The Jahangirnagar Review: Part II: Social Science, Vol. XLV, 2021
Printed in December 2021, ISSN 1682-7422 © Jahangirnagar University

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

Md. Ahsan Habib*

Abstract: The rural poor people always struggle for their livelihood. When a rural poor person is affected by a chronic disease, he and his family's sufferings know no bounds. Spending money for treatment for a long time, the poor family becomes poorer and in some cases it turns into a beggar family. The state, for the sake of its socio-economic development, has to take steps to standardize its healthcare system which is one of the prerequisites of becoming a welfare state. Though the healthcare system in rural Bangladesh is 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 families of which, one or another member is affected by the chronic 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 Departments of the government. It is also attempted to find a way of solving the crisis with the limited assets of the government. The suggestions include personal or health insurance, provision of granting loan with zero or minimum interest and taking improvised healthcare systems to union level.

Keywords: Chronic Disease (CD), Money for Treatment (MT), Government Regulated Health Insurance (GRHI), Treatment Aid Bank (TAB), Union Health Multipurpose Complex (UHMC), Database of Poor People (DPP),

1. Background

1.1 Introduction:

Healthcare is one of the basic needs which determines the overall activities of every human being. 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 and it is also guaranteed in 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 reported that the state shall adopt effective measures to improve rural areas and to improve public health. Moreover, Goal number 3 of Sustainable Development Goals (SDG) is " Ensure healthy lives and promote well-being for all at all ages" that means, we have to take action to ensure healthy lives and well-being for all. According to the World Health Organization (WHO) , 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

* Deputy Secretary, Internal Resources Division, Ministry of Finance. Email: ahsan24bcs@gmail.com

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. At the union level, a health sub-center has also been established. 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.. 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 objectives of the study are:

1. To analyze the sufferings of those rural people who live from hand to mouth and affected by chronic disease.
2. To identify how this problem is affecting the socio-economic condition of the country.
3. To find out the mechanism of ensuring healthcare facilities to the village poor people within their capability.

1.3 Justification of the Study/Rationale

Bangladesh's health sector has undergone a notable improvement in the last few years but still, we have many things to do. 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.

Raton Mia was an agro laborer in Kashiabari village under Boalia Union, his wife Ruby Khatun was a housewife, they have one son named Sohag and two daughters Joly and

Poly. Joly reads in class Nine, Sohag reads in class Seven, Poly is dumb and deaf. In 2018 Raton had a Stroke disease. He had high blood pressure for a long time but he was not aware of the danger of it. After the attack he received treatment in the divisional town, Rajshahi but later he had no money to continue treatment. Gradually he deteriorated and he was unable to move. Sohag stopped going to school and became a child laborer. Joly also dropped study and she was given in marriage at her child age. After one year Raton died. By this time, the cervical cancer of Raton's wife was diagnosed. Now the sufferings of the children know no bounds. This is the scenario of many families in rural areas. We have to think deeply and find a way to protect such families. This paper attempts to do the same.

The Government alone cannot solve this problem with its limited wealth because there are thousands of such distressed families. So we have to find out the way. Earlier many research works have been conducted related to rural healthcare, that is, 'Limitations of Rural Healthcare System', 'Maternal and Child health', 'Immunization', 'Community Clinic', 'Nutrition' ' Necessity of Comprehensive Healthcare' etc. But this paper deals with the cases of those rural chronic patients who have no money for treatment on the one hand and one the other hand their earnings have been stopped due to disease.

If it is possible to carry out the research successfully and to present some recommendations to address the problem, the Bangladesh Government, as well as the Ministry of Health and Family Welfare, other concern ministries, Directorate General of Healthcare Service will be able to know ins and outs of the said matters. It will help concerned authorities to adopt necessary policies 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.

1.4 Scope and Limitation of The Study:

The methods which have been adopted here are interview and questionnaire methods because it is easier to find samples since there are huge patients in rural areas. Patients and relatives are very much interested in expressing 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.

