BARRIERS IN POOR PEOPLE'S ACCESS TO PUBLIC HEALTH FACILITIES IN BANGLADESH



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Prepared for

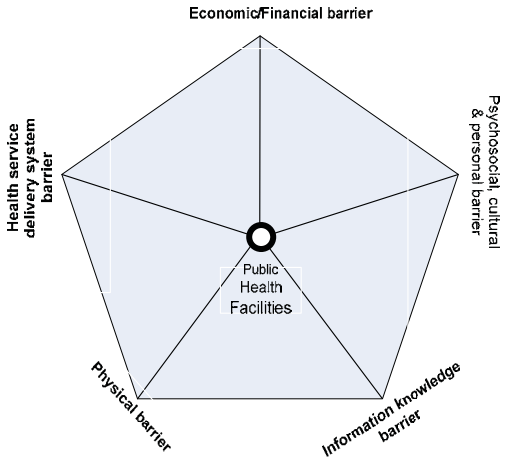
ActionAid Bangladesh

Dhaka: April 2006

EXECUTIVE SUMMARY

It is believed that poor people's access to public health facilities is constrained by many factors. Keeping this in view, the main objective of the study was to identify the diversified barriers of poor people which create impediments in accessing public health care services/systems of Bangladesh.

Barrier model to public health service facility



Five types of barriers are considered in the study. These are: a) physical barrier; b) economic or financial barrier; c) psychosocial barrier; d) information/ knowledge barrier; and e) health service delivery system barrier. Access to the public health facility will be perfect or ideal when all the barriers are removed. The bigger is the gap between centre point of health service and specific barrier, the farther is the access.

The study had two components: i) Quantitative; ii) Qualitative. As the main objective of the study was to identify barriers of poor people, poor households in each area were determined through deprivation ranking. The prime purpose of the deprivation ranking exercise was to identify the most deprived households in the rural community of Bangladesh.

The sample districts are Netrokona, Banderban, Kurigram, Narail, Maoulvibazar and Patuakhali for Dhaka, Chittagong, Rajshahi, Khulna, Sylhet, and Barisal divisions respectively. Total number of households in the survey was 226. Data on complaints (illness, sickness, disease, health conditions) of the respondents and their household members were collected, using close and open ended questions. All illnesses described in the survey were self reported. To identify the barriers, ill persons of the household who were needed to be taken to the public health facility but did not go were asked about the reason. In-depth interviews of any one (1) of the ill persons who went to the public health facility were taken to explore root chain of the barriers.

Key findings

- According to community people, being ill means inability to move, work and eat properly. High fever, severe cold and cough, diarrhea, tuberculosis, arthritis, tumour, measles, chicken pox, eczema, cancer, abdomen pain, etc are considered as disease to them. Most people do not consider the following as diseases for which they need to go to the public health facilities: fever, cold and cough, headache, jaundice, stomach upset.
- Mean days of suffering of 281 incidences are 103 days. Mean days of suffering of some diseases, like, asthma, tumour, diabetics, heart disease, eye and ear disease, peptic ulcer and TB are more than six months.

- Among household members who were ill and needed to be taken to the public health facility (during six months preceding the survey), 77% of them (23% did not) visited public health facilities.

- The reasons for not going to the public health facility are manifold. Of those, who did not visit public health facilities, about 87% reported that they did not seek care because of various problems associated with the public service delivery system itself. Different components of this variable are: 'no benefit is found without personal intimacy', 'doctor/female doctor is not available', 'doctor does not behave well', 'doctor does not give enough time', 'doctor does not give ear to', 'doctor unnecessarily prescribes different pathological tests', 'doctor unnecessarily asks for different pathological tests', 'doctor unnecessarily prescribes different diagnostic tests', 'doctor unnecessarily asks for different diagnostic tests', 'other staff do not behave well', 'free items have to get in exchange of money', 'drugs given there are not effective', 'drugs are not given there', etc. More than one-third mentioned that economic/financial issues such as, 'difficulty in going pending household chores', 'needs time which causes income loss', 'transport cost' compelled them not to go there. Because of physical/geographical reasons (for example, 'far distance', 'difficult roads'), 6% did not go to public health facilities. Some (4.6%) of the ill persons did not seek treatment for psychosocial, cultural and personal reasons such as, 'elders discourage to go there'. Very few (1.5%) reported cognitive reasons (for example, 'don't know whether asthma treatment is there', 'need signature as a bond to be treated in public health facility'). Similar pattern is found when different types of diseases are considered.

