, long travel and waiting times as the major factors of dissatisfaction and barriers to utilization of public hospital services (CIET, 2004; HEU, 2003).

The FG data also suggest that in the hospital setting sometimes patients are given the wrong treatment due to negligence or delay in proper diagnosis of the disease. They either delay or do not refer the patients in adequate time to consultant services. It is evident from the FG participants that pains in abdomen or backbone, are often treated by giving painkillers for long periods of time without referral to consultant for proper diagnosis. It is found that by the time out patient departments (OPDs) refer them to the IPD consultant services, it has been too late. People may be in a critical treatment or cure difficult and there is a risk of deterioration in the health condition. The study findings mirror similar studies showing that respondents of Dhaka Medical Hospitals are more likely to find physical access to their hospitals difficult (Rahman, 2002). It is consistent with the evidence that significant numbers of patients are dissatisfied with the outcome of their consultancies. This is particularly acute in the area of communication, with language difficulties being noted by illiterate rural women. It echoes more recent evidence that Bangladeshi women show a strong preference for seeing a female doctor, something which was not always possible in the locality (Hossen and Westhues, 2011).

The FG findings highlight perceptions that the quality of caring services in hospitals are decreasing due to government drives to reduce cost. They perceive that services provided by nurses are not up to the standard expected by patients. The participants perceive patient- nurse ratio is not rational to provide quality services to the patients and sometimes responsible for strain relationship with patients and their attendants. Lack of training about customer care is another source of tension. There are perceived feelings of discrimination among some illiterate women patients who feel that they do not get same respect or importance like other educated male patients when they are in hospital. Both the interview and FG data suggest that the participants feel patients' consumer rights are violated by some health practitioners and business companies due to malpractices of diagnostic centres and a high

increase of medical prices. The FG participants also feel that they get less priority from nurses and others working in the hospital sector and sometimes become exploited financially and emotionally.

Although several studies highlight the common issues e.g. lack of cleanliness of toilet or bathroom, long waiting hour, lack of quality of food as major area of dissatisfaction (Ashrafun and Uddin, 2011). My study put forward another important area of patient's grievances and dissatisfaction is the issue of consumer rights of patients. There are problems within health sector management that reduce the opportunities to provide adequate care for poor vulnerable patients. Bangladeshi patients belong one of the most vulnerable and less organised sections of society; their consumer rights are violated by different business groups e.g. private pharmaceutical companies, diagnostic centres etc. However, the patients recognize the necessity of diagnosis for better treatment, they point out the malpractices done by diagnostic companies by providing commission to doctors which ultimately reduces patients' consumer rights. They think some doctors are interested to refer diagnostic services without considering patients' financial solvency. They perceive that the diagnostic companies are providing commission by taking money from patients who actually bear the burden of commission on their own shoulders. In addition, majority of the participants in the Upazilla level expressed their deep concern about the uncontrolled involvement with private business. The study found that there are some doctors who are running their private business even at the time of government working hour.

## CONCLUSION AND RECOMMENDATIONS

This study confirms existing evidence that Bangladeshi patients' have a growing concern with lower level of satisfaction in public health care services. They face multi-dimensional problems, characterised by deteriorating health conditions, high cost of treatment, poverty and the risk of negligence due to less welcome behaviour pattern of health professionals. The data highlight a continuous cycle of marginalisation of patients resulting from the interplay of health service providers and their business partners e.g. private pharmaceutical companies, diagnostic centres etc. which reduce the opportunity of protecting patients' consumer rights at large scale. In addition, the cost of medicine, lack of availability of free drugs and diagnostic services and behaviour pattern of doctors, nurses increases the risk of service exclusion of patients. The problems are compounded by differential expectation and experiences of service users which reveal that patients demand quality health care services at free of cost which are not available to them. A major issue for the participants in the study was the behaviour pattern of doctors and nurses which limit their ability to access and proper utilization of health care resources and satisfaction. However, some patients were concerned about their ability to get medical appointments, hospital accommodation, some complained of being discriminated against in comparison with other educated people who have some connectivity with doctors and nurses in hospital. Having different expectations of how much services can realistically be given is a source of tension and can lead to strained patient- doctor relationships. Tensions and stress accumulate when health professionals are over burdened with responsibilities. As the literature shows that there are a serious shortage of doctors, paramedics, nurses and midwives. The nurse-doctor and medical technologist- doctor ratios are among the poorest in the rural areas. The average doctor patients' ratio in Bangladesh is 4000: 1. There are 43 thousands registered doctor against 21 thousand nurses. Nurse patient ratio is 1: 15 in Bangladesh as against international standard for 1: 4. It is very difficult to provide quality health care services for the vast majority patients with limited number of health care professionals. By contrast, patients become dissatisfied when they see government doctors are spending much time at their private business centres and they cannot afford modern treatment offered by those centres due to financial insolvency.