The problem is that 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, or what is the actual monthly income of the family. Because they think that if they disclose everything, they will not get the Government help from the Social Safety Net Program. In some cases, patients don't want to disclose their health conditions, 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 uninvestigated. A person is involved in various professions simultaneously. Moreover, people don't want to understand the limitations of health care institutions. So during giving their opinion, they think something is their right but that is their illegal demand.

2.1 Literature Review

A number of research papers, books and articles related to healthcare, health administration, universal health coverage and rural health have been reviewed such as:

Shakeel Ahmed Ibn Mahmood in his paper **'Health system in Bangladesh'** presented the success of Bangladesh Health Sector and analysed the challenges of this secor. In the sub-title 'Challenges of Bangladesh's Health Sector' he depicts the scenario of human resources, Doctor, Nurses, Informal Healthcare provider, healthcare Governance, political commitment and leadership, public private partnership etc.

Aasha Mehreen Amin, in her article **'Getting Health to Rural Communities in Bangladesh'** focused on how rural people are benefited by the healthcare provided by the Non-Government Organizations like The Gono Shashthya Kendra headed by Dr. Zafrullah Choudhury. She says " While government-run hospitals offer low cost medical care, they are often inaccessible, crowded, understaffed and lacking medicines". This article mainly presents the contributions of various Non-Government agencies in the rural healthcare sector.

Attitude of Rural Community towards Health Care Utilization at Primary by Md Ziaul Islam, Assistant Professor, Department of Community Medicine, National Institute of Preventive and Social Medicine (NIPSOM), Mohakhali, Dhaka, and 3 others.

In the research book "**Tackling Noncommunicable Diseases in Bangladesh" by** Sameh El-Saharty, Michael M. Engelgau, Karar Zunaid Ahsan, Tracey L. P. Koehlmoos, and

Michael M. Engelgau, the healthcare system of Bangladesh has been presented and it has been analyzed how Bangladesh is fighting against noncommunicable diseases. According to the researchers, the objectives of their research are as follows:

- ➔ To develop an NCD burden and risk factor profile,
- ➔ To assess the health system's capacity to prevent and control NCDs,
- ➔ To take stock of ongoing NCD activities and identify remaining challenges, and
- ➔ To develop a range of policy options and strategies for the prevention and control of NCDs.

Khaleda Nazneen (August 2001) **Governance of Healthcare Sector in Bangladesh**, CPD

This book critically examines the existing healthcare delivery system in Bangladesh and its outcome. It also deals with quality of healthcare and healthcare governance in Bangladesh. Data were collected at random from two hospitals: Dhaka Medical College Hospital and Bangabandhu Sheikh Mujib Medical University Hospital

In the article "Quest for a Healthy Bangladesh: A Vision for the Twenty-first Century Bangladesh" by Henry B Perry deals with the healthcare situation of Bangladesh and current status of health,population and family planning programmes with an emphasis on primary health care services.. It reviews some of the major initiatives in health, population and nutrition which are emerging and considers how primary health care services can be strengthened in Bangladesh so that health for all can become a reality in Bangladesh .

Taufique Joarder in his article entitled "**Universal Health Coverage in Bangladesh: Activities, Challenges, and Suggestion"** focuses on the attempt to ensure universal health coverage in Bangladesh and finds out barriers. He also puts some suggestions on how to overcome those barriers to ensure universal health coverage.

Almost all these researchers are objective and focus on the healthcare, health administration, universal health coverage and rural health, nutrition and family planning 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.

But my study is new and quite different from the 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.

2.2 Operational Definition of Key Words

a. Union: 'Union' usually referred to as 'union council' or 'union parishad' is the smallest unit of local government in Bangladesh. In this study union means union territory or the area under this administrative zone. In this writing whenever the Boalia union is mentioned it indicates the total area of that territory.

b. Poverty: The World Bank defines poverty[1] in absolute terms. The bank defines extreme poverty as living on less than US$1.90 per day. (PPP), and moderate poverty as less than $3.10 a day. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty. When a person's income is too small to spend for the basic necessities of life such as food, nutrition, healthcare, clothes education, housing, he is considered to be poor. In rural Bangladesh, the landless farmers, agro-labors, rickshaw pullers, abandoned women, maid servants, sales-associates and other day-laborers etc. A person is beyond poverty line when,

1. He has the capability to buy food for himself and his spouses and to fulfill the demand of nutrition.
2. Has the capability to spend money to receive medical care when he is ill.
3. He has a house which is safe and comfortable.
4. He has the ability to spend for the education of him and his spouses/children.
5. He has employment either in any organization or on his own.