- Mean expenditure of OPD patients within government health facility was Tk 12. Tips consist of one-fifth of mean expenditure for the urban patients. Outpatients in the public health facility receive Tk 128 worth subsidy services. Mean expenditure in the private health facility was Tk. 317, of which 86% was spent on drugs.

- In government health facility, mean expenditure for IPD patients is about Tk. 36, more than one-third of incurred expenses consist of tips. Inpatients in the public health facility receive Tk 438 worth subsidy services.

- Overall, mean expenditure of IPD patients in private health facility was Tk. 690, of which 92% consists of drugs. Expenses incurred in the private health set up are nearly 20 times higher than what they spent in the public health facility.

- The reasons for doing prescribed test or buying drugs from outside the public health are: doctor's suggestion to purchase drugs from outside as non-availability in a specific health facility (71%). Other reported causes are: health facility does not do pathology/diagnostic test or provide drugs, quality of report is not good in the public health facility.

- Some of the services, although prescribed, could not be done by the patients. Overall, mean value of undone services for OPD and IPD patients are Tk. 238 and Tk. 98 respectively. The reason for such behaviour as mentioned by the respondents is lack of money.

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- Total mean necessary expenditure (adding up expenditure in public and private set up and value of undone services) is Tk 238, of which, only 2% was spent on public health facility, 57% in private health set up and the rest (41%) could not be done although prescribed by the medical doctor. For inpatients, total mean necessary expenditure was Tk 3310, the share of the public health facility was only 4%. Private health set up consists of 84% and the rest (12%) goes to value of undone services.

- There is 98% and 96% gap to get access of outpatient and inpatient services from the public health facility for the poor people.

Recommendations

- Poor can not effectively participate in health service management and monitoring. They are not able to ensure access and quality of health services. The concerned authority should keep an eye to establish effective 'health watch groups' in the local level.

- Low quality of services as well as official and unofficial charging act as disincentives to the poor to use public health services. Improving provider attitude together with quality management is required in order to build responsive, client focused services.

- Poor households become poorer when they have to meet up catastrophic health expenditure like for heart disease, injuries and accident, and surgery. The HNPSP is believed to increase the provision of services for emergency obstetric care and traumatic injuries, but it is not effectively found out. Health financing strategies should be designed to protect against catastrophic illness costs for the poor and protection against its impoverishing impacts.

- Poor will be benefited if resources in the health sector would be shifted to the districts with poor health outcomes and health needs.

- Consistent complaints of poor people regarding attitude and reluctant behaviour of medical and non-medical staff in the public health facility call for effective step in improving efficiency. Usually staff hardly prefer to work in poorer and more remote areas. Strong incentive along with greater managerial control need to be instituted to ensure service delivery.

- Drugs consists major portion of total expenditure of an illness episode even a significant amount of undone service is drugs. This calls for effectiveness of existing Essential Drugs Policy. Strategies can be designed to improve the Policy such as, making drugs economically affordable to poor people, effective regulation on dispensing practices in pharmacies, rationalization of prescribing practices of doctors. This is more so due to potential rise of prices of life saving drugs associated with the patent rule under WTO.

- This study gives overall picture (with disease specific) of access barrier of poor in the public health facility. There is also a scope to identify the gap between need and access in 'diseases of the poor' and non-communicable diseases, for example, tuberculosis, arsenicosis, asthma, cardiovascular disease, diabetics. Research can be done to understand the factors that constrain health systems from meeting quality maternal health care to the poor.

- Information about providers' perspectives on quality of care is limited. An attempt can be taken to identify the potential barriers from the health service provider to deliver quality of care to the poor people.