

# Understanding elderly client satisfaction with primary health care in rural Bangladesh

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## ABSTRACT

**Objective.** To examine the elements of patient satisfaction that affect and influence health care utilisation by elderly people in rural Bangladesh.

**Methods.** Based on the Primary Health Care in Later Life: Improving Services in Bangladesh and Vietnam (PHILL) project's qualitative baseline study of older individuals and their caregivers in four villages in the southeast region of Bangladesh, this study conducted six focus group discussions and 30 in-depth interviews at village and household levels between February and November 2003, in a sample of elderly individuals and caregivers aged 60 years or older. A non-random strategy of sampling was used to achieve maximum variation for gender and economic status. Both physical and mental abilities of elderly participants were considered while selecting respondents.

**Results.** Mobility, cost and payment flexibility, and cultural perception of medical outcome are primary determinants of satisfaction and utilisation. The private sector is more successful in meeting the particular demands of elderly satisfaction, i.e. better availability and flexible payment systems.

**Conclusion.** The private sector health care system has much to offer the government system as it attempts to address the needs of the elderly. The elderly are highly heterogeneous and vary greatly with regard to socioeconomic status. The user fee structure of the public health care system should reflect this reality. A possible effective strategy would be to provide free health care services for the poorest and most vulnerable elderly, and at full cost for richer patients. Flexibility in the payment system is vital. In rural families ability to pay for the health care is often seasonal, especially for those engaged in agriculture. Credit purchase for medicines and health care therefore appears attractive. There is a critical need to coordinate between these private and public sector primary health care, especially with regard to specific training needs of local village providers, establishing an effective and timely referral system to channel elderly patients to the public sector, and introduce a much-needed preventive health care.

**Key words:** Aged; Bangladesh; Patient satisfaction; Primary health care

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## INTRODUCTION

In most developing countries, changing demography

has been associated with increased average life expectancy and a higher proportion of elderly (>60 years) in the population. This increased number of

old people creates a unique and growing pressure on public health care delivery systems. More than in the past, primary health care providers face a range of illnesses and physical and mental conditions prevalent in old age. The challenges posed by the latter disorders differ from those of the wider population, with respect to both the type of illness and certain associated constraints.

Primary health care has been defined as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community. Moreover, it must be at a cost the community and country can afford and sustainable in the spirit of self-reliance and self-determination”.<sup>1</sup>

The reality of primary health care for older people varies dramatically from one society to another. In more-developed regions, primary health care is provided by institutional networks that are more or less sustained by public support, and services are sought from them by elderly individuals. In the developing world, the picture is rather different, as the modern health care system might not be the first point of contact for an elderly person. Insufficient knowledge about their health needs and their lack of autonomy are constraints that affect health care decisions of the elderly.<sup>2</sup> Furthermore, such decisions are often embedded in the wider family circle of the elderly patient.<sup>3</sup>

In the reality of village life, the elderly people are serviced by both public and private health care providers. In many developing countries, the public sector has attempted to expand its share of primary health care in rural areas, but still suffers from underutilisation.<sup>4,5</sup> In this regard, patient/client satisfaction has become an important indicator of the perceived quality of health care influencing service utilisation. In the developed world, the focus on patient/client satisfaction in the health sector was related to marketing and health care accountability.<sup>6</sup> National health care systems in the developing world are only now becoming more sensitive to the need for more client-based delivery approaches.<sup>7,8</sup> With this aim client satisfaction with primary health care services has to be multidimensional and vary within each cultural context and according to factors such as age and gender.<sup>9,10</sup>

With an estimated 141 million people, Bangladesh is the eighth most populous country in the world.<sup>11,12</sup> Except for some small island states, it has the highest population density in the world and according to recent statistics it is also one of the poorest; currently, one third of the population lives beneath the poverty line, earning less than USD1 a day, and 85% of the poor reside in rural areas.<sup>11,13</sup> Decreased fertility<sup>14</sup> and improved life expectancy<sup>15</sup> has rapidly increased the number of elderly people, now 6% of the population, or 7.3 million inhabitants. Bangladesh therefore has one of the largest populations of elderly in the world, and the number is projected to more than double by 2025.<sup>16</sup> In Bangladesh, the health care system is comprised of a range of public and private sector health care providers. The public sector is organised into four distinct tiers: medical college hospitals, district hospitals, Thana Health Complexes (THC), and union health and family welfare centres (UNHFC). Private sector providers include non-governmental organisations (NGOs) and other non-profit entities, traditional and homeopathic providers, qualified pharmacists and unlicensed drug sellers, qualified and unqualified modern care providers, and government doctors engaging in private practices.<sup>13</sup>