[1] The World Bank Group October 7 2020 (https://www.worldbank.org)

According to the Bangladesh Bureau of Statistics, in 2018, Bangladesh has 21.8% people below the poverty line and 12.9% people below the extreme poverty line [2].

c. **Chronic Disease:** Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability. In another term a disease that persists for a long time is called chronic disease[3]. A chronic disease[4] is one lasting 3 months or more, by the definition of C. Chronic diseases tend to become more common with age.

3. METHODOLOGY

3.1 The Study Area:

My study area is the total Boaila union territory. Boalia Union is in Gomastapur Upazila under Chapainawabganj District. It is situated 35 kilometers north of Chapainawabganj district town and 5 kilometers western side of Rohanpur, the Upazila headquarter. Gomastapur Upazila 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[5]

Serial No.	Description	Quantity
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

Before forming district administration at Chapainawabganj in1984, GomastapurUpazila as well as the whole Chapainawabganj district was under the Rajshahi district. From the British period, the people of Boalia, as well as Rohanpur, feel comfortable going to Rajshahi for treatment, education, or for other purposes.

[2] Bangladesh Bureau of Statistics Report 2017
[3]U.S. National Center for Health Statistics
[4] Source: https://www.medicinenet.com/chronic_disease/definition.htm
[5] Papers supplied by Secretary, Boalia Union Council

3.2 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	

3.3 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 of 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[6]. Then anyone or other places/institutions they choose to receive healthcare.

3.4 Diseases taken in consideration:

Seven chronic diseases have been included in this research, these are,

(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.)

3.5 Method

The research is based mainly on the data collected from the root level people. Both qualitative and quantitative methods for this study have been adopted, but qualitative elements are more prioritized than quantitative elements. To carry out this study, 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. Another technique

[6] Opinions of a few doctors(LMAF), Reference 6.7

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 in expressing 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 in disclosing 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.

3.6 Sample Group, Data Collection and analysis

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 included people such as Patients with chronic disease, relatives of the patients, family members or attendants of the patients, village doctors, public representatives, medicine sellers, Social Welfare Officer, Doctors of Upazila Health Complex.

Mainly descriptive analytical method has been adopted in this study. 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.

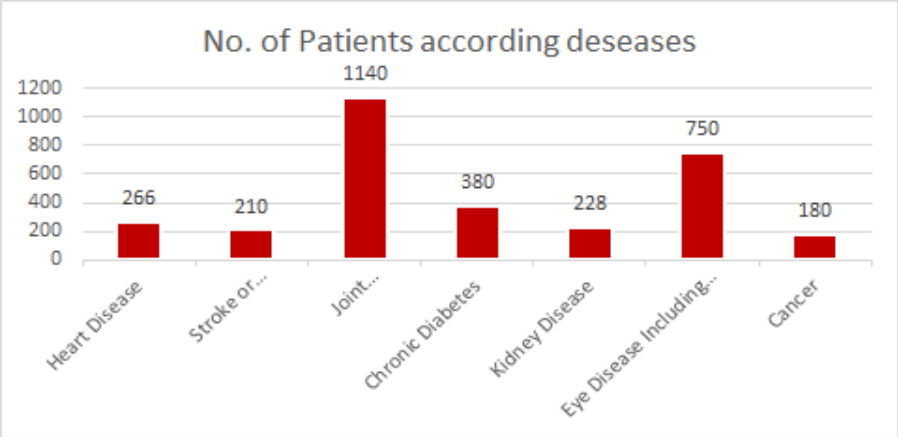
Information on the tables was explained, other data were analyzed and explained. Interviews were reviewed. By these analyses, explanations, investigations, and overviews, the sufferings of the poor patients with morbid diseases were found out and how the society and the state are losing workforce were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

4. Data Analysis and Findings

4.1 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.

