Seminar Paper
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Submitted by

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Challenges of Ensuring Medical Facilities to Rural Poor People: A Case Study on Boalia Union of Chapainawabganj District

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Keywords: *Rural Poor Patients With Chronic Disease (RPPCD), Money Crisis for Treatment(MCT), Government Regulated Health Insurance(GRHI), Treatment Aid Bank (TAB), Union Health Multipurpose Complex(UHMC), Online Database of Poor People (ODPP),*

ABSTRACT

Health is an important basic need of every human being. But healthcare facilities in the rural area are still not sufficient. The poor rural people always struggle for their livelihood and clothing. When such a poor person suffers from morbid diseases, he and his family's sufferings know no bound. Health is an important basic need of every human being and the state for the sake of its socio-economic development, has to take steps to standardize its healthcare system. It is one of the prerequisites of becoming a welfare state. Though gradually improving, still, it is not satisfactory. This research paper tries to go into the depth of the sufferings of those people and to find out how these crises affect the socio-economic conditions of the country. Through the questionnaire, interview, and observation it is attempted to depict the picture of those rural poor family of which, one or another member is affected by the morbid diseases, how they try to collect money for treatment, what are the difficulties they face in receiving a loan, what are the procedural hazards to get help from the Social Welfare Department of the government and how the condition of the family is being deteriorated. It is also attempting to find out a way of solving the crisis through the limited asset of the government. The suggestions include personal or group health insurance, provision of granting loan with zero or minimum interest and taking improvised healthcare systems to union level.

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1. INTRODUCTION

1.1 Background

Healthcare is a basic need of every human being and it is health that determines the overall activities of man. The overall health condition of the citizens of a country has a great impact on the socio-economic, cultural, and political field of a country. Like almost all the countries all over the world, medical care is considered to be a fundamental right of every citizen of Bangladesh according to article 15(A) and 18 of the Constitution of the People's Republic of Bangladesh. It is a fundamental responsibility of the government as well as the state to ensure medical care for all citizens and to ensure nutrition and improvement of public health as its primary duties. Article 16 of the Bangladesh Constitution also says that the state shall adopt effective measures to improve rural areas and to improve public health. One of the 17 goals of sustainable development is to ensure the good health of all citizens. Becoming a healthy nation can only ensure sustainable development.

According to the National Health Policy, 2011, health is not merely the absence of disease or infirmity. Rather health is a state of complete physical, mental, and social well-being. It is also stated that every citizen has a basic right to adequate healthcare and the state and the government are constitutionally obliged to ensure healthcare for its citizens. The government is trying its best to address the demand for medical care of the people and to a great extent, the government is successful in this field. The present government has established a community clinic at the ward level, and Union Health and Family Welfare Center (UHFWC) at the union level which provides mainly Primary Health Care (PHC) services including maternal and child health services, family planning services, EPI, Behavioral change communications and limited curative care. At the union level, a health sub-center has also been established where FWVA and SACMO (Sub Assistant Community Medical Officer) have been working. Besides these the government is taking 'My village- my town' program to transform villages into towns that means all the facilities of towns will be provided in villages which will also include healthcare. Nowadays the dimension of human disease has undergone a great change. Chronic diseases that were very rare among rural working people have become common at present days in villages such as diabetes, kidney disease, joint pain, high blood pressure, stroke, eye disease, cancer, etc. There is no adequate treatment of these diseases in rural areas. Even at the Upazila level, scopes of treatment are very limited. To get

minimum to moderate facilities, people have to go to Medical College Hospital which is situated at the division level. Now the government is taking steps to establish medical colleges in districts. But the new medical colleges cannot ensure standard treatment facilities due to lack of professors (doctors), nurses, technicians, supporting staff, equipment, and other facilities. In this context, patients and attendants have to go to divisional towns, the capital city Dhaka and sometimes to a foreign country. And while doing this, village people suffer mentally, physically, and economically a lot and thus the government efforts are considered to be unsuccessful. Health service is mostly dependent on government sectors and though the private sector and NGOs have also a great role, these two sectors are also regulated by the government sectors. And ultimately any defamation or failure goes to the government. To address new chronic diseases and provide service to a greater number of patients, Government, NGOs, and private sectors are trying hard but most of the medical facilities have been provided in rural areas especially in big cities which most of the rural working people and peasants cannot afford. Under these circumstances it is very important to provide healthcare facilities to the rural poor people at their affordable cost.

1.2 Objectives of the Study

The main objective of the study is to assess the sufferings of the village people with chronic disease in the context of rural economic condition,that is, what difficulties they face in collecting money, grant in aid or loan . It also aims to find out the hazards they face when they seek medical care and how this problem is affecting the socio-economic development of the country. It also aims to identify other challenges in ensuring medical facilities to the village poor people and how to overcome the problem.

1.3 Justification of the Study

While choosing this subject matter, I have taken into consideration how this study will contribute to authorities and other beneficiary groups. Earlier many research works have been conducted related to rural healthcare, that is, 'Rural Healthcare System', " Rural Public Health Situation", 'Comprehensive Healthcare', 'Community Clinic', 'Union Health and Family Welfare Center (UHFWC)', 'Maternal and Child Health Services', 'Family Planning Program' etc. Almost all these researchers were objective and focused on the overall health and nutrition of the country. But no research has yet been carried out on this subject matter,

that is, what are the hazards village poor people with chronic diseases have to undergo in healthcare institutions ,what are the difficulties in collecting treatment money, what the socio-economic losses the state has to carry due to the shortcomings of treatment and which measures should be taken by the state to minimize the sufferings of people and the loss of the state.

If it is possible to carry out the research successfully and to offer some recommendations to address the problem then the Bangladesh Government, as well as the Ministry of Health and Family Welfare, Ministry of Finance, Directorate General of Healthcare Service, will be able to know ins and outs of the said matters. It will help concerned authorities to adopt the necessary policy and take effective measures to eradicate these problems and thus ultimately the rural poor people will be benefitted. This may bring a great change in the rural health care system.