Public sector primary health care services in Bangladesh are provided through three main types of health institutions: (i) the THC, designed to bring the primary health care to rural people; (ii) the UNHFC, also known as Family Welfare Centres that provides family planning out-patient services at the union level; and (iii) hospitals and clinics, which serve as referral points for primary health care. As of 2000, Bangladesh had 460 rural thanas and 402 thana-level health complexes. Government health expenditure has slightly risen recently and in 2002 was estimated as Tk.180 (US\$1= Tk.59) per capita. The country has 3083 persons per hospital bed and 4521 persons per physician.<sup>17</sup> At the same time there has been a dramatic expansion of primary health care infrastructure into rural areas, with important results in, for example, maternal care and family planning. Nonetheless, Bangladesh is not meeting its stated goal of comprehensive coverage reaching vulnerable groups, like elderly people.<sup>18</sup> One reason being the lack of any national policy for the elderly population,<sup>19</sup> in the absence of which, existing infrastructure has been characteristically underutilised.<sup>4,20</sup> Despite the increased number of newly established thana health centres, their staffing with skilled medical

professionals remains a big challenge.<sup>21</sup> Skilled doctors often are unwilling to work in rural areas, as a result, there is a decline in public confidence in such primary facilities.<sup>22</sup> Very little attention has been devoted to the actual quality of service delivered in these health care outlets, or to how wide a range of patients are covered by them.

This current system is supported by a combination of government and donor investment. The closest point of access to this system is at the thana or union level; however, the primary services offered at these points are mainly concentrated on mother/child health and family planning.<sup>23</sup> World Bank and other reports systematically document the absenteeism of medical professionals, especially in poorer villages and unions.<sup>22,24</sup> With regard to maternal care, it points to the structure of the Ministry of Health and Family Welfare itself as a cause of waste and inefficiency in health care delivery. The Health and Population Sector Strategy states that the current structure functionally impedes referrals, generates conflicts, and thus contributes to the low utilisation of public facilities.<sup>25</sup> Further evidence shows that although government health facilities are supposed to provide most services almost free of charge, informal and unofficial charges can be as high as ten times the official rates.<sup>4,26,27</sup> Andaleeb<sup>28</sup> therefore argues that current shortcomings in the provision of public primary health care—including poor responsiveness to patient needs, ineffective communication, and corrupt practices—affect its perceived quality, and thus the levels of satisfaction and, ultimately, levels of utilisation.

The second option in rural areas is the network of private service providers, which includes rural medical practitioners (trained and non-trained), homeopaths, traditional healers (e.g. kabiraj, ojha, etc.), and medicine shopkeepers and drug retailers. Despite the significant effort and investment of the government to create an effective and universal public sector health care system, the private sector still provides the majority of actual care in rural areas. For instance, in 1997, the private health care sector supplied over 71% of the total value of health services (value of health services for each provider as measured by payments made by patients or by the government on their behalf), with drug retailers accounting for a full 46%.<sup>13</sup> As the private services are non-subsidised and depend on income from clients, they are more

responsive to customers' expectation.<sup>29</sup> Generally, in rural areas they are well known to village residents and are easily accessible. Private service providers, for the most part, have not had formal medical training, and many have acquired their knowledge and skills through intergenerational transmission. However, this system constitutes the first point of contact when illness occurs. If the problem can be adequately resolved at this village level, the patient will not consult the public sector. Although NGOs accounted for only a small share of the health service delivery (3% in 1997), their role in health promotion has been very important, especially with regard to contraceptives use and oral re-hydration therapy. Non-governmental organisations in Bangladesh enjoy the reputation of having intimate knowledge of grassroots realities and effective community contact, greater accountability, flexibility, and innovativeness. This makes them better positioned to act as local service providers.<sup>12,13</sup>

This paper explores the determinants of elderly satisfaction as it relates to experiences with the utilisation of public and private health care facilities. Using qualitative field data from rural Bangladesh, it assesses how and why the elderly choose between private and public health care providers.