Sl. No.	Name of Disease	No. of Patients	Died during the period	Became incapable of working
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	Chronic Eye Disease	750	0	610
7	Cancer	180	20	130



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

4.2 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 died or became incapable of working due to lack of proper treatment. These incapable persons would have worked more than 20 years. If they would work worth taka 500 per day, an estimated **loss of economy of Boalia union** is shown below:

Total loss = Number of Incapable or Deceased Person x Income Per Day x
Approximate Working Day per Month x Study Time Duration

=NIDP x IPDx AWDMx STD

= 1530 x 500 x 25 x 20

= 382,500,000 /-

So total loss for one year is=382,500,000/20 x12

=229,500,000 taka

This loss is only for seven 7 diseases and if we incorporate all other diseases then projected loss would be much higher. It is noted that normally a rural poor person works 25 days a month. This is only about monetary loss. Other losses are as follow:

- The person would have make his/her son /daughter efficient human resource
- His experience / intellects would benefit the family and nation

Under this circumstance if the government uses this amount, that is, 229,500,000 taka per year in Boalia union as a loan or grant for poor patients, the government will not have to bear any loss.

4.3 Socio-Economic Scenario of the Study Area: Economic, Social and other conditions of the study area are discussed below (4.1.1 to 4.1.3).

4.3.1 Profession of Household Heads

The number of total households is 8890 and each household contains 3.85 members on average.

The same person is engaged in various professions and so summation is not applicable here.

Sl. No.	Description of Household	Households	%
1	Agro-based households (Land Owner)	5156	58%
2	Agro-based households (Landless)	2223	25%
3	Service holder's Having Income Less than 16000/-	800	9%
4	Service holder's Having Income More than 16000/-	445	5%
5	Business based households (Monthly Income Less than 20000/-)	1245	14%
6	Business based households (Monthly Income More than 20000/-)	178	2%
7	Agro family having <5 Bigha land	4445	50%
8	Agro family having 5 – 10 Bigha Land	889	10%
9	Agro family having 10 – 20 Bigha Land	445	5%
10	Agro family having >20 Bigha Land	533	6%
11	Agro Labour Family (Also involved in other works)	2223	25%
12	Labour other than agro (Also involved in other works)	1778	20%
13	Maid Labour	178	2%
14	Workless family (having no worker)	178	2%
15	Others	1778	20%

This table[7] clearly indicates that most of the people or households are dependent 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 professions simultaneously.

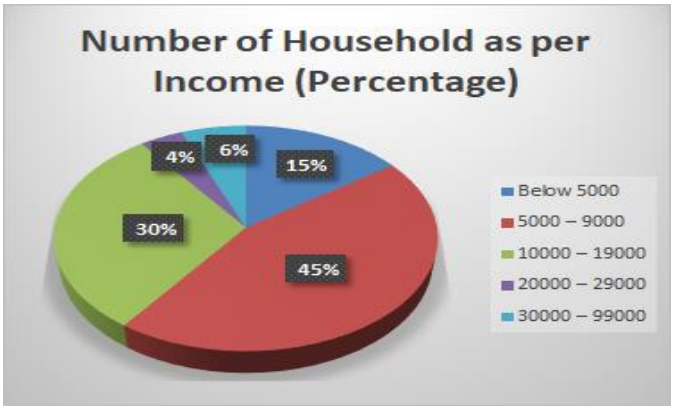
The families mentioned only in serial number 4, 6, 9 & 10 have economic capability of receiving health care facilities.

[7] Data collected from research area.

4.3.2 Number of Households in Respect of Income:

According to the income of every household of Boalia union, a classification is shown in the following table.

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



The above table and Pie Chart are 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 funds.

4.4 Absence of Online Database of poor people: For poverty alleviation and implementation of any plan, adequate and appropriate information is the precondition without which it may come to 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 poverty alleviation and implementation of any plan, adequate and appropriate information is the precondition without it may come to failure. It will help the government and other authorities to a great extent. During crisis moments it will reduce the hazards. But, an online database is yet to be formed by the government from which people can get information easily.