Besides, the Government is adopting 'My Village-My Town' program to ensure urban facilities in villages which will also include Healthcare facilities .This study will help the government to formulate plans and fix strategies to materialize 'My Village-My Town' program.

1.4 Scope Of The Study:

The research area of this study is Boalia union of Chapainawabganj districts which contains 27 villages in which 34240 people reside. Total population of Boalia union is considered in this study.

Seven morbid diseases have been included in this research, that is,

(1) Heart disease, (2) Neurological disease/Stroke, (3) Diabetes, (4) Orthopedic disease/Joint pain (5) Eye disease including cataract and glaucoma, (6) Kidney disease. (7) Cancer.

The poor patient who suffered from 01 January 2019 to 31 August 2020 that is, 20 months has been taken as the study time.

Though the subject matter of this study is confined with the people inside the Union area, the health authority of the Upazila level, district level, division level, and all over the country have been included in the discussion because the patients affected by chronic disease have to receive treatment at various places of the country. Ministry of Health and Family Welfare and Directorate General of Healthcare Service, Ministry of Finance, and after all the whole Government controls the healthcare system, so those institutions have also been included in

the discussion. The people suffering from those seven diseases are the main subject matter of this study. The main focus of the research is how do the rural poor patients with chronic disease collect money to receive treatment, to what extent the patient and his relatives suffer in receiving treatment, what are the limitations of our healthcare system, and what can the State or the Government do to help these rural poor people. I have adopted an interview and questionnaire method because it is easier to find samples since there are huge patients in rural areas. Patients and relatives are very much interested to express their bitter experiences. Another thing is that village poor people are not too busy to avoid interviewers and they think if they enlist their name anywhere, they may get help from the government.

1.5 Limitations Of The Study:

It is very much difficult to find out the actual economic condition of village people. Sometimes people don't want to disclose their economic status, such as, how much acre of land they have, what is the actual monthly income of the family. Because they think that if they disclose everything, they will not get the Government help of the Social Safety Net Program. In some cases, patients don't want to disclose their health condition, especially people with infectious disease. Diabetic patients are also unwilling to disclose information. In many cases, the symptoms of diseases are revealed to some extent but the patient does not care or he thinks that it will be cured. Sometimes a patient dies being the disease uninvestigated. Regarding profession, it is very difficult to find out how many people are involved in various professions simultaneously. Moreover, people are unconscious and so they don't understand what their right is and what their illegal demands are. They don't want to understand the limitations of health care institutions. So during giving their opinion, they think something as their right what is their illegal demand.

Illness is a continuous process. In course of time, people are getting older and at any time a person may get sick. But especially at old age, a person becomes more vulnerable to disease. As a result of some diseases, he dies. So to make the study successful, I have selected 20 months from 01 January 2019 to 31 August 2020 as considered time.

2. LITERATURE REVIEW

Bangladesh's health sector has undergone a notable improvement in the last few years but still, we have many things to be done. With the increase in population,the dimension of human disease has undergone a great change. Chronic diseases that were very rare among rural working people now have become common nowadays such as diabetes, kidney disease, joint pain, high blood pressure, stroke, eye disease, cancer. There are no adequate treatment facilities for these diseases in rural areas. Even at the Upazila level, scopes of treatment are very limited.

Most of the research work carried out regarding Bangladesh rural healthcare deal with Rural Healthcare System, Rural Public Health Situation,Comprehensive Healthcare,Community Clinic,Union Health and Family Welfare Center (UHFWC), Maternal and Child Health Services, Family Planning Program, Success of EPI. A few works, books, articles are being presented here:

Shakeel Ahmed IbneMahmood in his article, ***Health system in Bangladesh (2012)*** in the book ***Health System and Policy Research (vol. 1, issue 1)***, describes the main challenge of providing healthcare delivery and Bangladesh and tried to find out the limitations of the health sector in Bangladesh. He also put his observation that governance, training, and monitoring allowing more governmental involvement and the needs of the informal health care service providers is necessary for ensuring healthcare delivery. These observations will certainly play a great role in improving health service in Bangladesh but in this paper, he did not find out how village people suffer from chronic diseases and how government can minimize the sufferings of them. Moreover from 2012 till 2020, a great change has taken place in the medical sector and due to the change of dimension of diseases, it is important to carry out new research in this field.

Sameh El-Saharty, Michael M. Engelgau, KararZunaid Ahsan, Tarcey L. P. Koehlmoos in their book *Tackling Non Communicable diseases*, focus on the management of non-communicable diseases that are increasing after the increasing life expectancy and declining fertility rate. They analyzed the factors causing NCD. The health care system in Bangladesh, its limitations, the impact of NCD on socio-economic conditions strategic planning and co-ordinations, weak regulatory framework, lack of alignment between the goals of health strategy and documents and operational plans, suggestion to development and implement

effective and timely responses that reduce population-level risk factors and NCD burden in Bangladesh suggested to form policy framework to address the threat. NCD capacity assessment, NCD risk factor, NCD policy, health suggestions, public health. This book is a rich document that will help the government and its organs to rethink of improving the health sector. But as it has been aimed here the economical and mental sufferings of the rural affected by chronic diseases of a remote particular are not presented here.

Khaleda Nazneen in her ***Governance of Healthcare Sector in Bangladesh***, August 2001, CPD, examines the existing healthcare delivery system in Bangladesh and it focuses on the importance of preventive outcome care for the population of especially Bangladesh. She emphasizes outpatient care in public hospitals which will reduce any risk factors and public sufferings and reduce the workforce wastage of the country and save resources of the nation. But this book uses data collected from two hospitals Dhaka Medical College and BSSMMUH. They did not collect data from any UHFP Complex or remote district hospitals or they did not collect information for rural sufferers.

