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The Incentives and Constraints of Government Doctors in Primary Healthcare Facilities in Bangladesh

Naomi Hossain
Rashid-uz-Zaman
Nicola Banksand
Hanne Cecilie Geirbo

BRAC Centre, 75 Mohakhali, Dhaka 1212, Bangladesh
Tel: 9881265, 8824180-7 (PABX), Fax: 88-02-8823542
Email: research@brac.net
Web: www.brac.net/research

BRAC Research & Evaluation Division

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E-mail: research@brac.net, www.brac.net/research
Telephone: 9881265, 8824180-87

For more details about the report please contact: naomih@msbx.net

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ACRONYMS

ACR	Annual Confidential Report
BUET	Bangladesh University of Engineering and Technology
CIET	*Centro de Investigación de Enfermedades Tropicales* (Tropical Disease Research Centre)
CMMU	Construction and Maintenance Management Unit
CS	Civil Surgeon
CSO	Civil Surgeon's Office
EOC	Emergency Obstetric Care
FCPS	Fellow of the College of Physicians and Surgeons
FMRP	Financial Management Reform Programme
LLP	Local Level Plan
MO	Medical Officer
MP	Member of the Parliament
NGO	Non-governmental Organization
RMO	Resident Medical Officer
SSPS	Social Sector Performance Survey
SSPQS	Social Sector Performance Qualitative Survey
UHC	*Upazila* Health Complex
UHFPO	*Upazila* Health and Family Planning Officer
UHSIC	*Upazila* Health Service Improvement Committee
USC	Union Sub-Centre

INTRODUCTION

The incentives and constraints shaping the behaviour of health service staff are increasingly recognised to be the key determinants of how effectively public healthcare systems deliver services, particularly at the community level. Problems of absenteeism and high vacancy levels; illegal charges and corruption; and incompetent, rude, neglectful and generally unprofessional treatment of patients, have all been identified as significant factors in patients' dissatisfaction and poor health service quality; all are rooted in problems of weak incentives and motivations to attend or provide quality services. These are particularly acute problems given that they tend to be most severe in countries that can least afford to waste their precious medically-trained human resources.[1]

This paper presents new evidence about the personal and professional motivations and incentives of government doctors in Bangladesh, a country in which health services have notoriously suffered from the problems listed above. Based on original research in government primary health care facilities in Bangladesh, the paper explores three motivating contextual factors relating to how doctors behave in rural government health facilities: a) resource levels and management conditions; b) conditions of governance and accountability, including institutionalised practices of corruption and formal and informal mechanisms for creating pressures for accountability to patients and communities; and c) social, personal and domestic factors.

Background and methods

The paper is one of a series of research outputs based on the Social Sector Performance Qualitative Study (SSPQS), a qualitative study of governance and management in health and education facilities across Bangladesh in 2006. The SSPQS was a follow-up to the Social Sector Performance Surveys (SSPS), public expenditure tracking surveys undertaken in the government health and primary and secondary education sectors in 2004 and 2005. The purpose of the SSPQS was to add depth to the understanding of key issues that arose from the SSPS, using qualitative methods to triangulate, explore, and illustrate selected findings. The focus in the SSPQS, from which the present paper draws, was on exploring the relationship between the performance and quality of services provided by schools and clinics, on the one hand, and how these facilities are governed and managed, on the other.[2]

Research was conducted on 12 health facilities, 6 at *upazila* and 6 at union level in 6 districts across Bangladesh. The evidence on which the present paper is based is drawn from

- In-depth interviews and discussions with 31 doctors working in or attached in supervisory roles, to 10 of these 12 facilities. One set of questions covered issues such as career history, personal circumstances and professional aspirations, as well as working experiences within the facility. Health sector managers (Resident Medical Officers or RMO, responsible for the *upazila* in-door or hospital services), *Upazila* Health and

[1] For a global view of these issues, see WHO (2006) and World Bank (2004). On Bangladesh, see Chaudhury and Hammer (2003) and CIET (2004).

[2] The health sector public expenditure tracking survey is published as FMRP (2006). The Social Sector Performance Qualitative Survey is published as FMRP (2007). Other papers from the SSPQS study, including one on the professional experiences of nurses and another on patients' views of *upazila* and union health facilities are to be published as BRAC Research and Evaluation Division research reports (in Bangla).

Family Planning Officers (UHFPO, responsible for monitoring and coordinating health and family planning activities across the *upazila*) and 5 Civil Surgeons (district level health official) were also interviewed about their experiences as managers.

- Focus group discussions (FGD) with nurses on their professional experiences, including their relations with doctors and patients.
- Interviews with patients immediately after their visit to the facility regarding their experiences on that occasion.
- FGDs with community members relating to other experiences in the local health facility.
- FGDs with members of the local community elite, to elicit their views on local health services.

The findings from these qualitative research activities were analysed and interpreted in light of the findings from the main national survey on the health sector (reported in FMRP 2005).

The overall approach of the paper is to focus on findings that appear to illustrate patterns of behaviour and attitudes common across facilities, preferably where these are supported by national survey data or evidence from other sources. A limitation of the approach is that at times it may appear to give priority to the views of doctors, even when these views can be seen to justify or conceal inappropriate or unprofessional behaviour. An attempt is made to address this problem by, as far as possible, interpreting doctors' perspectives in light of the views of patients and other evidence on how doctors behave. All interpretations of the material presented here represent efforts by the researchers to interpret the incentives and constraints facing doctors in Bangladesh using as wide a range of supporting evidence as possible.

Findings in brief

The present paper attempts to situate doctors' behaviour within a fuller understanding of their contexts and the constraints they face within the Bangladesh health system. The main findings of the paper include that:

- The management of physical facilities, equipment and resources, including human resources is severely constrained by shortages and the lack of facility-level management authority; these constraints significantly weaken incentives for doctors to be present and to perform effectively. The few doctors actually present in rural health facilities are likely to be over-burdened with patients and demoralised by the poor facilities and equipment.
- There are no effective formal mechanisms for patient feedback or doctor accountability, although strong informal pressures are in place which compel doctors to collectively ensure a minimum presence. Informal pressures can turn violent, however, and are a cause of doctors' fears for their personal security.
- The material incentive and career structure for government doctors means that rural health postings are not the most desirable jobs, although there are some groups of doctors who can build lucrative private practices and find satisfaction in the role of rural government doctor.
- Social, personal and domestic factors influence doctors' motivations to be present or to perform, but they pull in different directions, with humanitarian considerations to serve the poor competing with domestic and social factors which attract doctors away from rural facilities.

MANAGEMENT AND RESOURCE ISSUES WITHIN HEALTH FACILITIES

Government doctors at all levels emphasize the constraints faced by the inadequacy of the physical facilities, equipment and supplies available to *upazila* and union health facilities. Doctors on the frontline of service provision also complain of being overstretched: too few doctors are posted in rural facilities, not all of those are regularly in attendance. Job satisfaction levels and professional morale are also low. Health sector managers (Civil Surgeons, RMOs and UHFPOs) have little power to address these problems, however: they have little managerial discretion or authority to procure supplies or building repairs or to hire, fire or in other ways discipline facility staff.

PHYSICAL FACILITIES, EQUIPMENT AND SUPPLIES

One constraint reported by doctors on their ability to provide effective services is that free medicines, equipment and other supplies are inadequate. Spending on medicines across the system is low, at around Tk. 5.4 or less than US$0.1 per capita spent on average at *upazila* health complexes.[3] And drug spending allocations are determined by *upazila*, without taking into account differences in population size or health and socioeconomic status. Per capita spending on drugs and supplies at the *upazila* level is estimated to vary between Tk. 2.3 and Tk. 10.1, depending on population size (FMRP 2005:71). One RMO complained that the next *upazila*, with three unions, received the same allocation for drugs as his, with 13. A doctor at a union sub-centre explained that drug supplies frequently ran out halfway through the allotment period. Experience with drugs running out and concerns that staff or patients may sell free drugs on the open market have encouraged a number of strategies for managing the scarcity. One officially sanctioned method is to instruct doctors not to provide free medicines for courses of longer than two days at a time, after which the patient is required to return to collect a further two-day supply. Other forms of rationing reported by doctors to be used in union facilities included opening only a couple of days a week, in a demonstration of how resource scarcity can be used to justify absenteeism.