4.5 Absence of Government Regulated Health Insurance:

Health insurance can play a great role to address the treatment crisis of poor people with chronic diseases. Every citizen should have been brought under the compulsory health insurance scheme. In Bangladesh, there is no provision of health insurance. That is why rural poor people suffer a lot. Because every citizen has the ability to deposit 50 or 100

taka per month but they cannot spend a large amount at a time for treatment. Besides this, without a compulsory system they cannot deposit money rather they spend all the amount. In many countries in the world, there are health insurance systems.

It must be government regulated because the poor people will not be interested to deposit installment as they have no faith in non-government insurance companies.

Compulsory health insurance system was introduced in Madhupur, Ghatail and Kalihati upazila of Tangail district but it could not attain optimum success. Because pre-requirement initiatives such as establishing collecting authority, making infrastructures, appointing necessary manpower, forming a specialized bank, creating online databases, formulating policy, rules and regulation etc. have not yet been implemented. It is notable that depending on other agencies/offices, it is not possible to make compulsory health insurance successful.

4.6 Urgency of Treatment Aid Bank /Treatment Fund:

It is a setup of economic activities which will ensure the success of compulsory health insurance programs. This bank will collect installment of insurance, provide loans to poor patients, allot grants of the government and simultaneously it may regulate other financial activities of social safety net programs of the government.

The total number of patients 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, crops or family ornaments.

When a family head becomes critically ill and cannot not earn a living, his family cannot cope financially, especially to pay bills, buy food, clothes, bear school expenses for children and other day to day expenses. Then the family has nothing to do without selling land, deschooling children, engaging children in child labour or placing their family members in hopeless condition. 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, his family members may become derailed and may be involved in crimes or unethical activities. 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 Boalia Union, 18 NGOs are working with microcredit activities. So far information can be collected, no scheduled 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. Under these circumstances, it is demanded by the respondent groups to establish a specialized bank.

4.7 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 through social welfare departments. A person with chronic disease gets 20 to 50 thousand taka 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 and sometimes selection of beneficiaries could not be impartial because there is no perfect database to identify actual poor people. Sometimes poor people also do not know about government help properly.

4.8 Suffering of rural people because of ineffective Healthcare Administration.

The government is trying to improve the health care system but the supervision system is not satisfactory. Apart from healthcare, a strong set up is needed to be established which will run the healthcare administration. In many cases it is observed that 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 [8]says, ''health sector needs reforms, eradication of misuse of money and improved management''.

4.9 Sufferings of rural people because of inefficient Hospital/Bed:

It is not possible to establish all kinds of hospitals or medical facilities in rural areas, people have to go to towns, but due to Shortage of hospitals and beds at upazila /district level**,** rural people have to suffer. Upazila and district level hospitals are also suffering from a shortage of specialist doctors, nurses, equipment, and infrastructure. To provide health care smoothly the following manpower and bed are needed both in rural and urban areas[9]:

[8] The Daily Prothom Alo 16 May 2020
[9] Interview of Sumeet Aggarwal, MD, Midmark India The Daily Prothom Alo 22.02.2018

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 there are only 8 beds per 10,000 people, while in the USA 29, in the UK 25.4, in China 43 and in Bhutan 17. So it is clear that Bangladesh has a very low number of hospital beds in comparison to other countries. In this study area, there is no government or private hospital except a community clinic and doctor-patient ratio is absolutely minimum.

4.10 Sufferings of rural people because of Shortage of Doctors at upazila /district level:

It is not possible to establish all kinds of hospitals or medical facilities in rural areas, people have to go to towns, but due to Shortage of Doctors at upazila /district level or due to unequal distribution of doctors/nurses, rural patients are being deprived of treatment facilities at minimum/reasonable cost.

The international unit of manpower in the health sector[10] is 10000 people. According to the World Health Organization for every 1000 people, a doctor is needed. Doctors available per 10000 people in India 9 in the USA 51, in China 20, in UK 28 in Srilanka 10, while in Bangladesh 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.

4.11 Sufferings of rural people because of limitations 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. But when the disease goes beyond tolerance level most of the poor people at first go to 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.