## METHODS

This paper is based upon a qualitative baseline study of primary health care for older people in rural Bangladesh.<sup>30</sup> It was carried out in four villages in Chandpur Sadar Thana, Chandpur district, in southeast Bangladesh. Since the study largely explored attitudes and perceptions regarding health care decisions, a qualitative research methodology was adopted. The qualitative tools included focus group discussions (FGD) and in-depth interviews at the village and household level. The sample consisted of elderly individuals aged >60 years as well as their caregivers. Sampling was non-random, purposive, and opportunistic. The researcher team sought out sources of maximum variation, such as gender and economic status, and ensured that older women as well as older men from different wealth categories were included. The team also took advantage of interviewing opportunities, which arose in the course of fieldwork. For example, if the selected individual was absent, unable or denied participation, another individual fulfilling the research selection criteria,

who was present and keen to be interviewed, was substituted. Both the physical and mental abilities of elderly participants were taken into consideration while selecting respondents. During the fieldwork phase, six FGD and 30 in-depth interviews were conducted; typically they involved elderly individuals and their caregivers, with an average of five persons per session. The interviews were semi-structured and informal, and respondents had ample opportunity to talk about issues in a flexible, friendly environment. The qualitative data collection took place between February and November 2003.

The fieldwork explored the determinants of satisfaction with health care in two interrelated ways. First, respondents were asked to discuss/evaluate their level of satisfaction with the health care they received. Second, it analysed the underlying reasoning by which elderly people make health care-seeking decisions. Although such decisions are multidimensional, according to recent literature patient/client satisfaction evidently has a major impact on patterns of utilisation.<sup>28,31,32</sup>

Previous studies suggest that satisfaction is 'relative'<sup>33</sup> and that its central dimension depends on patient 'expectations', in the sense that if expectations are met satisfaction is experienced.<sup>34-36</sup> In the context of marketing studies, there has been wide use of 'disconfirmation theory' to explain client dissatisfaction, but some have argued that this theory is not easily applied to the health care sector. As Newsome and Wright<sup>34</sup> state: "health care is not homogeneous; it is a distinctive, complex mixture of emotion. Hence its tangible and the intangible consumption cannot be viewed in entirely the same light as for a consumer product, such as a television or a washing machine." Schneider and Palmer<sup>10</sup> argue user opinion in health service quality assessment is a 'social' rather than a 'technical' phenomenon. Moreover, use of quantitative questionnaires to capture satisfaction with health care services in industrialised societies has been criticised for their inevitably limited and simplistic approach to the expression of satisfaction. Williams<sup>6</sup> emphasises that patients/clients maintain a complex set of "important and relevant beliefs" which must be understood in attempting to assess client satisfaction. In this regard, qualitative research methods offer a greater potential for exploring belief systems and relating them to health care behaviour.<sup>10,37</sup> In this study, for example,

the heterogeneous nature of the existing primary health care services in rural Bangladesh as well as the unique socio-cultural characteristics of this rural population are explicitly addressed in the qualitative methodology.

After a review of available tools and techniques in the field of such qualitative research, a multimethod data collection strategy was devised, for both the key informant in-depth interviews and FGD. These techniques were employed with elderly respondents and main caregivers in the study area to gather a wide range of perspectives on the relevant issues. Each individual was interviewed at his/her own premises at his/her preferred times. Several respondents were interviewed several times on different topics related to their health care using personal experiences, preferences, and satisfaction. These iterative interviews created a unique opportunity to pursue important themes more systematically.

The research team did not ask individuals direct questions about whether they were satisfied with a particular source of health care service in the area. Rather, individual and household satisfaction was introduced as part of the discussion regarding the utilisation of health care services. Thus, insights into satisfaction were framed within an information flow on how different sources were accessed. Admittedly, there are analytical challenges related to the interpretation of 'satisfaction' from the perspective of both interviewer and interviewee. However, it was felt that subjectivity was minimised simply by not introducing direct questions using the term satisfaction. Without any pre-established criteria, the respondents were free to express themselves and discuss their satisfaction at multiple levels.