Some doctors also argue that it is not always appropriate to hand out free medicines simply because patients expect these. In the view of some doctors, many uneducated patients do not understand how modern medication works and demand pills and injections in the belief that these will solve their health problems. In fact, the health problems of the poor are primarily caused by poverty, overwork and malnutrition, for which medication can do little. But whether they withhold medication because supplies are short or because to do so is appropriate, doctors are aware that this leads to considerable patient dissatisfaction. A survey of government health service users found that only 23% had received all their drugs free in 2003, a figure which had actually declined from one-third in 1999 (CIET 2004).

Constraints faced by frontline service-providing staff are not always recognised by those who view the situation from a distance. District-based Civil Surgeons did not usually see medicine supplies as a constraint to service provision. One UHFPO explained:

[3] This compares to public sector per capita spending of around US$5.6 in Thailand, US$0.85 in Indonesia and US$0.38 in Myanmar. These figures may, however, include tertiary and other levels of spending and therefore not be strictly comparable with *upazila* spending figures (FMRP 2006: 71).

> Everyone knows that the supply of medicine is very poor. We get an annual supply of medicine worth Tk. 465,000 only. But our politicians and the senior officials do not want to accept or admit this fact. We have to say that 'we have everything'. I raised the issue of inadequate supply at a meeting and the Civil Surgeon was very annoyed with me.

This may not necessarily be an official cover-up, as the situation looks different to those who do not have to deal with irate patients on a daily basis. Surveying the system as a whole, for example, the SSPS survey in health found that facilities in general had a 'reasonable' supply of drugs and other commodities in stock (except for safe motherhood drugs; FMRP 2005). This finding possibly reflects the success of methods of managing or rationing stocks, while discounting patients' dissatisfaction and constraints on doctors' effectiveness that these lead to.

Some doctors were also concerned about the variety and quality of drugs available, believing that some government-issued drugs are less effective than those available in the market. Other concerns included the lack of transportation for delivering medicines to *upazila* and union facilities and for officials' own transport. The availability of biomedical and other necessary instruments was also reported to be a serious constraint. Most *upazila* and union level facilities lack the full range of equipment required to fulfil their basic service mandate. Doctors reported of refering patients to private diagnostic centres or clinics for tests, scans and xrays, which patients interpret as attempts to earn commissions on unnecessary referrals. UHFPOs and RMOs also reported that when the equipment is available, they frequently lack supplies such as xray film, ambulance fuel, or pathological reagents. In one of the facilities studied, there was a specialist Dental Surgeon in post, but no dental equipment.

Basic infrastructure and facilities also present constraints. The SSPS survey in health found that only around half of facility buildings could be judged as being in good physical condition (SSPS 2006; chapter 6). Many *upazila* health facilities lack toilet or bathing facilities for patients, regular electricity and water supplies, adequate security arrangements, or even functioning roofs and sewerage systems. Many doctors reported that the accommodation provided was so poor that they were unwilling to stay at the facility. In one *upazila*, the roof of the accommodation assigned to junior doctors had been leaking for years. The situation appears to be even worse at the union level: one doctor described his centre as small and congested, with little air or light. Members of the team who conducted the present research described another union sub-centre building as follows:

> [It] is made of tin, which has become red with rust. Its floor consists of soil. There is only one room, with one table by the window. Here a pharmacist sits. Beside him a doctor sits on a chair. There is no extra room or table for the doctor … No regular cleaner is provided, and a bat was hanging from the ceiling.

In addition to the practical constraints on their capacity to function effectively, doctors are evidently demoralised by these working conditions. One said: 'two doctors sit in one room with a piece of hardboard between tables. How can a doctor find the frame of mind to treat patients in such a manner?'

Problems with inadequate and poor quality facilities, equipment and supplies are compounded by the lack of authority or discretion to increase or improve the efficiency of allocations of supplies. As one UHFPO put it: 'first the equipment must be available, and then comes the question of utilisation'. The cumbersome process of procuring additional resources

or even routine maintenance[4] limits the extent to which managers can address constraints relating to supplies, equipment and facilities. One UHFPO reported having written to the Civil Surgeon's office for the x-ray films and dental equipment that they lacked, failing which they had made direct contact with the Central Medical Stores Depot. A significant factor determining the effectiveness of service delivery at the facility level is the lack of managerial authority over resources at this level: less than 9% of budget allotments are available for discretionary spending by managers (SSPS 2005: 29). We turn now to an examination of how the lack of authority to hire, fire, discipline and reward staff shapes human resource management.

HUMAN RESOURCE MANAGEMENT

Staffing levels

The SSPS survey found that the average number of doctors (excluding UHFPOs and RMOs) actually in post in *upazila*s across the country was around half that of the numbers officially sanctioned for these facilities, at 3.78 (instead of 7; FMRP 2005:48). Few facilities have specialist staff in post (around 76% have no gynaecologist, and some 90% lack other specialist doctors (FMRP 2005:48)). The situation was even worse in union facilities, where some 68% of union sub-centres had no doctor in post at all. Inadequate staffing levels create pressures on those doctors in post, and inevitably affect the quality of service provision. There were signs that the situation had begun to improve in 2006, the year following the SSPS survey, as more doctors were being recruited through the civil service examination; in many facilities, the research team found new doctors had been recruited. One *upazila* had recently recruited three new doctors, much to the relief of the RMO:

> Before the new doctors were recruited, it was only the UHFPO and I here. It was a terrible time. I had to work around the clock and I had to manage everything in both the in-patient and out-patient departments. I had a heart attack at the time due to overwork, stress, and anxiety.

While doctors in facilities where all posts were filled reported treating 150 to 200 people a day, in one facility with five vacant posts, the workload rose to 200 to 300 patients per day. Such high volumes are consistent with SSPS findings of high levels of use by catchment area populations – the busiest *upazila* facilities can see over 9,000 and union facilities 2,000 patients per month, respectively. It seems likely that under-staffing leads to excessive pressure on individual doctors, and is unlikely to produce job satisfaction or to encourage regular attendance.

Absenteeism and loss of service time

The notion of 'ghost doctors' – doctors who are on the payroll but make only token appearances in health facilities - has captured the public imagination, largely thanks to a World Bank survey conducted in 2003 which showed absentee levels of 41% of government doctors in *upazila* and 44% in union facilities (Chaudhury and Hammer 2003). The SSPS survey in health conducted in 2004 found similar levels of absence: 35 and 42% respectively. However, the SSPS survey explored the causes of these absences, and found that a less startling 8% of *upazila* and 21% of union doctors were absent without permission, the rest were either on permitted leave or absent for official purposes (FMRP 2006: 66).

[4] Frustrations were also apparent with the Central Medical Maintenance Unit (CMMU), with only one UHFPO reporting that he would call in the CMMU for routine maintenance. It seems the CMMU is notorious for delays and inefficiency, and most facility managers preferred to carry out maintenance using their own resources.

Whether permitted or not, it is clear that the regular absence of doctors severely compounds the problem of high staff vacancy levels. A rough calculation gives a sense of the scale of the problem. If just over half of doctors' posts in *upazila* facilities are filled, and more than a third are absent at any given time, the total number of hours of doctors' time actually available for service delivery at the *upazila* level can only be between one-quarter and one-third of that planned for within health policy. The situation is likely to be considerably worse in union facilities.

Why are doctors absent so much of the time? Public discussion of the issue suggests the common assumption that the high social and educational status of doctors makes them reluctant to live in rural areas for extended periods, and that opportunities for private practice are greater in cities, also discouraging rural postings. Based on data collected from doctors' career history information and interviews about their personal and professional aspirations, the present research has been able to develop a more nuanced picture of the causes of absenteeism among government doctors. This suggests that high levels of absenteeism are likely to be concentrated among particular groups or types of doctors and at particular stages of their lives.