A Vision for the Twenty-first Century (1999) is a wonderful research book by Henry B Perry (author), published by The University Press Limited (UPL), The World Bank.
In this book, the author has presented the situation of health, population, and family planning program of Bangladesh. The book also analyzes the primary health care services. It also examines the major initiatives in health, population, and nutrition. In this book, the author admits that Bangladesh is improving its Primary Healthcare services, family planning, and population control programs but due to some faults in the management system the speed of improvement is not optimum and sustainable. The author puts some recommendations to overcome the obstacle of the health sector.

Similarly in the book- *Healthy Village: A guide for Community and Community Health Worker* Guy Howard describes the healthy village approach for improving the health of the rural communities. The purpose of this guide is to provide a model of the type of information and approaches for promoting healthier villages. In this book, topic such as water and sanitation, drainage, wastewater management, housing quality, domestic and community hygiene and provision of health services, providing extensive source material for adaptation to local needs and conditions are depicted for sustaining healthy village. Though this study is

similar to the health care system through Community Clinic in Bangladesh. But the context of this study is clearly different from the present study.

Taufique Joarder, in his article ***Universal Health Coverage in Bangladesh: Activities,***

Challenges and Suggestion

Narrates the healthcare system of Bangladesh, shortcomings and puts some observation and recommendations regarding healthcare of the people of Bangladesh.

Aasha Mehreen Amin, in the article ***Getting Health to Rural Communities in Bangladesh*** **published in the** Bulletin of the World Health Organization, 2008, depicts the picture of healthcare system in rural Bangladesh.

But my study is new and quite different with these research works mentioned above. My study deals with the particular rural poor people with seven chronic diseases. It emphasizes on the hazards village poor people with chronic diseases have to undergo in healthcare institutions, their difficulties in collecting treatment money, the socio-economic losses the state has to carry due to the shortcomings of treatment and which measures should be taken by the state to minimize the sufferings of people and the loss of the state.

3. METHODOLOGY

3.1 The Study Area:

My study area is the total Boaila union territory. Boalia Union is inGomastapurUpazila under Chapainawabganj District. It is situated 35 kilometers north of Chapainawabganj district town nd 5 kilometers western side of Rohanpur,the Upazila headquarter.GomastapurUpazila is located in between 24◦ 44' and 24◦ 58' north latitudes and in between 88◦ 13' and 88◦ 58' east longitude. The basic information of Boalia union is given below

Serial No.	Description	Quantity	Remarks
1	Total Village	27	
2	Total ward	9	
3	Total population	34240	
4	Total Voter	19449	
5	Total Family	8890	
6	Population Per Family	3.85	

It is notable that household stands for Family.

If one wants to go to divisional town Rajshahi by road he has to travel 5 km east, then 33km south, then 50 km east. To go to Rajshahi by train, you needn't go via District town, rather straight from Rohanpur to Rajshahi there are various trains by which you can go to Rajshahi via Amnura rail junction. Before forming district administration at Chapainawabganj in1984, GomastapurUpazila as well as the whole Chapainawabganj district was under the Rajshahidistrict. From the British period, the people of Boalia, as well as Rohanpur, feel comfortablegoing to Rajshahi for treatment, education, or for other purposes.

At a glance some information of Boalia Union is presented in the table below:

3.2 Method

I have adopted both qualitative and quantitative methods for this study, but qualitative elements are more prioritized than quantitative elements. To carry out this study, data were collected from both primary and secondary data sources. Data was collected from 01 June 2020 to 01 October2020. Primary data was collected from various villages of the study area, sitting in tea-stalls, Union Council Office, community clinic offices, and the residences of the sample group. To collect data from primary sources, the questionnaire method, interview method, and observation method, Group Discussion method has been adopted. For the questionnaire method, several question forms were prepared and it was supplied to the sample group. The question pattern was prepared based on research objectives. All the aspects of the question paper have been explained to the common sample groups. After they had filled it up it was collected. Another technique was interviewing individuals. For the interview, some parameters related to the subject matter were set and with the course of the interview, other related questions were asked to collect more information. The questionnaire, interview methods were considered suitable because the sufferers are interested to express their feelings and to disclose the facts. The observation method was effective in this study because receiving healthcare is a long time process and it was not difficult to observe everything and to gather experience as patients and attendants were interested to disclose everything. Group discussion approach also helped to understand the crises and find out the solutions. Secondary data was collected from books, research works, articles, reports, essays, journals, newspapers, television, different websites, online news portals, etc.

3.3 Sample Group

The sample was selected on a random basis and it was selected from all the regions of the research area and all sorts of people young and old, educated and low educated, patients and attendants, etc. The sample group was included in the following people:

a) Patients with chronic disease
b) Relatives of the patients
c) Family Members or attendants of the patients
d) Village doctors
e) Public representatives
f) Medicine sellers (As they are not qualified pharmacists)
g) Social Welfare Officer
h) Doctors of Upazila Health Complex

3.4 Data Analysis

After collecting data from both primary and secondary sources, all data were processed, analyzed, and explained. Data were included- interviews, table of information, related news, media reporting, patient visit, observing the hospitals and clinics, written and verbal applications of the patients seeking financial help, etc. In some cases, MS Excel is used and calculator are used frequently

Information on the tables was explained, other data were analyzed and explained. Interviews were reviewed.

By these analyses, explanations, investigations, and overviews, the sufferings of the poor patients with morbid diseases were found out and how the society and the state are losing workforce were investigated and solutions were presented. The whole analysis process was descriptive and qualitative.

4. RESULT AND DISCUSSION:

4.1 Socio-Economic Scenario Of the Study Area

4.1.1 Economic Condition of Rural People:

In comparison with other parts of the country, the economic condition of the Boalia union is not bad. The present economic condition of this union is much better than that of 15 years back. The standard of living has increased from the first decade of the twenty-first century. But this does not mean that all the people have enough capability to spend on the sudden disease.