The resulting qualitative data set was processed using text analysis techniques. Within the wide range of recorded responses, repeated patterns were identified and underlying reasons explored. The text was reviewed several times to understand the contexts of similar responses.

## RESULTS

The data from the qualitative interviews suggest that patient/client satisfaction varies significantly between public and private providers. In rural Bangladesh, satisfaction with primary health care was based on (a)

**TABLE**  
**Indicators of satisfaction/dissatisfaction with government and private health care services**

| Services            | Satisfaction indicators  | Dissatisfaction indicators   |
|---------------------|--|--|
| Government services | Health service providers' behaviour, politeness, showing respect to the patients<br>Medical outcome                              | Difficult to access the service, including payment of bribe to the middle man to access free service |
| Private services    | Flexible payment options and small discount<br>Easy accessibility and providers' availability for home visits<br>Medical outcome | Late referral to other specialised services when necessary   |

a rational evaluation and (b) an emotional reaction to the structure, process, and outcome of services.<sup>38</sup> The rational component of satisfaction was usually stated in terms of the medical outcomes and whether the patient considered the services to be adequate and appropriate. The emotional component was related to such things as responsiveness, respect, and politeness.<sup>7</sup>

The comparison of elderly client satisfaction between the public and private health care provider systems (**TABLE**) identified three factors that seem to determine satisfaction with regard to this patient group. These factors were: mobility and access, cost and payment flexibility, and cultural perceptions of the medical outcome.

### **Mobility and access**

Particularly in Bangladesh the mobility of the elderly is a significant constraint. The necessity of travel to a THC or any other public health care facility was a substantial burden for elderly individuals and their families, not only because of the demands for travel but also due to lost time (often in waiting to be attended). By contrast, private sector health providers are available in villages and bazaars (i.e. located nearer than public services), and most importantly, they commonly make home visits to care for the elderly patients. In the respondents' words: "The doctor (a medicine shop owner) is known to us, so we go to him, we can get medicine on credit and he respects older persons. If needed, he makes home visits to see older patients...the doctor gave good medicine and I took expensive medicine too, with the blessing of God I am ok now..." (a 62-year-old male). For older couples living on their own without adult children, proximity is even more critical as sometimes an older person has to call upon the doctor at home. As one 75-year-old male respondent living with his elderly wife put it: "When I feel ill, I ask my wife to call that doctor (a rural medical practitioner)...my wife calls

him and he comes whenever called...we are happy with his service."

### **Cost and payment flexibility**

Related to the mobility factor is the cost of treatment and flexibility of payment. A major characteristic of the elderly in rural Bangladesh is their financial instability. Elderly pensions are inadequate relative to rural livelihood needs. Since most families depend upon agriculture as their main source of income, cash availability varies widely over the course of the year. Furthermore, many elderly rely upon remittances provided by migrated children, which is also an uncertain source of support. Thus, any additional and unexpected cost associated with illness places a severe burden on the elderly individuals themselves and on their families. The qualitative data suggest that the relative cost of primary health care is lower in the private sector. Although public health services are intended to be mostly free-of-charge, there are real costs associated with travel and the informal payment (baksheesh) often demanded by the middlemen who serve as gatekeepers. Moreover, the patients require to have money in hand and available in order to seek such services. As the respondents put this matter: "...better qualified doctors (MBBS) are too expensive... unless the situation is very dangerous, we don't go to them" (a 75-year-old male). "...I went to hospital (district hospital) once, stayed there for 2 days... I liked their treatment, but it costed me Tk.4000... too expensive" (a 60-year-old male). "...when I was very ill, my son took me to a MBBS doctor in Chandpur hospital, we can't go instantly of course, because one needs to have the money upfront for treatment there" (a 68-year-old male). "...I prefer not to go to a qualified MBBS doctor, because we have to have cash in hand to seek treatment, and of course it is more expensive..." (an 83-year-old male). One respondent, a 75-year-old woman, provides an example of how transportation costs increase for an elderly patient: "It can be very expensive sometimes

to get free treatment. For example, when one is well, a ticket for one seat on the mini-taxi is ok, but when the passenger is sick, you have to take the whole taxi, which, of course, is expensive."