How the careers of government doctors are structured has a particularly direct impact on their incentives to attend and perform in rural facilities. Doctors interviewed for this research explained that the imperative of completing postgraduate training was a key factor behind doctor absenteeism:

> Doctors want to stay in Dhaka for higher studies. Some junior doctors are home sick and remain absent frequently (Civil Surgeon).
> Some MOs remain absent every now and then … Everyone is concerned about their career, so they remain absent and study (Recently post-graduated gynaecologist).

It helps understand how the incentives of young doctors are structured. A junior doctor in a rural (*upazila* or union) facility typically earns a small salary and has not been there long enough to build a private practice. This doubly disadvantageous position is likely to last the full two year *upazila* or union posting required of new recruits to government service. Many young doctors are reported to treat those two years as a sentence being served in preparation for further training, rather than as a posting to settle into or to develop professionally. Those two years will, very likely, be spent studying for the FCPS examination or other postgraduate study opportunities, rather than building up a private practice or a good relationship with the local user-community. Their performance at the *upazila* or union level has no impact on their likelihood of gaining access to training or other opportunities.

More senior specialist doctors[5] also have limited incentives to stay in rural posts, as they have considerably greater opportunities for private practice in cities. And affluent specialist doctors with large private practices also find rural postings unattractive because their families are likely to remain in Dhaka, where schools and other amenities are more suited to their lifestyles.

Groups less likely to be absent and for whom vacancy levels are lower are the RMOs and UHFPOs. These doctors are typically on a government health service administration career-track; lack postgraduate qualifications; and who may be posted to their districts or even

[5] There is provision in each *Upazila* Health Complex for four specialist doctors in addition to the RMO, the UHFPO, two generalist doctors (usually junior doctors) and a dental surgeon. All positions requiring further training have high vacancy rates: 69 per cent of *upazila* facilities have no anaesthesiologist; 73 have no gynaecologist; 76 lack a dentist; 90 per cent have no specialist doctor; and 86 per cent lack a specialist surgeon. By contrast, only 4 per cent of *upazila* facilities lack a UHFPO, but a still high 39 per cent have no RMO (FMRP 2005: 48).

*upazila*s of origin. Their incentives for being present include a) stronger pressures through the administration for them to be present; b) greater opportunities for building private practice over a period of time as the reputable government '*boro daktar'* ('big doctor'); c) local origins. The final section of the paper will look in more detail at how social differences between different groups of doctors lead to differences in their incentive structures.

Other factors thought to affect doctors' attendance included concerns about security, which appeared to concern women in particular (and on which more below), and the poor quality of doctors' accommodation.

A particularly important factor in influencing levels of absenteeism among doctors is the weakness of administrative mechanisms for disciplining absenteeism or other professional breaches. Neither Civil Surgeons (the district-level administrative authorities) nor UHFPOs (*upazila*-level health service administrators) have the authority to hire, fire or even transfer doctors who perform poorly or are regularly absent; at best they can make recommendations to higher authorities at the Directorate level. One UHFPO bleakly stated:

I have yet to see any action having been taken against any doctor [for absenteeism].

Another UHFPO explained the importance of good connections:

> The doctors who remain absent usually have good relations with the higher authorities and politicians. If we look for the doctors, the politicians stand beside him and say, 'Don't bother looking for him, he will not be able to go to your facility'.

The lack of authority to discipline doctors, and the negative impacts on facility performance was highlighted most graphically by another UHFPO:

> A doctor has been unofficially absent from this facility for about three years. For these years his post has not been vacant [and so no replacement could be brought in]. Many letters have been issued. Now there will be a final circular in the newspaper addressing him to join, then he will be terminated. It takes a long time to terminate a government employee.

A final factor relating to absenteeism is the that UHFPOs and RMOs have a number of responsibilities that keep them out of office for several days a month, including meetings with other officials, NGOs and agencies, as well as public health and disaster management activities. Doctors stationed at union centres may also be deputed to *upazila* facilities when these face staff shortages. Other duties constitute more of a burden, particularly those dealing with court summons or the police. Respondents emphasised the time-consuming nature of such duties, often requiring long distance travel for police or court appearances. In some cases, doctors are also required to staff polling stations during elections.

Job satisfaction

An important factor relating to absenteeism is job dissatisfaction. Government regulations specify that doctors must serve at the *upazila* or union level for two years after recruitment. The research found that new recruits are frequently frustrated about not being able to use their medical training to its full extent, as the health conditions they see at the *upazila* level are minor, common illnesses. Many patients suffer from no specific disease, and complain of weakness and lassitude, usually the result of poverty and malnutrition. One doctor described these as 'vague patients'. 'Writing up the names of a few drugs is not a job for a doctor', another young doctor complained. Some worry that postings in remote health facilities may

make them forget their skills and training, compared to the complicated medical conditions that they see at medical college: 'two years spent at *upazila* level is two years backward', said one doctor. The facilities and equipment are also inadequate for specialists to use their skills to their full extent:

> I am a postgraduate gynaecologist, but there are no facilities to perform gynaecological and obstetrical operations in these facilities, so I cannot apply my knowledge and skill … Despite being specialised, I am posted here, where there is no scope for me to deliver my services as a gynaecologist (Newly-recruited doctor at an *upazila* facility).

Doctors also fear the consequences of any failures to cure patients, despite the fact that they have no control over the supplies of drugs and equipment on which recovery may depend.

A UHFPO explained that there are few material and other incentives through which they can motivate staff. Health facility managers emphasised the effectiveness of motivational techniques rather than penalties (which they are unable to impose) in bringing about improvements in staff performance. 'Emphasising skills, being sympathetic, and showing a friendly attitude and justice are imperative', stated one UHFPO. Motivational techniques included encouraging staff to be conscientious with respect to their responsibilities; showing appreciation for their work; giving regular feedback; providing tea and snacks; working towards shared goals and ambitions; or praising small achievements.

GOVERNANCE AND ACCOUNTABILITY

ACCOUNTING TO SUPERIOR OFFICERS

UHFPOs are responsible for monitoring the performance of the *upazila* health facility and staff, on which they report monthly to the civil surgeon's office at the district level. However, staff at different levels complained of not receiving feedback on their performance from their superiors. Most doctors saw performance appraisal and feedback as valuable and important. Newly-recruited doctors valued their regular meetings with their managers, who in turn felt that staff morale was raised by regular meetings and rewards for good performance. But the power of appraisal and monitoring to create incentives for good performance is severely weakened when corrupt means used to improve a poor service record:

> It is very possible that a doctor may never be present in the USC, but his [report] is good. For example, one newspaper published a story that a candidate was absent for his examination, but his paper was submitted. How could this be possible? If the president of the Bangladesh Medical Association makes a phone call, then everything is ok. So how can the ACR [Annual Confidential Report, the main feature of the system of staff performance evaluation in the civil service] work? The whole system is now corrupt!
>
> It's [performance evaluation] meaningless. Power is everything. One can be punished if he has no power even if their performance is good. Likewise, if you have any relationship with the minister, then everything is ok. (Interviews with doctors, March 2006).

The civil surgeon monitors the functioning and performance of health facilities in the district, but the frequency of their visits depends partly on the accessibility of the facilities. One civil surgeon explained, 'As [an *upazila*] is very remote, I have only had the chance to visit this facility once in the last year', and was forced to rely on telephone conversations. Civil Surgeons noted the lack of an official system for measuring and ranking the performance of different health facilities, and they usually observe the facility, speak to patients and staff, and check records and facility documentation. Many health facility staff felt that regular monitoring by the civil surgeon's office had the potential to play a major role in ensuring effective service delivery, although they reported being over-burdened and felt insufficient personnel was considered to be an obstacle: some proposed the situation could be improved by creating deputy civil surgeon posts at all civil surgeon's office irrespective of size of the district.

PATIENT PARTICIPATION

Service-user groups and feedback

Doctors recognised that the government health system lacks an effective mechanism for enabling patient participation in facility governance, but most felt this was appropriate. Some doctors were adamantly against patient participation in any substantial form:

> People do not know about the health system. They cannot contribute to the management of health facility. People should not be involved in running the health facilities (RMO).