Now people have money to have the necessary food and clothing. A village doctor Mr. Md. Obaidullah Dulal pointed to some shops and told that nowadays you see the fruits hanging in the case for sale and people are buying them every day. But only 20 years back there was no provision of selling or buying fruits like orange, apple, pomegranate, guava, other than a banana in this market. 20 years back there was not a single poultry shop or butcher shop in the bazaar but at present, there are several butchers shop and poultry shops in this bazaar (Boalia Council Bazar). This indicates that the purchasing capacity of the general people has been raised. But this does not mean that all the people have the same capability. Still, now 70% of people of the Boalia union do not have any savings. So when they fall sick they have to collect loans from NGOs or individuals or they have to sell assets like cattle, ornaments, or even their small piece of land. Till now 50% of people live from hand to mouth.

When any member of the above family is affected by any disease, the whole family becomes helpless. They cannot sit idle or without any effort. To arrange treatment on the other hand they cannot manage money.

4.1.2 Profession of Household Heads

The number of total households is8560 and each household contains 4 members on average.

Sr. No	Description of Household	No. of Households	%
1	Agro-based households (Land Owner)		58%
2	Agro-based households (Landless)		25%
3	Service holder's Having Income Less than 16000/-		9%
4	Service holder's Having Income More than 16000/-		5%
5	Business based households (Monthly Income Less than 20000/-)		14%
6	Business based households (Monthly Income More than 20000/-)		2%

7	Agro family having 0.5 – 9 Bigha land		50%
8	Agro family having 5 – 9 Bigha Land		10%
9	Agro family having 10 – 19 Bigha Land		5%
10	Agro family having 20 – 99 Bigha Land		6%
11	Agro Labour Family (Also involved in other works)		25%
12	Labour other than agro (Also involved in other works)		20%
13	Maid Labour		2%
14	Workless family (having no worker)		2%
15	Others		20%

This table clearly indicates that most of the people or households are dependant on agricultural activities either through owning land or working on other landowners land. It is the most common occupation in the union. The second most common occupation is business. But small business owners are the majority. It is important to notice that most of the land owners have a very small portion of land. It is notable that many household heads or other members are involved in multiple profession simultaneously.

Number of Households in Respect of Income

Gross Monthly Income	Number of Households	Percentage	Remarks
Below 5000		15%	
5000 – 9000		45%	
10000 – 19000		30%	
20000 – 29000		4%	
30000 – 99000		6%	

This table is pretty self explanatory. Almost half of the population's earning range is between 5000 to 9000 taka per month. 30% of the people earn 10000-19000 taka. So when this portion of people seek treatment, they are quite helpless in collecting treatment fund.

4.1.3 Health Institutions in Boalia Union

Serial No.	Description	Number	Remarks
1	Total Community Clinic	3	
2	Total Sub Center	1	
3	Total Health and FWC	1	
4	Total pharmacy	35	
5	Private Clinic	1	
6	Charity HealthCare Center	1	MKMS Manobik Sebakendro
7	LMAF/ Polli Chikitshok	51	
8	Diploma in Medical Faculty	5	

4.1.4 Places/ Institutes Where Village people Receive Treatment

When a poor person in a rural area gets affected by a small disease, he hardly cares about it until or unless he feels severe pain or his normal movement is hampered. Though nowadays some conscious and rich people rush to town when they notice unusual symptoms in their bodies, the number is very low. When a rural poor person feels pain or get physically troubled, he goes to the nearest medicine shop or a village doctor, and if it is nearby, then he goes to the Community Clinic (CC), Health Sub-Center (HSC), or Union Health and Family Welfare Centre (UHFWC), takes a few tablets or syrups. Then when he gets a bit relief, he stops it. Again when he feels troubled, he goes to the same place, and thus when the condition gets worsened, the village doctors or medicine sellers advise him to go to Upazila, district, or divisional towns. Then anyone or another places/institutions they choose to receive healthcare.

a) Community Clinic/Union Sub Center
b) Medicine seller/Village Doctor
c) Homeo, Ayurvedic or Unani Medicines
d) Upazila Health Complex
e) District Sadar Hospital
f) Medical College Hospital/Divisional Hospital
g) Private Clinic/Diagnostic Centers
h) Hospitals/Clinics/Specialized Hospitals in the capital.
i) Abroad

4.2 FINDINGS

4.2.1. Huge Sufferings Of Rural Poor Patients With Morbid Disease:

The people of the Boalia Union area who were affected by or suffered from the 7 morbid diseases mentioned below from January 2019 to 31 August 2020 were taken in this study.

Serial No.	Name of Disease	No. of Patients	Died during the aforesaid period	Become incapable of work during the aforesaid period
1	Heart Disease/Heart Attack	266	75	150
2	Stroke or Neurological disease	210	80	110
3	Joint Pain/Orthopedic Disease	1140	20	750
4	Chronic Diabetes	380	85	250
5	Kidney Disease	228	38	160
6	Eye Disease Including Cataract And Glaucoma	750	0	610
7	Cancer	180	20	130

Out of the population 9.20% have suffered or have been suffering from 7 morbid disease and 7.24% people dies or becomes incapable within the considered period. But the death rate is the highest by stroke, heart attack or diabetic related complexities.

4.2.2 Monetary Crisis of Rural Poor Patients' Treatment.

To investigate the depth of sorrow of rural people with the disease, the interview was taken from 20 persons with the poor financial status of the Boalia Union who took treatment for their illness. For improved accuracy, only one patient from one house was selected.A survey in the Boalia union shows that about 90 percent of rural areas cannot spend for the treatment of chronic disease. Especially the people of the remote village who have a little scope of a business, who are dependent mainly on agriculture are more vulnerable. Landless farmers,day laborers, small businessmen, ferry mala can only afford some food and clothing and they do not have the economic capability to spend additional money for treatment.