Private sector providers, in contrast, charge moderate fees for their services, but offer payment flexibility—fees can be negotiated and paid later—which makes their services more attractive to the elderly users and their families. Similarly, they tend to purchase their medicines from local drug stores, where the shopkeepers also act as health service providers. They typically are well known by the elderly users, to whom they offer credit for medication purchases and do not pressure them for payment. In many cases, these providers may be relatives or family friends, which further facilitates flexibility of payment. In the words of several respondent: "...He (a rural medical practitioner) is a good doctor, he treated my mother-in-law and my husband too. He gives us medicine on credit, also gives us a little discount. I got well with his medicine...I still owe him Tk. 200 out of total cost of treatment Tk. 500" (a 60-year-old female). "...we go to him (a rural medical practitioner), he is known to us, and is there for us during good and bad times... we can get medicine on credit too...he is good and also gives us a discount" (a 70-year-old female). "...this doctor (a rural medical practitioner) is treating me for 30 years for high blood pressure. Since I am his long-term patient, I can get treatment on credit, sometimes he also gives a discount." (a 64-year-old female who is also a health care provider—kabaraj).

While the data suggest that cost is related to satisfaction among the poor elderly, a surprising twist occurs among the wealthier families. For the middle and upper-middle class, the cost of medicine is directly related to its perceived effectiveness. Thus when the medicine is more expensive, it is believed to provide better treatment. The respondents often used expressions such as, "I took an expensive medicine"; "I had Tk. 36 worth of injections and Tk. 13 worth of tablets." For these families, client satisfaction is not determined by the burden of health care expenses.

### **Cultural perception of the medical outcome**

The most common illnesses reported among the elderly during the fieldwork included eye problems such as cataracts, toothache, gastric pain, fever, body pain, weakness, uterine problems, loss of appetite, tuberculosis, and arthritis. Since preventive health

care for the elderly does not exist in either the public or private sector, the initial care-seeking decision is based primarily on severity and the level of discomfort. Dissatisfaction with private providers in terms of the objective medical outcome usually shifts care seeking to another private practitioner or into the public sector. The results of the research convey a very complex reality for the elderly. Thus, in some instances, success of the medical outcome appears to be a primary determinant of satisfaction. In the words of various respondents: "...of course, I am satisfied, my fever was cured after 4 days with the medicine..." (64-year-old male). "My brother took me to the doctor (MBBS at Chandpur) when I lost feeling on my left side...he treated me for 2 months, but his medicine did not work. Then I went to other doctor (MBBS at Chandpur) who also treated for another 2 months also with no effect. Since then, I have been treated by kabirajs...I am not happy with any of my doctors or kabirajs, because my disease does not get better, I have been to everyone suggested. How can I be satisfied?" (60-year-old male paralysed stroke victim).

Although the success of medical outcome can be an important indicator of client satisfaction, cultural perception introduces an element of fatalism into the quality assessment of the elderly. It is very common for the elderly to have a cultural perception about the ineffectiveness of the treatment and medicine in later life. Sometimes they show satisfaction with the efforts of the providers yet remain unwell, and express the view that medicine just does not work in old age. For example, there is a belief that no medicine is available for some elderly diseases like arthritis.

The research reveals that client satisfaction can be positive in cases where improvement lasts for only a short while because treatment was not continued. Also, in Bangladesh, patients simply become resigned to a situation that they associate with old age. In their words: "First I went to Dr M (a homeopathic doctor)... he is a good doctor, we can get treatment on credit... last time I was ill with rheumatism, I went to him... his medicine failed me; however, he is a good doctor. His medicine works better for young people, but for older people it simply does not work" (a 64-year-old female). "His (a rural medical practitioner) treatment is very good...he takes good care of the patients and his medicine is good, too...I like him a lot, but, as I

have said, medicine is not effective at an older age" (a 64-year-old female).