Another doctor felt that patients could not participate, as 'it is a specialised service and people do not know the details in the system'. The common view among doctors appeared to be that, at best, patients could be involved in health facilities through donations of supplies or equipment:

> Yes, patients can contribute [to hospital management] by making donations and contributions to the UHC, or by helping new patients (RMO).

> Yes, patient contributions [to hospital management] can be useful in some aspects. For example, financially solvent patients can bear the costs of their treatment – this will ensure that poorer patients get the full course of free medicine. Rich people can also donate many types of necessary items to the health facilities (UHFPO).

The statement of one doctor, that patient participation could 'contribute usefully to the management of the facility and increase the quality of services' by orienting them more closely to the needs of the poor stood out as the minority view.

There was generally more support for patient feedback mechanisms than for fuller forms of participation, although many doctors also felt that existing provision, including informal means by which patients communicate personally with staff, was adequate. One UHFPO claimed he had developed a system through which hospital staff would elicit the views of patients waiting for services about their needs and their experiences at the facility. In response to a request by the research team to observe this practice, however, he noted that 'staff shortages' had caused them to discontinue the practice. There was some recognition of the weaknesses of such casual approaches to gathering service-user feedback: it leads to reactive rather than proactive actions; they cannot always listen to patient complaints during busy opening hours; patients may be unwilling to make complaints in person; and verbal complaints may be forgotten as they are not formally recorded.

There was a shared perception that formalising grievance procedures might help improve services. One popular solution was a complaints box: the issues raised could be discussed at regular staff meetings, making it easier for doctors to learn from their mistakes and to allow progress on resolving problems to be tracked. Practical objections to such a system included that it would be of no use to illiterate patients, and that typical patient complaints centre on the availability of medicines, a matter over which staff have no power. Nurses felt even more strongly than doctors that patients already have ample opportunity to complain, and that it should not be made easier for them to do so. It is likely that their lower social status and gender (doctors are usually men and nurses are all women) places nurses more squarely on the frontline, where they bear the brunt of complaints about inadequate services.

Given the general resistance to patient participation in the governance and management of health facilities, it is no surprise that the Local Level Plan (a policy initiative to improve accountability to health service users) is dysfunctional. Not all doctors were aware of the Local Level Plan. Those who knew of it, explained that lack of instruction from above was the main reason for its failure:[6]

> There is provision for regular stakeholders' meetings in the Local Level Plan [which] was introduced in 2001-02. We sent the first Local Level Plan report to the centre [the Ministry]. But there was no feedback or further instructions. Recently we received a letter instructing us to restart Local Level Plan activities (Civil Surgeon).

The *Upazila* Health Service Improvement Committee is another formal mechanism intended to engage local politicians and community leaders in monitoring and participation in the health facility. The committees are of longer standing than the Local Level Plan, and nominally, at least, more active. However, their effectiveness depends on the commitment and interest of local politicians, in particular the MP. In most cases, the committees meet no more than once a year, and are usually then ritual events to celebrate a visit by the local MP. The rest of the time the committees do not meet, as one UHFPO explained, because 'if we organised it without him (the MP), he would be offended, so we cannot do this. A civil surgeon confirmed that instead of monthly meetings, their regularity depends on the interest and availability of the MPs, who chair the committees.

Informal pressures

The research found a range of informal pressures on doctors and health facilities through which patients attempt to influence services and hold service-providers to account. These range from fairly minor complaints to more serious acts of violence. The highly public form of free consultation that takes place in government health facilities may be quick and convenient for doctors, but it also provides dissatisfied patients with an instant audience and the opportunity to make public complaints in ways that embarrass doctors. A number of such instances were observed by the research team. Public grumbling about the service received was not always seen by poor patients as a formal means of complaint. It seems possible that such forms of complaint are possible because they are not seen as direct challenges to the status or authority of doctors, even though they might have the effect of ensuring the complainant receives more attention. In one case, a patient who had been observed complaining about her treatment denied that her grumbling amounted to a complaint. How, she asked, could someone like herself - a poor village woman – complain about people of such high status as government doctors?

[6] It is worth noting that one study found that interventions to improve accountability by a strategy of involving citizen participation through Community Groups set up with official guidelines 'appear to have had negligible positive impact or outcomes' on service delivery (Mahmud 2007: 68).

Both doctors and nurses interviewed for this research indicated that a difficult aspect of their job was dealing with dissatisfied patients, confirming that public grumbling is a source of pressure on health professionals. One doctor explained that.

> It is not possible to supply medicine when there is no supply, but they [the patients] will not understand this. Sometimes they create trouble. If a patient dies, sometimes they do not want to listen or to understand the consequences. They start to make trouble and destroy things.

A second form of pressure is the fear of violent attack. Attacks on health facilities or their staff are believed by health professionals to be reasonably common.[7] In three of the six health facilities studied there had reportedly been recent attacks by disgruntled members of the community,[8] in each case in response to perceived medical negligence. In an *upazila* facility identified by the qualitative and quantitative research to be particularly poor-performing, violence by community members were believed to be a reasonably regular occurrence. A patient at the facility explained that in the absence of regular means of listening to patient complaints, locals had committed *bhangchur* (vandalism) on a number of occasions in protest against bad service, after which the situation improved briefly before reverting back to the original situation. On a smaller scale, frustrated patients are also reported to threaten violence against individual staff members: a patient at a union health facility told a story of how when one member of her community had failed to get free medicine, her son had grabbed the *daktar* (in fact the Medical Assistant) by the collar and demanded medicine. For two weeks afterwards he took no money from patients. The situation then returned to normal. In a facility with better performance, protests against informal payments for services had been common in the past. Private practice had been eradicated quite recently, and the protests had reportedly stopped since.

New doctors may lack knowledge of the community, and so be unaware when a patient they are treating is influential and well-connected or not. Some respondents suggested that this helps to reduce doctors' worst behaviour. Whether or not doctors have had personal experience of such attacks, regular press reports of mob violence or attacks on (often private) health facilities that result from medical negligence appear to have had an impact on reducing at least the worst excesses of neglect. It is a pressure that doctors themselves identify as influencing their behaviour for the better:

There are two implications of informal patient pressures for the performance and morale of doctors. Firstly, it seems clear that patient complaints and threatening reactions to inadequate services can generate stress in conditions over which staff lack control, such as shortages of medicine or medical supplies. And fears about their personal security in rural health facilities are common among government doctors. Exposure to the reasonable frustrations of patients faced with inadequate services is likely to further reduce staff morale and weaken their incentives to accept or be regularly present in rural postings. Secondly, these unregulated and at times violent forms of protest take place in the vacuum left by the lack of regular channels for reasonable feedback and grievance procedures. This suggests opportunities for policies that improve patient participation structures by communicating to health staff the benefits to their own well-being of greater patient participation.

[7] See also Gruen *et al* (2002).

[8] In each case these were significant events and the reports were substantiated by more than one respondent.

OTHER SOURCES OF PRESSURE ON DOCTORS' PERFORMANCE

Local politics

Doctors report being under considerable pressure to perform favours for local political leaders (see also Gruen *et al* 2002). These include allowing them to distribute free medicines among community members; supplying them with false injury certificates or admitting political supporters with minor injuries as in-patients, to enable criminal cases to be filed against members of opposition parties. One UHFPO described the consequences of one such incident:

> Here a medical officer was forced to issue a false injury certificate for his patient … the court convicted the doctor, but no one will consider the circumstances and pressure under which he issued the false certificate.

These pressures frequently involve violence and the threat of violence, and it is clear that local political leaders are a major source of threat to government doctors' lives and well-being. One doctor had been assaulted after a misunderstanding with a political leader, and later lost his job; another was facing a case against him after a violent altercation with a local politician. There were also reported threats to doctors' lives. A crucial factor here is that doctors, particularly UHFPOs, are valuable to local politicians, as evidence given by government medical officers can be used to harass or imprison political opponents. It is clear that the political uses to which government doctors can be put is a factor behind political interference over transfers and appointments: as noted above, there are some cases in which doctors are appointed to posts because they have powerful political supporters. Such doctors are immune to pressures to perform from the administration and are unlikely to answer to the community. One UHFPO noted that as a local man with good personal connections to the MP, he was himself protected against the machinations of local politicians. However, staff mentality is affected by all this'.

