Chapter 4

Causes of under utilization of THC

In Bangladesh majority of the population lives in rural area with per capita income around $260. The country has limited resources and it is facing continuous difficulties of managing different sectors. On the other hand political instability and corruption hampers country's progression. Natural disasters attack almost every year and destroy many valuable resources again. Moreover, poor literacy rate and disease pattern causes more burdens for the government (Appendix, Table A.1 and A.2).

4.1 Thana Health Complex (THC)

The Thana health Complex (THC) is the first referral level health care delivery institution in the rural area. There are nine doctors in each THC include three junior consultants of medicine, surgery and gynecology, two medical officers, one medical officer for maternal and child health and one dental surgeon. In addition, there is one Family planning officer, five nurses and other paramedical and non-medical functionaries. The THC comprises of thirty-one-bed in-patient department, outpatient department, and one family planning with one domiciliary component. All services are delivering free of charges but usually patients consume the private services with fee for service.

4.2 Problems of THC

Though in rural health care the government provides a modern system but unfortunately it is under utilized especially the inpatient department of THC. There are various causes of that are stated below.

4.2.1 Health Seeking Behavior of people

The world is growing fast with various types of modern technologies especially in health care market. The modern science has developed enormously in medical field and the cost of health care has increased very high but still health seeking behavior of rural people in Bangladesh remains same as 100 years before. The rural people of Bangladesh use drug store, quack doctors, traditional healer or religious person. The health care utilization pattern of Bangladesh is described in Appendix Table A.4. It is easy to interpret from Table A.4 that public facilities are utilized at minimum level in rural are that is only 7.8%. Self-care and drug store occupy big part in providing health care.

4.2.2 Unavailability, Limited resources

In theory total 381 THC was launched to bring the health care to the doorsteps of the rural people but in fact out of nine doctors in each THC less than 50% doctors regularly attend their office. Some of them are busy with private practice or any thing else. Most of the doctors argue about their absenteeism for transportation problems, resident problem or children's education problem. But they hide the truth that they take the chance of governmental weakness of monitoring and enforcement of regulations. Along with doctors other health personnel do the same offence.

Not only the manpower but other health care input likes drugs, surgical instruments are unavailable. The government of Bangladesh spends only 5.31% of total budget in health and major share 59% of this total budget spends for pay and allowance of health personnel. Therefore, unavailability is obvious. Table 4.1 shows the budget allocation for health sector during 1988-89 to 1996-97.

4.2.3 Quality of care

Quality of care is always questionable in THC but it is because of unavailability also and weak enforcement of regulations. Doctors and health personnel are usually reluctant as they are salary- paid and government regulations do not force them to do works seriously.

The same doctors can do private practice after hour, which is most profitable for them, and they are busy with private practice. The government is already spending about 70% of his health budget (Table 4.1 and Table 4.2) to give pay and allowance to the health personnel therefore, it is not possible to give them additional incentives for working at THC.

Table 4.1- Budget allocation for health of Bangladesh during 1988-89 to 1996-97, figure in Crore of Taka (1Crore= 10 million)

Financial year	Health	Family planning	Total	National total	% for Health
1988-89	404.60	241.66	646.26	15657.06	4.13
1989-90	472.07	327.25	799.32	19113.80	4.18
1990-91	522.79	324.47	847.26	23791.27	3.56
1991-92	602.00	371.50	973.50	15940.65	6.10
1992-93	738.33	312.01	1050.14	17234.00	6.09
1993-94	870.27	444.19	1314.46	19009.45	6.91
1994-95	1012.80	452.90	1465.72	21300.00	6.89
1995-96	1097.99	364.09	1462.08	29852.76	4.89
1996-97	1325.96	442.63	1768.59	33291.52	5.31

Source – Bangladesh Health Bulletin, 1996

Table 4.2 shows the proportion of revenue expenditure on health sector of Bangladesh in different financial year that may help to understand cause for unavailability in rural area. As the unavailability is marked, rural people easily bypass the THC guessing the normal phenomena of insufficiency and unavailability. They do not bother for referral system that is almost non exist and go to urban hospital directly. As a result THC facilities are under utilized especially indoor facilities.