The patient has not only to think about how he will collect the money for treatment, but also to think about how to provide food for his/her children and other spouses. In case, the patient is the only earning member of the family, the family has nothing to do but beg. The tender children leave school and join as novice workers at a very low wage. The female members of

the family are bound to work as a housemaid in others' homes which the husband or children never thought of. The wage is only some food or three to five hundred take.

The total patient of Kashiabari village who received treatment at various places and various hospitals during the said period is 20. The helpless poor patients and relatives collect money from the following sources:

Serial No.	Description	No. of Patients	Percentage
1	Deposited money, bank/hand	2	10%
2	Loan from the bank or NGOs	11	55%
3	Loans collected from relatives	8	40%
4	Loans collected from Usurers	4	20%
5	Land sale	2	10%
6	Ornament, Cattle, or Crop sale	10	50%
7	Collective donations	5	25%
8	Others	4	20%

The table shows that the majority of the people are getting a loan from local NGOs and relatives and they are also forced to sell their cattle, crop or family ornaments.

4.2.3 Absence of Government Regulated Health Insurance:

Health insurance can play a great role to arrange treatment of poor people with chronic diseases. Every citizen should have been brought under the health insurance scheme. But in Bangladesh, there is no provision of health insurance. That is why rural poor people suffer a lot.

4.2.4 Low Scope Of Government Grant or Help for

The government has taken steps to help the poor people affected by chronic diseases. The help is given by social welfare departments. A person with chronic disease gets 20 to 50 thousand takas at a time. But the process of getting this grant is very difficult and sometimes proper vulnerable people do not get help. All the poor chronic patients could not be incorporated in this program.

4.2.5 Problem of Collecting Loan

In Boalia Union, 18 NGOs are working with microcredit activities, of which 13 are internal and 5 are external. Five external NGOs are 1.BRAC 2.ASA 3.GrameenBank 4. BYES 5.

Pospopolli. So far information can be collected, no schedule bank gives a loan to any person for treatment. Even no NGO gives loans for treatment purposes, but it is very essential to have a provision of sanctioning loans to the rural poor patients, even without any mortgage or guarantee. Because the Government has to think that rural people start working at the early stage of life and their contribution to the economy is not negligible. if a person at forty years of age becomes affected by chronic disease. And if he becomes obsolete or dies at this age his family becomes helpless. Not only his family, but the state also becomes deprived of the workforce of a man. The man becomes the burden of the country and has to spend a lot of money on treatment so the Government creates a fund to provide loans for the poor people affected by chronic

disease. Even Treatment Aid Bank(TAB) can be founded for this purpose where the interest rate should be 0% or near this . Loan sanctioning procedure should be easy. A guideline should be prepared to allot and refund the money. Moreover a list of people with grading like P3-(P three Minus), P2-, P1- according to the gravity of poverty. This will be online and hard copy must be preserved at Union Health Information and Statistic Centre (UHISC). Steps should be taken so that no nepotism, anomaly or corruption can take place

4.2.6 Loss of Workforce and Influence in Economy

A survey on Boalia union showed that, among 34240 people, 3154 are affected by seven morbid diseases. Among them 2250 persons are incapable of spending money for treatment. These 2250 people somehow earn their livelihood but they do not have savings to spend in crisis moments. Among them, 1530 persons deceased or became incapable of working due to lack of proper treatment. These incapable persons would have worked 20 more years. If they would work worth taka 500 per day, an estimated loss of economy is shown below: It is noted that normally a person cannot work more than 22 days a month, and 20 indicates the total study time.

Total loss = IDP x 500 x 22 x 20(IDP= Incapable or Deceased persons)

= 1530 x 500 x 22 x 20

= 366000 /-

This includes only 7 diseases and excludes many other diseases and this is for one union .

If the government uses this amount of money per union as a loan or grant for poor patients, the government will not have to bear any loss.

4.2.7 Low Allocation in Health Sector especially Rural Area:

A global report on economic support of the health sector has been published in 2019 by WHO and World Bank collectively which tells that the southeast Asian countries spend the lowest for the health service of its citizens. In these countries people spend 46% ofthe money on their own while in Bangladesh, citizens spend more than 70% and the government bears 30%.

According to WHO, per person expenditure is given in the following table[2]:

Serial No.	Country	Per head expense (USD)
1	Sri Lanka	369
2	Maldives	2000
3	Pakistan	129
4	India	267
5	USA	9416
6	Bangladesh	88

This table is showing that the per capita expenditure (USD) is the least in Bangladesh, having only 88 USD. This is very poor compared to other countries in the table.

4.2.8 Lack of Supervision in Healthcare Machinery.

The government is trying to improve the health care system but the supervision system is not satisfactory. In many cases, doctors are absent for a long time. Sometimes he goes to the office once a month and the rest of the time he is busy with a private practice in the town. If there is strong supervision, this cannot happen. The government is supplying medicine free of cost but the poor patient does not get it. In some cases, it is observed that the government has supplied investigation machines and other instruments but it remains unused for a long time and sometimes the machines couldn't be installed or if installed, due to lack of technicians, it could not be operated. Chairperson of BRAC Hossain Zillur Rahman says, ''health sector needs reforms, eradication of misuse of money and improve management''[3]

4.2.9 Shortage of Hospital, Bed:

A total of 536 public hospitals with 37,387 beds provide inpatient care services in Bangladesh for a population of 160 million. There are 413 Upazila (sub-district) Health Complexes which have limited inpatient care services. Most UHCs have been turned into 50

[2]The Daily Prothomalo 16.5.2020, Jahangir Shah

[3] The daily ProthomAlo 16.5.2020

beds to provide health care to rural people. But infrastructure has not yet been developed fully. District hospitals are usually 100 to 200 bedded but these hospitals are also suffering from a shortage of specialist doctors, nurses, equipment, and infrastructure. The medical college hospitals are located in the regional urban hubs covering several districts and provide specialty care in a wide range of disciplines. These Hospitals provide tertiary care services. However, these hospitals have limited specialist doctors, diagnostic and laboratory services. To provide health care smoothly the following manpower and bed are needed both in rural and urban areas[4]:

Serial No.	Name of Post/ Facility	Required number per 10,000 people	Existing Numbers
1	Doctor	10	6
2	Nurse/midwives	30	10
3	Technician	10	3
4	Paramedics/Ward Boy	15	7
5	Bed	30	8.7

According to the World Bank, in Bangladesh per 10,000 people, there are only 8 beds. The comparative information of Bangladesh and other countries are given below[5]:

Serial No.	**Country**	**Bed per 10000 people**
1	USA	29
3	Japan	135
4	South Korea	122.7
5	China	42
6	UK	25.4
7	Bangladesh	8.7
8	India	5.3
9	Bhutan	17 (2012)

From the above table it is clear that Bangladesh has very low number of hospital beds in comparison to other countries.

4.2.10 Shortage of Doctors:

[4]1. ProthomAlo 16.5 2020 2. interview of Sumeet Aggarwal, MD, Midmark India [22.2.2018] 3. Prof DrAbulHasnat Milton, The Daily Jugantor 11.12.2019

[5]1. Wikipedia: Templates Hospitals Beds by Country; 2. The daily prothomalo 16.5.2020

The international unit of manpower in the health sector is 10000 people. According to the World Health Organization for every 1000 people, a doctor is needed. At present in Bangladesh, for 2500 people, there is only one doctor. In proportion to the population in Bangladesh at least 150000 doctors are needed. At present in Government and non-government level, about 70000 doctors are working.[6]

Keeping pace with the huge population, the number of doctors is very less at Union and Upazila level. To provide proper healthcare to the rural poor people which is also the goal of the government, a sufficient number of doctors should be posted at Union and Upazila level. The government is trying to send doctors at Upazila and Union level but somehow doctors can manage to be transferred or to be posted in big towns with deputation.

Health workers are concentrated in urban secondary and tertiary hospitals, although 70% of the population lives in rural areas[7].

Doctors available per 10000 people in various countries of the world are given bellow[8]:

Serial No.	Country	Doc per 10000 people
1	USA	51 [2017]
2	UK	28 [2018]
3	China	20 [2017]
4	Italy	40 [2018]
5	India	9 [2018]
6	Japan	24 2016
7	Bangladesh	6 [2018]
8	Nepal	7 [2018]
9	Pakistan	10 [2018]
10	Sri Lanka	10 [2018]

Compared to developed and developing countries, Bangladesh

4.2.11 Grievance Redress Authority at Upazila and Division Level:

An Authority is necessary at Upazila and Division level so that patients and their attendants can lodge complaints against doctors or other employees or authority

[6] DrAbulHasnat Milton, The Daily Jugantor 11-12-2019

[7] Country Case study (GHWA, 2008)

[8] 1. The daily prothom alo 16.5.2020 2. World H O Global Health Workforce Statistics,OECD 2018 , 3. World Bank data 2018 [Visited by me on 27-5-2020 7.00 pm]

4.2.12 Lack of Medical University with a multi-dimensional research facility A university is an institution that offers undergraduate and graduate degrees. Universities offer graduate programs leading to a master's degree or a Ph.D. Generally, universities have a more diverse offering of classes and programs than a college because of the larger number of enrolled students. In medical universities, there's a wider range of s copes to conduct research work than a medical college. A medical college is an institution that is under a university and generally offers bachelor's degrees, and some colleges also have associate degrees. If a medical University is established in every divisional city, then this university will be able to control all the medical colleges in that division. Now medical colleges are under public universities or BSMMU. The Government has already decided to establish a few universities, the process of establishing should be as early as possible.

4.2.13 Shortage of Specialized Hospital:

Establishing a specialized hospital in every divisional town is a must to improve the healthcare system in Bangladesh. At every division, a specialized hospital is necessary to be established such as a Cancer Hospital, a Neuroscience hospital, a Cardiology hospital, an Eye hospital, an Orthopedic hospital, a Kidney hospital, a Child hospital then the efficiency of the general hospital will be accelerated on the one hand, and on the other hand, the chronic patients of several diseases above mentioned will be highly benefited.

4.2.14 Establishing Effective Methods to cleanse Hospitals:

In Bangladesh, it is believed by people that the cleaner must cleanse toilets and other places of the hospital and people pretend to be unconscious so that the users must keep the environment clean. With this idea of people, it is not possible to keep everything clean, rather punishment should be imposed on people who are responsible for making the environment dirty. Ignorance of the law is not an excuse. So first of all we must make people conscious, by all media and by imposing punishment. Then we have to ensure the cleaning staff's sincerity. Postering, frequent audio announcement, announcement through radio and television can be the way of creating people's awareness

4.2.15 Lack of Pragmatic Database of poor people. For poverty alleviation and implementation of any plan, adequate and appropriate information is the precondition without it may come to the failure. But the most important matter is that any ambitious Government must have multidimensional data. The data should be reliable and open to all so that people can put comments and complaints and it can be corrected. Now is the age of information technology, so if we upload the information online then it will be the most effective. To provide Medical help or any other help, an online database of poor people will help the government and other authorities to a great extent. During crisis moments it will reduce the hazards. Poors should be Categorized in the following way

Group: P3- (P Three Minus, P---), Extreme Poor,

Group: P2- (P Two Minus, P--), Very Poor,

Group: P1- (P One Minus, P-), Moderate poor,

While enlisting a family in the poverty list, three things should be considered.

[1] Firstly, his or her economic conditions,

[2] Secondly, his or her parents' economic condition,

[3] Thirdly, his or her parents in the laws' economic condition.

The format will consist of the following points (a, b, c, d, e, f, g, h)-

(a) Name of the Head of household:.....