Although, there is a growing demand to reduce public spending both in the developing and developed countries to face current economic recessions, the ways in which patients from lower income strata can be protected from ill health and marginalization has been less emphasized. Since majority of the patients are from lower income group with low level of literacy, they are the most disadvantaged and vulnerable section in our society. Therefore, the policy makers and service providers should be more responsive to initiate effective policy measures and programmes to combat marginalisation and exclusion of that particular group. Therefore, the following issues should be taken into considerations:

### Cost of treatment and health care

Bangladeshi patients who live below the poverty line are at the risk of being poorer of the poor. Health care providers should recognise that the poor people cannot avail the different costs e.g. diagnostic charges; medicine costs etc. Therefore, appropriate measures should be taken to provide adequate services to their health care demands with minimum cost.

### Patients' expectation and responsiveness of health service providers

Hospital authorities should become more responsive to patients' expectation and demands. They should take steps to gain feedback from patients. Recognising the existing resource constraints, they should be more flexible and make adjustment in current service provision. For example, they can introduce free health cards for poorest patients regarding their income and provide free medical services including necessary medicines. Patients'

representatives can be engaged in planning, prioritizing and meeting health demands of that vulnerable group. This will in turn ensure confidence and satisfaction among the patient community and develop partnerships between doctors, patients and other workers to improve welfare and proper utilization of scarce resources.

### **Health care access and quality in service provision**

Easy and early access to health care services can make stark progress in using health care services and satisfaction of patients. Appropriate measures should be taken to improve efficiency in existing health care management by developing strong monitoring and evaluation cell to check corruption and violation of patients' general rights and exploitation. It is understandable that doctors and nurses are over-burdened and therefore, recruitment of doctors, nurses, dentists, ophthalmologists and other different groups of professionals are necessary to increase service provision and trust. Number of beds in district level hospitals should be increased to meet the pressure of large number in-patients demands. Health care staffs including physicians and nurses need continuous training to develop customer care and cultural sensitivity for providing quality services and ensure patient satisfaction. Patients' voices should be heard in implementing health projects for ensuring quality health care both at the field level health centres and district hospitals. For protecting patients' consumer rights, GOB should take necessary steps to build up different patient forums that will work as watch dog of patients' interest. The environment of hospitals and community clinics should be made cleaner and healthier. It is recommended to initiate some consciousness raising programmes about health and hygiene promotion activities for prevention of diseases. The security system of the hospital should be increased so that different intermediate groups (dalals) cannot exploit patients emotionally or financially.

### **Hospital social services and patient welfare**

Hospital social services should be more strengthened for promoting welfare and empowerment of patient. Patient consultation should be made before formulating any progressive plan. Govt. should take steps to build up patient forum in every hospital area to promote patient consciousness on their rights and operate expert patient programme (EPP) for people with long term illness which not only reduce public health cost but also promote patient's functioning through self-care management. Hospital social services should be introduced in every Upazilla level hospital and trained qualified social workers should be recruited to operate better services for the poor and establishment of local patient forum.

### **Quality management and good governance**

From literature review and field experiences, it is evident that prevailing problems and changing health situation of the country require reform in health sector particularly in the areas of management structure and service delivery system. A well-coordinated monitoring and evaluation systems should be strengthened to bring service providing agencies more accountable to their service recipients. The delivery of medicine should be properly monitored and supervised so that corruption could be decreased. Health budget of the country remain extremely low and should be enhanced. Without increasing public spending quality health care would not be ensured for a growing number of poor patients. Therefore, it is recommended that health budget should be increased in line with other South Asian average e.g. at least 03 per cent of the country's total GDP.

### **Building public private partnership**

Government alone is not capable to ensure improved health care for all and it is perceived that expansion of private sector investment will help to bridge the gap in required resources and services. In the recent years the growth of private and not for profit i.e. NGO sector constitute an important share in health care system. Therefore, the Govt. should take necessary steps to promote public private partnership and increase NGO involvement in providing primary and community based health care services. Cooperation can be established between public and private hospitals in areas of availability of tangible services or amenities of care including the availability of drugs and various health care related projects. In addition, regulations should be strengthened to ensure quality, standard and accountability of both public and private and voluntary sectors in operating services.

## **REFERENCES**

- Aldana, J. M., Piechulek H, and Al- Sabir A. (2001) 'Client satisfaction and quality of health care in rural Bangladesh' *Bulletin of the World Health Organization*, 2007: 79.
- Andaleeb S. S., Siddiqui N. and Khandakar S. (2007) 'Patient satisfaction and quality of hospital services in Bangladesh, *Health Policy and Planning*, 22: 263.
- Ashrafun L. and Uddin M.J. (2011) 'Factors determining inpatient satisfaction with hospital care in Bangladesh', *Asian Social Science*, 7(6): 15-19.
- Atkin, K. and Chatto, S. (2006) 'Approaches to conducting qualitative research in ethnically diverse populations', in Nazroo, J. (ed) *Health and social research in multiethnic societies*, London: Routledge.
- Bangladesh Demographic and Health Survey Report (2004) Ministry of Planning, Planning Commission, Dhaka.
- Bangladesh Ministry of Planning (1998) cited in Andaleeb S. et al. (2007) 'Patient satisfaction and quality of Hospital services in Bangladesh, *Health Policy and Planning*, 22: 263- 273.