While excessive political influence over health facilities does insulate doctors against pressures for improved performance, politics can also have positive impacts. Some politicians recognise that efforts to improve local health facilities create political popularity, and the research uncovered instances in which politicians had tried to bring about facility improvements. But even well-intentioned politicians were not always able to deliver resources, particularly when in opposition: the limited resources over which there was some local discretion were believed to predominantly go to the constituencies of ministers and other political leaders, within which *upazila*s where managers enjoyed good personal connections to political leadership were most likely to benefit.

The media

Fear of exposure in the media for negligence or wrongdoing appears to have become a source of pressure on government doctors' behaviour. Many doctors commented on articles they had read in the local or national press about medical negligence or corruption in the health sector. One doctor told of an article that exposed a doctor who was earning a commission from referring patients for unnecessary medical tests: one feverish child had been subjected to 23 tests. Another commented that the presence of three local newspapers which had printed reports about the *upazila* health facility meant that doctors 'were aware and tried to do their duty properly', because if their names were to appear in the paper this would cause them problems with the higher authorities and erode their respectability.

Some doctors felt that the impact of regular media exposure of medical negligence and corruption had been to bring the entire profession into disrepute. There were also concerns that some reporting on medical negligence and corruption was motivated by journalists seeking

bribes to withhold or publish stories. Some reportage on medical issues was believed to be pure sensationalism, as in this account reported by one doctor:

> A small child's body was brought to the *upazila* health facility after accidentally drinking a small amount of poison. The parents were devastated and asked the doctors not to perform an autopsy [to avoid having to cut the body open]. Given the child's age and the circumstances it was apparent that the death was an accident rather than suicide, so the doctors sympathised with the parents and returned the body without performing an autopsy. The next day an article was published in the local newspapers declaring that these named doctors had been given speed money to declare the suicide a normal death.

The pressures from the media may help to curb the worst excesses of medical negligence and corruption. In one health facility, for instance, staff reported that the fear of appearing in the newspaper had meant they coordinated their movements to ensure a doctor was on-site around the clock. But where doctors feel they lack the resources necessary to improve the services they can provide or fear unfair media coverage, the media impacts negatively on staff morale.

MATERIAL INCENTIVES

CAREERS IN THE GOVERNMENT MEDICAL SERVICE

Other positive aspects of government service cited include job security, regular pay and benefits, including a pension; and the important status of government doctor, which is of substantial value to a reputation in private practice. Good quality accommodation also appears to be an important material incentive for doctors to stay in an *upazila* facility.

Salaries may be regular, but they are low. Given their high social status, it is surprising that doctors in health facilities in Bangladesh are paid at best less than twice that of other staff (Table 1). In fact, the mean salary of doctors in union facilities is slightly lower than that of medical assistants, who usually receive three years of training after acquiring higher secondary certificate (HSC) qualifications. Perhaps because of their very different social positions, doctors interviewed for this research did not compare their pay and allowances with other staff within these facilities, but with doctors in developed countries, classmates in the private health sector (in one case, newly-recruited UHC medical officers contrasted their Tk 9,000 salary with the Tk 25,000 being drawn by their classmates at Dhaka's Apollo Hospital), and medical specialists.

These comparisons are of interest because they highlight the career paths to which this research found doctors in government service aspire. There are at least two distinct career possibilities for those who train as government doctors. The first is the more ambitious route, directed towards to the more desirable outcome: specialist postgraduate training, followed by a job abroad, in the private sector, or in a major urban public teaching hospital or facility, the last to be combined with a lucrative urban private practice.[9] Being in an *upazila* or union health facility does not move doctors onto that career path. One junior doctor explained that the mandatory two-year rural health facility posting was a de-skilling experience: 'two years spent at *thana* level is two years backward'.

[9] That this point applies more generally across the health service received further confirmation from discussions with young postgraduate student doctors in Dhaka.

Table 1. Doctors' pay compared with other facility staff (mean monthly, Tk)

Facility	Category of staff	Low	Mean	High
Upazila Health	Doctors	7,405	10,012	13,150
Complexes	Nurses	5,814	7,884	10,935
	Medical Assistants	6,885	9,849	10,835
Union facilities	Doctors	7,405	9,551	13,150
	Medical Assistants	6,885	9,773	10,737
	Health Assistants	4,014	5,410	6,153

Source: SSPS health report (FMRP 2005).

The choices available to a young doctor in a union or *upazila* facility are thus as follows: he (or rarely, she) will typically have a small salary and, to begin with, no private practice. This doubly disadvantageous position is likely to last the full mandatory two-year rural posting required of new recruits to the government health service. As noted above, many young doctors treat those two years as a sentence being served to qualify for further training, and not as posts worth settling into or for professional development. Those two years will, very likely, be spent studying for the FCPS examination or in seeking other postgraduate study opportunities, rather than building up a private practice or, even less likely, a good relationship with the local user-community. As noted above, the performance of junior doctors has virtually no impact on their likelihood of gaining access to training or other opportunities, and they have three incentives to be absent: firstly, their futures depend on their investments in studying at presently; secondly, because health facilities are neither intrinsically attractive nor lucrative places in which to work as a junior doctor; and thirdly, because there is little expectation that they will have to make themselves available more than a low minimum (although more senior doctors clearly expect them to behave reasonably well with patients). This career path appears to be most commonly pursued by young doctors from upper-middle class and urban households.[10]

The extent to which postgraduate study is vital to success in a medical career was highlighted by one unsuccessful doctor:

> As I have received EOC training, I have to stay in the UHC for at least two years according to the agreement. In any case, I am over the age for entry to postgraduate programmes … I am not satisfied with my job. I have been working for about 20 years as a medical officer without any promotions. People working in other sectors do not have to do further education for promotions. Like those who are working in the Secretariat - do they have to study more for promotions?

This bitter doctor may be able to move on to the second, less glittering career path. RMOs and UHFPOs are typically doctors who ended up in or chose to follow the administrative career route, possibly aiming for the civil surgeon's office or higher within the government health service. Doctors who do not choose or succeed in postgraduate training are likely to become RMOs or the more senior UHFPOs, or to remain in *upazila* or union health facilities as ordinary doctors without administrative authority or responsibility. While the RMO position entails more responsibility and power than being an ordinary medical officer, it does not attract a higher salary or better facilities, which was why, one RMO explained, 'nobody wants to take this post'. It is possible that the poor incentives to become RMO help create the high vacancy rates the post attracts (39% compared to 4% for UHFPOs; see footnote 5).

There are advantages here, too, however. The career path of an RMO or a UHFPO is likely to be geared towards acquiring a posting near their district or *upazila* or origin. One

[10] This point received some confirmation from discussions with colleagues of one of the research team members, Dr Rashid-uz-Zaman.

strong possibility is that this helps in building up what are often lucrative private practices. The career patterns of this group suggest that the private practice attractions may be so great that it is even worth their while to seek return transfers after a brief nominal posting elsewhere.[11] On the basis of our small sample, it is possible to suggest that the social profile of RMOs and UHFPOs is more likely to include origins in rural middle class households in which having become a doctor represents considerable progress in household education levels and gains in social mobility.

THE SCOPE FOR ADDITIONAL EARNINGS: CORRUPTION AND PRIVATE PRACTICE

A growing body of evidence on leakage and corruption in the government health sector demonstrates that patients face serious problems in the form of illegal charges for services and the unavailability of resources (e.g. drugs) that are supposed to be supplied free. However, knowledge of the extent to which the scope for illicit additional earnings creates financial incentives for doctors to be in *upazila* or union health facilities is uneven. Below we briefly explore our findings relating to three areas of illicit additional earnings which are believed to present for doctors in rural health facilities.