[10] World Health Organization Global Health Workforce Statistics, OECD 2018,

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 condition 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% said 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 a way to send the patients to private hospitals or higher level hospitals to escape his/ her duty. 35% stakeholders said that because of shortage of doctors and other manpower, fewer doctors become tired in rendering service.

5. Conclusion and Recommendations

After analyzing all the data, it can be mentioned in the conclusion that a chronic disease can devastate the personal and family life of the rural poor people. When the family head is affected by chronic disease, he and his relatives at first become anxious of collecting money for treatment.

Not only that they also become anxious for their livelihood if the patient is the only earner of the family. They cannot collect loans from government agencies as there is no provision of treatment loans. They collect loans from usurers at high interest rest. They can collect loans from NGOs but the interest rate is high. Moreover since they have limited income, they cannot pay the installment and at last they are bound to sell their valuable lands, cattle's or ornaments and the whole family becomes helpless and school going children and females are bound to work in others' house or farming land. So it also brings harm to education. In healthcare institutions they also face hazards. The brokers/ middlemen harass them. As they lack awareness, they are neglected by most of the people in hospitals and clinics. They also become the victims of monetary exploitation. Under these circumstances, this paper presents the following recommendations which may play a great role to solve the crisis.

5.1. Government Regulated Health Insurance:

Health insurance can play a great role to address the treatment crisis of poor people with chronic diseases. Every citizen should have been brought under the compulsory health insurance scheme. In Bangladesh, there is no provision of health insurance. That is why rural poor people suffer a lot. Because every citizen has the ability to deposit 50 or 100 taka per month but they cannot spend a large amount at a time for treatment. Besides this, without a compulsory system they cannot store money rather they spend all the amount. In many countries in the world, there are health insurance systems.

The first thing that must be ensured is the trust of the people in this scheme. It must be government regulated because the poor people will not be interested to deposit an installment as they have no faith in non-government insurance companies. 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.

The government has to categorize people in various groups depending on the basis of their economic condition. Insurance premium, benefits and how many diseases will be incorporated must be fixed by the government. To formulate all these systems, an expert committee should be formed and finally law, rules and guidelines must be formed. The management officials and staff should be chosen from efficient, honest and integrated persons

When a household does not pay the premium, the amount should be collected from the electricity bill, mobile recharge 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.

One thing we must remember is that 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 launching health insurance must be selected by the government with care and prudence.

5.2 Treatment Aid Bank (TAB) / Treatment Fund and Zero Interest Loan Facility

Under the circumstances described in 4.6, the government should form a **Treatment Aid Bank (TAB)** to aid the poor people affected by chronic disease and to make the system transparent and convenient to common people.

It is a setup of economic activities which will ensure the success of compulsory health insurance programs. This bank will collect installment of insurance, provide loans to poor patients, allot grants of the government and simultaneously it may regulate other financial activities of social safety net programs of the government. A guideline should be prepared by the experts of banking sectors, economists, and medical sectors to run the Bank. The interest rate should be 0% or near this. The beneficiaries will be selected from the online database of poverty which is stated in 5.3. The loan sanctioning procedure should be easy. 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.

5.3 Create an online Database For Rural Poor:

For poverty alleviation and implementation of any plan, adequate and appropriate information is the precondition without which it may come to 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.

People/ The Poor should be Categorized in the following way

Group: Pv2- (Poor Two Minus, Pv--), Very Poor, Extreme Poor,

Group: Pv1- (Poor One Minus, Pv-), poor,

Group Sv1+ (Solvent One plus)- Solvent +

Group Sv2+ (Solvent two plus)- Rich ++

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.

Final decision:

Category of the Considered Family: P2- /P1-/Sv1/Sv2

a. Date of Evaluation:…….

b. Notify with a date if any change is made by a complain……

a. Any comments/ Complaints by any persons

b. Signature of verifier and authority with date

5.4 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

5.5 Establishing Union Health-Statistic and Information Center (UHSIC): To collect and preserve all kinds of information related to health, UHSIC should be established.

5.6 Enrich Infrastructure: Sufficient wards, beds, office space, doctor chambers, lab rooms. If necessary, multi storied buildings can be built.