Table 4.2 Proportionate revenue expenditure on health in Bangladesh

Financial Year	Pay & Allowances	Contingencies & diets	Medical-Surgical requisite
1983-84	54%	23%	23%
1984-85	60%	19%	21%
1985-86	65%	15%	20%
1986-87	66%	17%	17%
1987-88	67%	16%	17%
1988-89	65%	17%	18%
1989-90	67%	17%	16%
1990-91	64%	16%	20%
1991-92	67%	16%	17%
1992-93	68%	15%	17%
1993-94	63%	20%	17%
1994-95	61%	24%	15%
1995-96	69%	15%	16%
1996-97	69%	12%	19%

Source- Bangladesh Health Bulletin, 1996.

4.2.4 Excess capacity

With nine doctors THC has some excess capacities, as it is udder utilized. The Operation Theater and surgical instruments are again underutilized due to multiple causes and that are related with the main problems. The investment sits idle in THC. From bed occupancy rate of different hospital under utilization of THC is visible Table 4.3 and Table 4.4.

Table 4.3- Hospital Bed Occupancy Rate in Different Hospitals of Bangladesh (1993-96)

Type of Hospital	Occupancy rate			
	1993	1994	1995	1996
Post Graduate Hospital	94.56%	108.15%	114.32%	105.22%
Medical Hospital.	107.73%	95.90%	116.02%	91.41%
General Hospital	43.86%	69.86%	125.55%	101.33%
150 Bed District Hospital	40.52%	74.37%	63.93%	111.53%
100 Bed District Hospital	109.76%	113.15%	113.21%	119.58%
50 Bed District Hospital	97.27%	100.72%	111.71%	113.65%
Thana Health Center	54.30%	61.66%	58.87%	63.03%

Source- Bangladesh Health Bulletin, 1996

Table 4.4-THC statistics OPD and IPD patients from 1992-1996

	1992	1993	1994	1995	1996
Total bed	12400	12400	12400	12400	12462
IPD patients	558626	635927	649412	639412	710137
Bed occupancy rate	51.41%	54.30%	61.66%	58.87%	63.03%
OPD patients	21687003	23509297	16226064	18526064	15648120

Source- Bangladesh Health Bulletin, 1996

4.2.5Traditional Believes and Superstitions

Literacy rate is very low in rural Bangladesh and most of the people have some common believes. Some minor illness they do not like to notice at first that may create big problem later on and they believe illness is God-gifted punishment. They just ignore their illness and do not use the existing health facilities or go to religious healer or traditional healer or do self-treatment from drug store. There are superstitions that female patients

are not allow to visit male doctors or not allow to take any family planning measure which they think type of sin. As a result THC is again **under utilized** to some extent.

4.2.6 Transportation problem

Transportation is another common problem for rural area. Some of the villages or Unions have no good communication with the respective THC especially in the rainy season. In rural area boat or cart is the main media for transport but during rainy season cart is not appropriate and dry season boat do not work. Therefore people usually fail to reach THC in due necessity. As a result THC faces **under utilization**.

4.2.7 Population movement

Flood and other natural disasters force every year to move some people from village to town. Beside this limited land is not enough for people to cultivate and get jobs all the seasons and increase demand and family burden leads them to move for towns where they think jobs are available. Therefore, number of rural people has migrated from rural area to urban area and no more utilize rural health care facilities.

4.2.8 Weak information system

The information system is very weak all over the country and it is worse in rural area. Therefore, people do not know what facilities are there in THC and what not.

4.2.9 Non-existence of referral system

The referral system does not work at all though there is a system to refer patient from Union-sub-center to THC. For lack of incentives and other facilities private doctors never refer patients to THC.

The study has tried to focus rural problems related with causes of under utilization of THC but there are others sectoral problems that affect health facilities in THC, which is not discussed here.