Sales of supplies and equipment

It proved difficult for doctors to discuss issues relating to corruption involving sales of drugs and supplies. There is ample evidence of beliefs that drugs intended for free supply are sold on the open market, and of routes through which this is likely to occur.[12] However, there are reasons to believe that even if the profits from sales of supplies and equipment do benefit doctors, they may neither be the main beneficiaries of such practices, nor is this likely to be their major source of additional earnings. A significant factor here is that doctors bear the brunt of patient dissatisfaction and complaints when drugs fall short, as was noted above. Some doctors pointed out that their frontline position ensures that they, as a group, gained little from limiting patients' access to government drugs. A second factor is that, as doctors, other facility staff and even patients pointed out, the market in government drugs is limited: the commercial value and quality of government drugs are generally understood to be low, so that other actors within the system, particularly those with easier access and lower opportunity costs, are likely to have greater incentives than doctors to maximise gains from leakage and corruption regarding supplies and equipment. Many doctors, including senior health sector managers such as civil surgeons, also hold the convenient view that while some leakage occurs at the facility level, most occurs at higher levels. Evidence on leakage at the upper levels of the system is extremely limited in nature. Overall, it is difficult to affirm whether or not the sales of medical supplies and equipment is an important part of doctors' incentives to perform (while simultaneously limiting their capacity to prescribe and therefore to perform).

[11] We found a number of RMOs and UHFPOs were on their second posting to the UHC.

[12] One survey found user reports of having to buy free government medicines in the market (CIET 2004). The research on which this paper is based identified different practices through which medicines arrived on the market via local facility staff (FMRP 2007). It is less easy to detect corruption higher up the system, however. For example, close scrutiny of the financial and supplies accounts indicates that drugs leakage on a large scale does not show up in the records of transactions between the district and *upazila* facilities. There is some evidence that union facilities receive less (around 93 per cent) of the supplies recorded as having been sent, however (FMRP 2005). A comparison of the average drugs issued to patients as recorded by facilities compared against that reported by patients, however, suggests that it may be through inflated patient numbers that the leakage is adjusted for. The Social Sector Performance Survey of primary health found that facilities were recording drug issues of two to three times that patients reported receiving (FMRP 2005).

Private practice

Doctors and patients talk fairly openly about private practice. Private services can be legally provided by government doctors, subject to certain regulations, including that it be conducted off government property and after government service hours (these stipulations are rarely followed in practice). There is little expectation among health service professionals that doctors will subsist on their government salaries. Private practice is widespread, although some doctors prefer not to discuss it, suggesting there is discomfort about the practice. Private practice contributes significantly to doctors' incomes: Gruen *et al.* (2002) found that 75% of doctors double their government salaries through private practice, while 20% quadruple it; other studies have arrived at similar estimates (FMRP 2005).

With restrictions, private practice is permitted after hours (after 2.30 pm, when *upazila* and union outpatient services are supposed to end), and off the premises, although there is some ambiguity regarding whether or not doctors are permitted to see patients in their accommodation which is attached to the facility. In fact, our research suggested that private practice more usually takes place in parallel with government service.[13] The degree of regulation varies from the rare facility in which private and public services are strictly separated, to the more usual and more mixed system, in which patients who come expecting free government service may sometimes receive what doctors believe to be their higher quality private services, for which they are then expected to pay. [There are also likely to be some doctors who regularly charge fees regardless of the service provided, but not surprisingly, few admitted this.] The more usual arrangement seems to be one in which private services are offered alongside, but are still to some degree separable from, public services.

Private practice on government health facilities is likely to be on a significant scale.[14] The SSPS survey found that 3% of patients leaving facilities reported paying during that visit, while 25% of the community members reported 'usually' making such payments. The presence of interviewers may have disrupted activities, although it is also possible that 25% of users will at some point – but not on every occasion - make such payments for services. A parallel paying outpatient department may also have been operating, in which case the SSPS teams would have been surveying mainly non-paying outpatients on the basis of the tickets they received on arrival, instead of other private patients (who would have had no reason to hold such tickets). Practices widely interpreted as corrupt may thus be the more complex matter of private and public services being mixed (see also Lindelow *et al.* 2005).

An important issue here is norms around service provision: the expectation is that public services will be low-quality, brief consultations for very common complaints. Both patients and doctors are, as a result, accustomed to expecting payments to be made for anything more complicated than common complaints—diarrhoea, acute respiratory infection (ARI) or malnutrition. It is easy for doctors to justify payments received on facility premises or during opening hours on grounds that patients in a 'serious' condition sometimes offer payment to queue-jump or be given more attention than the average outpatient. On at least one occasion, our researchers were told that the doctor's decision to charge the seriously ill patient a fee was so as to avoid him having to return in the evening to see the doctor during his private practice

[13] By which we mean consultations for which patients pay. This would exclude the practice by which doctors receive a commission from pharmacies for patient referrals or prescriptions (i.e. are not paid directly by patients, but patients still pay). We found no evidence of such relationships. However, we did find 'medical representatives', as pharmaceutical company sales representatives are known, influencing prescriptions in a particularly badly mismanaged *upazila* health complex. Staff are likely to receive a commission when they prescribe the brand being marketed.

[14] Although there are facilities in which such practices have been eradicated, including in one of the 6 *upazila* health complexes studied for the present research (see FMRP 2007).

hours, thereby reducing the time and travel costs to the patient. Private practice during public service hours may well involve some convenience to patients, but the logic of this entails that patients must be aware that private services can be obtained on the facility premises and during opening hours. One disadvantage of doctors making their private services available on facility premises and during opening hours is that it further reduces the time available for non-paying consultations.

Private practice is closely related to short consultation times, and therefore to the quality of public services is going below. The SSPS survey found that consultation times averaged approximately four or five minutes per patient; given that this usually involves a consultation in a room full of other patients, the time dedicated to an individual patient may be even less. Doctors themselves admit that one reason patients come to them privately is for longer consultations. Some of the reasons for short consultations include:

a) short opening hours in the outpatient department, with an unofficial 'norm' of core opening hours between 10.00 am and 1.30 pm;

b) that there are rarely more than two doctors available, and as long as at least one doctor is seeing outpatients, service is considered to be provided;

c) all patients are seen, as far as is possible; and

d) for many patients and doctors, the consultation is the token required to access free medicines. It is not about sharing information, discussing or understanding the problem or getting prescriptions (except for private patients). Physical examination is not routine, and the patient need not even be present.[15]

Few doctors were comfortable talking about the mixing of private and public services in health facilities, but some were franker than others:

> Most of the doctors conduct their private practice within the UHC. It is not ethically right for them to practice in the UHC, but I do not force them not to do so as this is going on everywhere in the country. They conduct their private practice in the morning and evening on a daily basis. It is not acceptable, but they come late and leave early to conduct private practice (UHFPO).

A common theme among doctors was that private practice does not necessarily lead to negligence or absenteeism: a doctor argued that the attendance of those who practice within their quarters was higher than that of those who practice off premises. Others emphasised that private practice creates positive pressures to perform well, to secure the good reputation vital for successful private practice, as in the view of this junior doctor:

> I don't think that private practice causes absenteeism. Doctors have to stay in the locality to become a popular private practitioner. In addition they have to perform well in the health facility where they are posted. Otherwise they will not be successful in private practice.

Others noted that having paid for services, patients were more likely to pressure doctors for better service, to come for follow-up visits, and to follow medical advice properly.

[15] For familiar complaints, women will often go to the outpatient department reporting their husband's symptoms, so that he does not waste a day's work travelling and waiting for service.

The idea that private practice creates incentives for doctors to under-perform so as to generate demand for their private services is not easily assessed.[16] One argument against the view that private services are detrimental to wider access to medical services was made by patients, who commented that an advantage of the government health system was that it gave them access to good quality, qualified government doctors. Another argument against the view that private service provision reduces provision for the poor is that markets for the services of government doctors are typically segmented: those who access their public services are not, according to the doctors interviewed for the present research, also usually able to pay to see them privately.