The second factor that relates medical outcome to client satisfaction has been defined by Donabedian,<sup>38</sup> as the process of giving or receiving care. In Bangladesh, even when the medical outcome is not successful, the elderly will show appreciation for the way they were treated, i.e. with respect, dignity, and attentiveness. In the words of the respondents: "The doctors and nurses in the Chandpur general hospital were very nice to me while I was in the hospital, I am very happy with them; I think the hospital treatment is very good" (a 60-year-old male). "I took my wife to the hospital (district hospital) when she was very ill... she was there for 4 days, and the nurses' behaviour was bad. So I took her out of the hospital...I did not even tell the doctor we were leaving. We arranged to put her on drips at home with the help of our regular doctor (a rural medical practitioner)" (a 62-year-old male). In effect, if doctors do not rush the examination and write a prescription immediately, but explore patient's problems with greater detail, the level of satisfaction is higher, regardless of the outcome. Phrases like "takes time", "examines carefully", and "touches and feels" provide insights into the criteria for appropriate care. Another cultural factor that may govern satisfaction is a sense of modesty or appropriateness. Some elderly patients will avoid a health care provider who wishes to examine the patient directly. According to a 90-year-old female respondent: "My family members explained my problem but he wants to see me. I have made a promise to God not to be examined by any doctor, so we go to places where they would not demand to see me."

In the case of private health service providers, the sense of satisfaction is largely determined by the relationship between providers and the users' families. Easy accessibility and predictable availability significantly enhances the level of satisfaction of the care-seeking elderly, especially when providers are willing to make house calls during day or night. For example, "We always go to him...he is our regular doctor (a rural medical practitioner), and he is available whenever we need him, day or night...he also comes to our home when needed...we are happy with him" (a 68-year-old male).

This high level of provider availability appears to offer a great deal of psychological comfort to elderly

users. They recognise that a sudden illness may occur at any time, including at night, and limited physical mobility often constrains access to other providers. Thus, the option of home visits provides 'peace of mind' and, as such, contributes to the level of satisfaction.

## DISCUSSION

In rural Bangladesh, primary health care services are not yet able to meet the specific health needs of its increasingly aged population. This inquiry into client satisfaction as an overall assessment of primary health care quality has identified three important, but complex and interrelated determinants—mobility and accessibility, cost and payment flexibility, and cultural perceptions of medical outcome. While the literature points to the success of the medical outcome as a primary determinant of satisfaction, the elderly sampled here portray a much more complex reality. Fieldwork reveals that they first seek health care attention at the closest, most convenient venue. If not cured, the patient will consult a range of, usually, private sector health care providers until the problem is resolved. Otherwise or if referred, the patient will absorb the cost and time of consulting the public health care system or some other specialised service. Of interest here is the observation that this process of care seeking does not tend to permanently identify one or another care provider as preferable. Thus, when the same elderly person is again afflicted with illness, the same process is repeated, which provides unique insights into utilisation preferences.

This study suggests that factors such as the interpersonal relationship with the provider (where the provider is known to the elderly), availability for the home visits (including during nights), and payment flexibility are the major determinants of satisfaction—especially as it affects utilisation. Positive medical outcome appears more secondary as there is a strong cultural belief that ill health is a part of old age and the medication is less effective in old age. In this sense, the private sector is more successful in meeting the particular demands of the elderly, i.e. better availability and a flexible payment system that is 'affordable' to the elderly and their families.

Moreover, the private sector health care system has much to offer the government system as it attempts to address the needs of the elderly. The

elderly population is very heterogeneous, and varies greatly with regard to socioeconomic status; the user fee structure in the public health care system should reflect this reality. A possible effective strategy would be to provide free health care services for the poorest and most vulnerable elderly, but at full cost for the rich. Flexibility in the payment system is vital. In a large number of rural families, the ability to pay for the health care varies seasonally, especially for agricultural workers. This makes purchase for medicine and health care services on credit very attractive.

Finally, there is an important opportunity in the overall provisioning of health care services to the elderly. This entails taking advantage of both private and public delivery systems. There is a critical need to coordinate between these two universes of primary health care, especially with regard to specific training needs of local village providers and establishing an effective and timely referral system. The system should channel elderly patients from the private to the public sector, and introduce much-needed preventative health care component.

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