(b) Name of members, age and occupation

Name of house head and other members	Age	Occupation	Total land in decimal	Monthly income of individual member (if have)

c) Information of parents family (if property not divided)

Name of house head and other members	Age	Occupation	Total land in bigha	Monthly income of individual member (if have)

d) Information on parents-in-law's Family.

Name of house head and other members	Age	Occupation	Total land in bigha	Monthly income of individual member (if have)

Final decision:

e) Category of the Considered Family: P3- / P2- /P1-

f) Date of Evaluation:.....

g) Notify with a date if any change is made:.....

h) Any comments/ Complaints by any person.....

4.2.16 Code of conduct for private practice:

Section 4 of the "Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance 1982" allowed the private practice of doctors employed in the public health services except for the office hours. The ordinance prescribes a fine of Tk 5,000 only for any Government doctor involved in private practice during office hours. Though Article 21(2) of the constitution says, 'Every person in the service of the republic has to strive at all times to serve the people'. The constitution is the supreme law it will be considered effective over other law if any contradiction arises. The question arises on the legality of the private practice of government doctors. Moreover, the private practice of the government doctors is illegal according to the service rules that prohibited public servants from engaging in other professions.

In this context, it has become very urgent to frame a complete guideline on the private practice of government doctors fixing their duty hours at government hospitals. Moreover, it is important to fix their fee and behavioral code during private practice. While doing this, the government should also hear the doctors because with this the interest of many patients is correlated.[9]

4.2.17 Establishing Medical Ombudsman at Central Level

Ombudsman is a Swedish word that means Legal Representative. An ombudsman or ombudsperson, ombud, or public advocate is an official charged with representing the interests of the public by investigating and addressing complaints against the public of mal-administration or a violation of rights. The ombudsman is usually appointed by the government or by parliament but with a significant degree of independence. (Wikipedia)

In Bangladesh, while receiving healthcare service, people often become aggrieved by the mismanagement, misbehavior, carelessness, or wrong treatment of healthcare staff. Sometimes healthcare providers also have some complaints against the attendance or any member of the health system. Sometimes even it is complained that the patient has died because of the mistreatment or carelessness of doctors or nurses. It is not like that all the complaints are true but it is important to investigate the complaints. There must be an ombudsman who will have a hearing with both parties present, find the truth, and let both

[9] The New Age, Feb 13,2019

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[9] The New Age, Feb 13,2019

parties know the fact and the action taken against the accused. The Ombudsman will have the right to work independently without any interruption.

Even at the district level, an ombudsman can be an appointment for the betterment of the service.

4.2.18 Shortcomings of Healthcare Institutes

4.2.18 (a) Crises in Upazila Health Complex (UHC)

In most cases, the people of remote rural areas don't want to go outside the union area to receive health care. Poor people don't think about the consequence of delayed treatment. In 50% of cases, patients rely on fate and want to be cured with the hand of village doctors.

Meanwhile, village doctors give the patients various medicines including antibiotic medicines. When the village doctor realizes that there is no possibility of being cured, then he explains the depth of danger and in this situation, the patient and the relatives are to some extent compelled to go to town to receive advanced treatment. Relatively poor people at first choose Upazila Health Complex (UHC).

Most of the Upazila Health Complexes are running with insufficient and inoperative medical equipment and acute shortage of doctors, nurses, and other staff. The posts of Upazila Health and Family Planning Officer (UHFPO), Resident Medical Officer (RMO), remain vacant very often.

The Upazila Health Complex was upgraded to a 50-bed hospital in 2011 with the post of 4 Emergency Medical Officers, 10 Consultants, 8 Medical Officers. But practically, shortage of doctors, nurses hampers treatment. In most of the UHC, there are only 2 or 3 doctors and 5/6 nurses posted. Medical equipment like the ultrasound and the ECG machines are lying inoperative for months, hampering diagnosis and treatment due to the shortage of operators and technicians.

To know the service delivery situation in UHC and to identify whether patients/attendants are satisfied, a questionnaire is supplied to each 20 number of patients and attendants who received services from UHC during the said period. In that Question paper there were mainly 3 questions as follows:

Question no 1- Are you satisfied with the service you received in the UHC?

Question no 2- If you are satisfied, then which service or services/matters pleased you?

Question no 3- If you are not satisfied, then which matters displeased you?

In answer to question no 01, 85% samples are dissatisfied and 10% are satisfied where 5% people are in a dilemma. (Annexure- 01).

Regarding the causes of dissatisfaction, they mentioned the reasons bellow

1. Lack of devotion of doctors and nurses.
2. Weak monitoring and management
3. Lack of Doctors concentration because of excess private practice.
4. Absenteeism and Irregular Attendance
5. Carelessness of Doctors to Patients
6. Hurry of Doctors in examining or talking to patients
7. Referral tendency of doctors
8. Shortage of doctors and Nurses in comparison to patients
9. Shortage of proper instruments
10. Shortage of technicians
11. Lack of professional expertise of doctors
12. Shortage of bed in UHC
13. Dirty Atmosphere (Beds, bathroom, toilet, compound).
14. Influence of middlemen/ brokers
15. Lack of Grievance Redress system

Among the stakeholders of UHC, 82% are dissatisfied with the lack of devotion and professionalism of doctors. 80% told that doctors are tired with private practice and they find no interest in the government hospital where they get no money from patients. 85% stakeholders said that doctors tried to find the way to send the patients to private hospitals or higher level hospitals to escape his/ her duty. 35% stakeholders told that because of shortage of doctors and other manpower, fewer number of doctors becomes tired in rendering service.

4.2.18 (b) Problems of District/Divisional Hospital/Medical College Hospitals

In answer to question no 3, mentioned in 4.2.18 (a) 85% patients and attendance pointed to the shortage of bed, Less number of doctors in comparison to number of patients,

88% stakeholders said that due to the dirty atmosphere (dirty Beds, bathroom, toilet, compound) hampers healthcare in these hospitals. 85% of patients and attendance pointed to the activities of brokers or middlemen. 82% stakeholders said that due to the connection of doctors with private clinics makes their healthcare costlier.