Whether or not the poor can pay, government services are both services for the poor and poor services, particularly because of the brief consultation times. Short opening hours and the unavailability of doctors are clearly related to the short consultation times offered in public facilities. To that extent, private practice does reduce services, but not necessarily because this creates demand for private services. To some extent, short opening hours are simply institutionalised bad practice. Facility managers justify short opening hours on the grounds that outpatients do not arrive before 10.00 am: in turn patients do not arrive earlier, because they expect to have to wait longer if they arrived when the facility officially opens.

An interesting and under-explored issue is whether doctors' private practice creates incentives to be present in rural *upazila*/union postings and to give good public service to develop a good local reputation. As we saw above, there are categories of doctors whom private practice attracts to such postings, usually non-specialist doctors, often with local origins. The picture is complicated because not all rural postings are equally attractive: some private practices flourish in rural areas, but not where the population is very poor or uneducated. At the same time, an *upazila* or union close to a large city is also unlikely to be a good base for private practice. The ideal conditions are where competition is low but demand is high. It is not clear that incentives for gaining a good local reputation can influence doctors' behaviour towards patients in government health facilities if, as doctors generally believe, those patients cannot themselves afford private services. However, the view that these incentives are so present was voiced in a number of contexts by both medical staff and patients, and it does appear to influence providers' behaviour. The belief that a good reputation impacts positively on private practice may well be sufficient to influence doctors' behaviour, regardless of its truth.

SOCIAL, PERSONAL AND DOMESTIC CONTEXTS

SOCIAL STATUS, ETHICS AND PROFESSIONAL REPUTATION

As a professional group, doctors have traditionally enjoyed extremely high status in Bangladesh. For middle class households, having a son or daughter become a doctor represents major social success, and bright schoolchildren are expected to aim for medical school. But their undeniably high social status is not adequately matched by the income and living conditions associated with employment as a government doctor. One doctor complained bitterly that:

> My father forced me to get admitted in the medical college. I got the chance to be admitted in BUET (the premier university for engineering studies in Bangladesh),

[16] See World Bank (2003) on the incentives and disincentives with respect to private medical practice.

but my father didn't allow me to start. I would have been an executive engineer by now, I could have had a big house and a luxurious car.

Private practice and the increasing number of opportunities in private clinics and hospitals entail that many doctors are able to earn well over their government salaries, although as we saw above, a flourishing private practice is very likely to reduce the time spent delivering government health services. But for doctors weighing up the relative advantages of private and government medical service, there are also ethical and professional status issues to consider.

Many doctors clearly feel that their motivations for working in the low-paid government health service include moral and humanitarian considerations. For some doctors, it is clear that the willingness to undertake the hard work and long training required in their profession is grounded in the social veneration of doctors; in some cases, this respect for doctors was acquired early, through childhood illnesses and contact with doctors. Many doctors also felt that, as one put it, their 'motivations for coming to work and doing the job properly are that they are serving humanity'. Doctors struggling to work amidst inadequate resources and other sources of job dissatisfaction reported that being able to provide some comfort and assistance to poor sick people was a source of some satisfaction. Unable to do his job properly without the necessary equipment, one dental surgeon emphasised that when his patients thanked him for his help, he felt pride that inspired him with the drive and determination to continue medical practice. One young doctor had been inspired by a colleague who had worked for twenty years without promotion, but who was clear about the importance of his contribution to the society: 'the people of this country are indebted to me', he told his young colleague. For a number of doctors, this desire to serve humanity was rooted in religious and ethical beliefs.

It is clear that a major attraction of government medical service is the social respect that goes with the position. Unlike many government jobs, doctors believe their profession to be seen as honest and respectable, in the view of one doctor: 'people respect me more than any other profession'. Respect and status are an important of the reason that private practice as a government doctor is believed to more successful than as a private doctor. From discussions with patients and staff, it seems clear that government doctors are generally believed to have more qualifications and experience, so that government service is partly about certifying a level of professional skill.[17]

What is less obvious is that a local private doctor with a good record and an approachable manner can also compete in this market, particularly if because they will have had a chance to build up a reputation and relationships with community members. Partly for this reason, government doctors emphasised that it was in their own interests to perform well within the government health facility, because their performance was the ultimate determinant of the success of their private practice:

> Popularity does not depend on being a governmental or non-governmental [doctor]. It depends on how long doctors spend with patients. It depends on person-to-person communication and relationships. A doctor's attitude, their degree, consultation times, reputation – these factors are also major elements. And the main fact is who can cure a patient (RMO).

[17] Services of 'doctors' are widely advertised in rural areas of Bangladesh; these are often not doctors but government service Medical Assistants or even less qualified pharmacists, Family Welfare Assistants or Visitors. '*Daktar'* or 'Doctor' covers a wide range of professionals who broadly work in the modern medical health services sector. Some patients speak of '*bara daktar*' when talking about senior government doctors, usually referring to the UHFPO.

Although being a government doctor helps, a good reputation is vital. And nurturing a good reputation requires constant tending, was the common view.

DOCTOR-PATIENT RELATIONS

The interactions between doctors and patients place strong, but not necessarily positive pressures on performance - misunderstandings are commonplace, and can have serious implications:

> We have a good reputation for service delivery, and this reputation comes from the civil surgeon for our hard work. But because of a shortage of manpower, this reputation is not reflected all the time by our patients. Even if we are satisfied that we are doing the best that we can given the circumstances, patients are not satisfied. On the one hand, we have patient pressure, but on the other hand, we have shortages in staff … what can we do?

The picture commonly painted by government doctors is of a struggle to provide good quality consultations and follow-up services under severe time, drug and supply constraints; their view is very often that poor patients are rarely satisfied because they are chronically weak and unable to understand medical science or follow simple instructions.

Patient misunderstandings are believed by doctors to result in a number of problems. Several doctors reported mix-ups when patients had to be referred to other facilities, wrongfully believing that *upazila* health facilities have the capacity to deliver more sophisticated services. The prescription of non-government drugs for more serious medical conditions can also lead patients to believe that doctors are not providing them with the free drugs to which they are entitled. Such misunderstandings, doctors emphasised, can fuel allegations of corruption and considerable patient anger, manifested in complaints, a loss of trust, and at worst, violence:

> You cannot get angry or rebuke rural people, or they will get angry. If, for example, patients come and directly demand medicines by name [without consultation], the doctor must be very careful. If he says no, the patient may circulate that the UHC does not want to give away the government medications that they are entitled to. He must be careful to make them understand the process; that he must go to the doctor and tell him about his symptoms [and only then can he be prescribed medicine]. This way, if patients are motivated in this way, they will be oriented to both doctors and the hospital.

Doctors do not typically believe that their superior rank impedes communication with poor patients:

> Patients can easily communicate with doctors, [they] are the most accessible government officials. Rural poor people cannot even think of talking to an officer-in-charge (OC) at a police station, but with doctors, anyone can talk easily (Civil Surgeon).

Instead, issues of communication mainly focused on narrow issues regarding the difficulties for doctors in understanding the local dialect (hardly the major linguistic barrier in Bangladesh it is in other countries). Some doctors noted that their instruction and technical language was English, and this sometimes presented a barrier in terms of understanding local terms for different symptoms. For new recruits, *upazila* or union postings are sometimes their first direct contact with the rural poor, and many initially find it difficult to understand local dialects and terms for different symptoms, although they soon learn, with the assistance of

more seasoned colleagues. RMOs and UHFPOs often displayed greater confidence in their ability to communicate with local people than junior doctors, partly the result of experience and partly because of their characteristically stronger roots in or close to the areas in which they work.

Illiteracy and lack of education were, however, widely seen as a cause of patients' lack of understanding about appropriate health-related behaviour, as in these views:

> Illiterate people do not understand things very well. For example, despite a huge campaign to promote the use of iodized salt to prevent goitre, many people still use non-iodized salt. Many people still have not started drinking safe water. Because of the illiteracy of the patients, their level of compliance with the instructions of the doctors is often poor.

> We just cannot keep [the health facility] clean – you see, it was cleaned just a moment ago, but if people throw betel leaf spittle, then what can we do? Nothing can be explained to rural people!