5.7 Appoint Sufficient Doctors, Nurses, Technicians and other Manpower: If necessary, separate organizations like PSC should be established to appoint doctors, nurses, technicians etc.

5.8 Proper Utilization of Government Fund: Misuse of Government is a great obstacle towards the development of health sectors. A Monitoring authority has to be formed who will supervise development activity including proper utilization of funds.

5.9 Establish Sufficient Medical college/University/Specialized Hospitals and other institutions: At district or regional level, Medical college/University/Specialized Hospitals and other institutions should be established so that rural people can easily go and receive treatment.

5.10 Code of conduct for private practice: Rural people has to go Upazila and district level and seek treatment from private practitioners. With a view to preserving the interest of the common patient, Code of conduct for private practice should be prepared. 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 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[11].

5.11 Improving Grievance Redress System:

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 authority who will have a hearing with both parties present, find the truth, and let both parties know the facts and the action taken against the accused. The Authority will have the right to work independently without any interruption.

6. References

1. Shakeel Ahmed Ibn Mahmood (2012) Health system in Bangladesh ,Health System and Policy Research (vol. 1, issue 1)
2. Sameh El-Saharty, Michael M. Engelgau, KararZunaid Ahsan, Tracey L. P. Koehlmoos Tackling Non Communicable diseases
3. KhaledaNazneen (August 2001) Governance of Healthcare Sector in Bangladesh, , CPD
4. Henry B Perry (1999) A Vision for the Twenty-first Century published by The University Press Limited (UPL), The World Bank.
5. Taufique Joarder, Universal Health Coverage in Bangladesh: Activities, Challenges, and Suggestion.
6. Md Ziaul Islam, Assistant Professor, Department of Community Medicine, National Institute of Preventive and Social Medicine (NIPSOM), Mohakhali, Dhaka, Sanjoy Kumar Chowdhury, MBBS Student (Batch K-61), Dhaka Medical College, Dhaka, Sharmin Farjana, MBBS Student (Batch K-60), Dhaka Medical College, Dhaka Attitude of Rural Community towards Health Care Utilization at Primary, (DOI: https://doi.org/10.3329/jom.v9i2.1433) .
7. Aasha Mehreen Amin, (2008) Getting Health to Rural Communities in Bangladesh (Article), Bulletin of the World Health Organization,
8. Randall P Elias, Tianxu Chen and Calvin E. Luscombe (2014), Comparisons of Health Insurance Systems in Developed Countries, Encyclopedia of Health Economics, Elsevier Press,Inc.
9. Guy Howard Healthy Village: A guide for Community and Community Health Worker

[11] The New Age, February 13 2019

10. Daily star (2008). Better health for all. Available at https;//www.
11. Thedailystar.net/newDesign/news-details.php?nid=55870. Accessed on may 11 ,2012
12. Daily star (2011) Bangladesh's commendable advances in healthcare. Available at: https//www.thedailystar.net/newdesign/news-details.phn?nid=233141.Accessed on may 8, 2012.
13. Ferdous Arfina Osaman (2008), health policy programmes and system in bangladesh. Achievements and challenges. South Asian survey. p263-288.
14. New age (2008). Rethinking how the state delivers health services. Available at: https://www.newagebd.com/edit.html#2. Accessed on:may,22,2012\
15. a) Sayera Khatun, village-Durgapur
    b) Dr. Obaidullah Dulal (LMAF)- Kalupur
    c) Dr. Golam Sarwar, MBBS
    d) Dr kamrul Huda, Lecturer
    e) Zillur Rahman, Ex Chairman, Boalia Union Parishad
    f) Md. Mozibur Rahman, Asst. Professor, Kasiabari
    g) Md. Rezaul Karim, village-Durgapur
    h) Sharmin Akhter, Health Care Provider
    i) Md. Josim Uddin, village-Lalapur
    j) Md. Ali Hasan, village-Kasiabari
    k) Amit Hasan Raju, village-Kanchontola
    l) Md. Ferdous Mahmud Antor, village-Kalupur
    m) Abdul Kader Zilani Bulet, village-Polashbona
    n) Md. Rabiul Islam, Secretary, Boalia union