4.2.18(c) Problems of Private Hospitals or Clinics

The causes of dissatisfaction with private clinics or hospitals differ with those of the government owned hospitals. Regarding private clinic and hospitals, the causes of dissatisfaction, they mentioned are given below

1. Profiting tendency and Commercialization
2. Influence of middlemen/ brokers
3. Weak monitoring and management
4. Over Billing Tendency
5. Shortage of doctors and Nurses in comparison to patients
6. Shortage of proper instruments
7. Lack of professional expertise of doctors
8. Unnecessary Test and surgery for earning money

In answer to question no 3, mentioned in 4.2.18 (a), 90% stakeholders blamed the profiting tendency of the management, 75% told that for commercial purposes unnecessary tests and surgery are carried out. 60% stakeholders blamed insufficient doctors, instruments, 78% samples told that due to shortage of space in private hospitals they are dissatisfied

5. RECOMMENDATIONS

5.1 Government Regulated Health Insurance:

Health insurance can play a great role to arrange treatment of poor people with chronic diseases. Every citizen should have been brought under the health insurance scheme. The first thing that must be ensured is the trust of the people in this scheme. Generally, people have the presumption that at the time of maturity of the scheme or when the beneficiary becomes eligible to get the fund, the authority or the insurance company plays various tricks so that they don't have to pay the due money. So it is better to run the health insurance by the government-owned organizations. Every poor citizen should have been brought under health insurance. When a person does not pay the installment, the amount should be collected from the electricity bill or other bill or from the social safety net allowances which are provided by the government. In this field, the government will not conduct business rather it will try to save the poor citizens. It should be remembered that citizens are the children of the state and the government has to help the citizens when they fall ill.

In addition to personal insurance,there should be group insurance. Suppose in a village there are one thousand people. For every five hundred people, there will be a group and the group will pay (500×10) taka per month. A committee will collect the amount and deposit it to the government fund. When any member of the group falls ill, the govt insurance company will pay the amount. The procedure of granting the money will be lucid and free from unfairness. One thing we must remember that is the success of every project depends on firstly the system or mechanism and secondly on the fair dealings of the employees. With a corrupted mind no project can be successful. So the key persons of launching health insurance must be selected by the government with care and prudence.

5.2 Treatment Aid Bank (TAB) and Treatment Fund

The government is constitutionally obliged and has a moral duty to help its backward people. A workable person has a contribution to the economy but when a man falls ill and is unable to work, he becomes the burden of the state. So the government should form a healthy fund to aid the poor people affected by chronic disease.

As there is not a healthy fund for allotting grants for rural poor patients, they become very helpless when they fall ill. Sometimes they take loans from NGOs or village usurious or village creditors at a very high rate and capital including interest become high and at a certain stage, they are bound to sell their small land and other valuables. All these matters hamper the healthy atmosphere of the society. In the present economic context of Bangladesh,it is not very difficult to form a fund.

5.3 Zero Interest Loan Facility

The Government has to create a fund to provide loans for the poor people affected by chronic disease. Even a bank can be founded for this purpose. The interest rate should be 0% or near this. The loan sanctioning procedure should be easy. A guide lime should be prepared to allot and retain the money. Moreover list of people with grading A,B,C, according to the gravity of poverty. It will be online and hard copy must be preserved at Union Information and statistic Centre steps should be taken so that no anomalies happen

In this context,the Government should establish a bank to provide loans for the poor patient's treatment. This bank will provide a loan for only treatment purposes with zero or very low

interest which will not exceed 2 percent. The bank will have other businesses from which it will survive. The government will also give subsidies to the bank. No mortgage should be demanded. People of the community will be the guarantor. Later if it is proved that the debtor is not paying the installment despite having the capability, exemplary punishment will be imposed. The guidelines of running the Bank should be prepared by the experts of banking sectors, economists, and medical sectors.

5.4 Create an online Database For Rural Poor:

For poverty alleviation and implementation of any plan, adequate and appropriate information is the precondition without it may come to the failure. But the most important matter is that any ambitious Government must have multidimensional data. The data should be reliable and open to all so that people can put comments and complaints and it can be corrected. Now is the age of information technology, so if we upload the information online then it will be the most effective. To provide Medical help or any other help, an online database of poor people will help the government and other authorities to a great extent. During crisis moments it will reduce the hazards. Poors should be Categorized in the following way

Group: P3- (P Three Minus, P---), Extreme Poor,

Group: P2- (P Two Minus, P--), Very Poor,

Group: P1- (P One Minus, P-), Moderate poor,

5.5 Establishing Union Health Multipurpose Complex

To materialize the vision "My Village, My Town" a health complex should be established and this complex may be named Union Health Multipurpose Complex. The complex should be established on an undivided land and at the middle point of the union so that people of the whole union get maximum benefit with minimum hazard. The plan should be prepared to keep in mind the demand for the future 100 years. If necessary, land should be acquired which must be not less than 5 acres. In it there should have the following establishment:

A) A Full-fledged Hospital

B) Herbal/ botanical Garden

C) A Herbal Medical Center

D) Health Awareness Center cum library

E) Residence for Doctors nurse and others

F)Union Health Statistic and Information Center

5.6 **"My Village, My Town" Manifesto** and Ensuring Healthy Environment for sound health

A big land with a herbal garden. Plants and bush areas must be preserved. No housing on agro land or forest or bushland. No shop or market on agro land or forest or bushland. No, lesson of oxygen. The health care zone must be demarcated. a botanical garden with an amusement facility. Ancient trees should be preserved. The water area must be preserved. For the increasing number of peoples' oxygen, ophthalmic, and mental health a certain amount of plants, bush, and at least 25% of the forest is necessary.At any cost, it must be ensured for the safety of the human generation and a healthy environment.

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