There was general acceptance that it was easiest for doctors to communicate with educated and literate people, but there were also signs of sympathy and understanding for poor patients. One doctor was hesitant about prescribing government drugs he knew to be of low quality, but which were free. A doctor stationed at a union clinic claimed that he prioritised the allocation of the limited free drugs to poorer patients, knowing that they cannot afford to pay for drugs from the market. One UHFPO had introduced initiatives to help his poorest 'at-risk' patients, including providing pregnant women with clay money banks at their first ante-natal consultation, to encourage them to save throughout their pregnancy to pay for any emergencies at the time of delivery.

What doctors rarely admitted was that the typical practice is to give low quality, short consultations to poorer patients who do not pay privately for their consultations. There are many reasons for this, including that doctors serving outpatients are frequently under considerable pressure to see many patients in a single session – some reported seeing as many as 200 patients in a day. The reasons for such pressure in turn include high levels of vacancies; the practice among doctors of a rota, taking turns to remain absent for long periods at a time (ensuring extra pressure on the doctor who remains in post at any given time); and the assumption common among doctors that poor patients suffer from a narrow range of poverty-related diseases for which efforts of extended discussion of symptoms and diagnosis are a waste of their time.[18]

DOMESTIC FACTORS

Chief among the domestic factors that influence doctors' attendance and performance in rural facilities is the availability of high quality schools for their children. Doctors are particularly likely among professional groups to prioritise investments in the education of their children; outside of Dhaka and a few of the larger cities, there are few schools of the quality doctors aspire to for their children. Many doctors therefore commute between a family home in one of the larger cities, and a – usually unsatisfactory – arrangement at the health facility. One doctor noted that the constant separation from his family meant that he had 'sacrificed a lot' for his

[18] A recent study that studied both doctors' knowledge and practise in Delhi demonstrated that doctors typically do less than their medical knowledge and training has taught them they should do; that more trained doctors do make more effort in consultations; and that doctors who charge fees tend to make more of an effort than government doctors (whose salaries are independent of patients) (Das and Hammer 2005).

daughter. One RMO tried to travel to Dhaka every weekend, but this was not always possible. To explain how much he missed his family, he said: 'Do I call them every day? Much more than that, I call every two hours'. Another doctor explained his aims as follows: 'After the FCPS examination, I will resign from my government job and join a private hospital, preferably in Dhaka where I can live with my family'. It is abundantly clear that for many doctors' families, particularly those in crucial stages of their educational career, settling in rural *upazila*s or unions is not a consideration.

Spouses' jobs were also a consideration that meant many doctors had to be apart from their families for some of the time. For doctors with spouse-doctors, another consideration was finding employment within the same *upazila*. One doctor posted at a union facility had two children and a doctor husband, and explained the rationale behind her transfer to a union facility as to do with her desire to be posted to locations where she could be close to her family: 'my aspirations are all bound up with my family.' Having both husband and wife practicing as doctors was also seen to have financial benefits. Some saw the double salary reduced the need for doctors to practice privately, allowing them to spend more time with their children. Caring for elderly parents was an additional factor: one RMO explained that:

> As I am originally from [this *upazila*], and my parents' home is here, I will be happy if I can spend my life here … While younger people may like to move here and there, later in older life one likes to be [near one's family].

CONCLUSIONS

This section summarises the main findings of the research into the incentives and constraints of doctors in rural health facilities in Bangladesh. It concludes with a sketch of their implications for policy relating to the attendance and performance of doctors in rural health facilities.

SUMMARY OF THE MAIN RESEARCH FINDINGS

The research reported here is distinguished from other research on doctors because it provides a rounded picture of factors shaping the attendance and performance of doctors in rural health facilities, with an emphasis on understanding how doctors view their incentives and constraints.

The findings of the research include that equipment, drug supplies and physical infrastructure are serious constraints on doctors' performance at the rural facility level. Where specialists are available, they are hampered by the lack of specialist equipment; drug shortages dent trust between patients and doctors and prevent the prescription of rational drug regimes. Physical infrastructure is too poor to attract doctors to government accommodation, as well as frequently unsanitary, dangerous, and a cause of low morale among staff and patients. Staffing levels are another problem, as doctors struggle to provide services supposed to be provided by twice as many doctors. Posts for specialists are particularly unlikely to be filled, as is the sole post for a doctor in union facilities. Those doctors who are present in these rural health facilities therefore have to work hard, reporting seeing as many as 200 patients per day, under significant physical and resource constraints.

The absence of doctors who are posted to rural facilities compounds the problem of high vacancies levels in the system. Although doctors' absences are more often than not permitted absences, the research identifies groups of doctors and stages of doctors' careers during which this is a more serious problem. Factors associated with absenteeism include postgraduate

training, low levels of job satisfaction, and, crucially, the weakness of disciplinary actions against absenteeism.

The arrangements for governing health facilities do not effectively permit formal patient or user participation or feedback, nor do doctors believe that patients should be more involved in facility governance. Some performance monitoring is conducted by health service administrators, particularly by UHFPOs and civil surgeons. But the results of performance monitoring are not shared with staff, who therefore lack a means of assessing their own performance against other facilities'. Patients and other groups (the media, local politicians) do, however, influence doctors' behaviour, but this occurs through unregulated routes that at times erupt into violence.

The material incentives for doctors to join the government service are mainly related to the scope for postgraduate training opportunities and private practice. Doctors' performance at the facility level has no impact on their chances of accessing postgraduate training; by contrast, there are reasons to believe that doctors who stay longer and develop better patient relations are likely to build a more lucrative private practice.

Finally, the research explores the usually neglected area of social, personal and domestic factors influencing doctors' willingness to be present and to perform in rural health facilities. It is clear that the professional ethos of doctors in Bangladesh includes humanitarian considerations, and that for many doctors, it is the knowledge of having helped sick, poor people that is their main source of job satisfaction. High social status and respect is also an important motivation for being a government doctor. Social differences between patients and doctors affect how well they communicate, but are rarely believed to amount to a major obstacle in patient treatment.

POLICY IMPLICATIONS

Through its exploration of doctors' career histories and the broader social and professional contexts that shape their incentives, this paper throws fresh light on some critical policy issues relating to doctors' attendance and performance in rural health facilities. We briefly recap findings on two of the most significant below.

Increasing the level of doctors' service provision

The crucial failure of current policy is that only a small proportion of the doctors' time and services for by policy are actually provided at the rural facility level. This is because a) only half of doctors' posts in these facilities are on average filled; b) doctors are frequently absent; and c) when they are present, doctors are rarely motivated to give lengthy consultations (unless these are privately paid for).

The paper demonstrates that while there are strong reasons for many doctors to avoid rural health facilities, the incentives of other groups of doctors may work in the opposite direction. We found that far from being uniform, doctors' incentives to be present or to perform vary considerably depending on their personal backgrounds and life stages, and how these interact with their professional aspirations and career trajectories. Any policy that will succeed in raising the amount of doctors' time and services that are available to poor patients in rural health facilities will need to either a) change the incentive structures that currently ensure many doctors stay away; and/or b) recruit doctors from among those in the profession who are less reluctant to work with poor rural communities, and whose incentives are therefore more closely aligned with the needs of policy. A vital lesson is that while not all doctors are equally disinclined to be posted to such facilities, attempts to post some doctors (for example,

specialists) to such facilities are virtually futile under current employment and management conditions.

Enabling patient participation in facility governance and management

Given that major policy initiatives were put in place to establish stronger mechanisms for patient participation over the 2000s, a striking finding of the research was the strong resistance of doctors to an acceptance of the logic – regardless of the practicability – of more patient involvement. At the same time, doctors typically argue that patients complain because they do not understand the facilities' procedures or their own health problems; they also display a well-founded fear of abuse or violence at the hands of angry community members who suspect maltreatment or negligence. This suggests a) that there is considerable work to be done to persuade the medical profession that patients can and should be enabled to participate in the governance and management of health facilities; and b) doctors may be persuaded in this respect if they are convinced that part of the reason for doing so is to regulate the forms through which patients protest, in order to prevent violent or humiliating actions against doctors.

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