- Bryman, A. and Burgess, R. (1994) *Analysing Qualitative Data*, London: Routledge.
- Bulmer, C. (1998) 'Clinical decisions: defining meaning through focus groups', *Nursing Standard*, 12 (20), 34-6.
- Calnan et al., 1994; Epstein, Laine, Farber, Nelson and Davidoff, 1996, cited in Ashrafun L. and Uddin M. J. (2011) 'Factors determining inpatient satisfaction with hospital care in Bangladesh', *Asian Social Science*, 7(6): 15-19.
- CIET Canada and Ministry of Health and Family Welfare, Government of Bangladesh (2004) cited in Andaleeb S. et al. (2007) 'Patient satisfaction with health services in Bangladesh', *Health Policy and Planning*, 22: 263- 273.
- Dagger T., Sweeny J. C. (2006) 'The effects of service evaluation on behavioural intentions and quality of life', *Journal of Service Research*, 19: 33-48
- Denzin, N. K. and Lincoln, Y.S. (2003) *Handbook of Qualitative Research*, 2<sup>nd</sup> edition, Thousand Oaks, CA: Sage.
- General Economic Division (2005) *Bangladesh: Unlocking the Potential*, Planning Commission, Government of the People's Republic of Bangladesh.
- HEU (2003a) Public health services utilization study, Dhaka: Health Economics Unit, Ministry of Health and Family Welfare, Government of Bangladesh.
- Hossen, A and Westhues, A (2011) 'Improving access to government health care in rural Bangladesh: the voice of older adult women', *Health Care for Women International*, Routledge, 32(12): 1088-1110.
- International Monetary Fund (2013) Bangladesh: poverty reduction strategy paper, IMF Country Report N0. 13/63, Washington, D.C.
- Islam, M. Z. and Jabbar, M. A. (2008) 'Patients satisfaction of health care services provided at outpatient department of Dhaka Medical College Hospital', *Ibrahim Med. Coll. J.*, 2 (2): 55-57.
- Kirby (2002), Wilkinson and Marmot (1998) cited in Hossen, A and Westhues, A (2011) 'Improving access to government health care in rural Bangladesh: the voice of older adult women', *Health Care for Women International*, Routledge, 32(12): 1088-1110.
- Marshall C., Gretchen, B. and Rossman (1999) *Designing Qualitative Research* (3<sup>rd</sup> edition), London: Sage Publications.
- Miles M., Huberman A. (1994) *Qualitative data analysis: An expanded source book*, Thousand Oaks CA: Sage Publications.
- Ministry of Health and Family Welfare, 2003; cited in Andaleeb S. et al. (2007) 'Patient satisfaction with health services in Bangladesh', *Health Policy and Planning*, 22: 263- 273.
- Nyer P. (1999) Cathartic complaining as a means of reducing consumer dissatisfaction, *Journal of Consumer Satisfaction, Dissatisfaction and Complaining Behaviour*, 12: 15- 25.
- Oja Pl., Kouri TT, Pakarinen AJ (2006) cited in Andaleeb S. et al. (2007) 'Patient satisfaction with health services in Bangladesh', *Health Policy and Planning*, 22: 263.
- Rahman et al., (2002) cited in Aldana, J. M. et al. (2001) 'Client satisfaction and quality of health care in rural Bangladesh' *Bulletin of the World Health Organization*, 2007: 79.
- Rahman MS, Ashaduzzaman ASM and Rahman MM (2005) Poor people's access to health services in Bangladesh: focusing on the issues of inequality, Network of Asia- Pacific Schools and Institutes of Public Administration and Governance (NAPSIPAG), Annual Conference, Beijing.
- Richardo B, Hussmann K, Munoz R, and Zaman S. (2004) Comparative advantage of public and private providers in health care service in terms of cost, pricing, quality and accessibility, Dhaka: Health Economics Unit, Ministry of Health and Family Welfare, GOB.
- Sen and Acharya's study (1997) cited in Aldana, J. M. et al. (2001) 'Client satisfaction and quality of health care in rural Bangladesh' *Bulletin of the World Health Organization*, 2007: 79.
- Siddiqui A. M. A. H. (2003) *Health in Poverty Reduction Strategy: Bangladesh Perspective* (Report of the DORP: Searching Micro Situation) Development Organization of the Rural Poor, Dhaka
- Strauss L. and Corbin, J. (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*, Newbury Park: Sage.
- Thomas, D. (2003) A general inductive approach for qualitative data analysis (on line) Available from: <http://www.health.auckland.ac.nz/hrmas/resources/qualdatanalysis.html> [Accessed on 27-04-2008]
- WHO, 2006, UNDP, 2009 cited in International Monetary Fund (2013) Bangladesh: Poverty Reduction Strategy Paper, IMF Country Report N0. 13/ 63, Washington, D.C.

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