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Patients Awareness of Health Right: A Hospital-Based Pilot Study from Dhaka City

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Abstract

Background and Aim: Awareness on health rights is an important issue to secure good medical practice especially where health is the most unattended sector in developing countries. We explored the current level of awareness on Health Rights among patients attending a busy tertiary care government hospital in capital of Bangladesh

Methods: Under an analytical cross-sectional design 200 participants (male 126, female 74) were purposively selected. Pre-coded, pre-tested, interview-administered structured questionnaire was used. Demographic data was also assessed along with knowledge and attitude towards Health Rights. Awareness level was graded using the Likert scale.

Result: Largest portion of the study population included service holders (38%) and city dwellers (51%) and crossed primary or secondary level of education (60.5%). Majority (56%) had no perception about health rights with an enormous discrepancy between knowledge and attitude (good knowledge and attitude, 0.5% and 42% respectively). Sequentially, the awareness level was 59% and participants with access to watch television showed maximum level of awareness (13.6%). Level of education (<0.002), income (0.004), place of habitat (<0.001) and media accessibility (<0.034) were related with awareness.

Conclusion: The greater part of the health care seekers was not aware at satisfactory level. Promotional activities on the perception about Health Rights (Patient's Rights) are crucially needed which can be effective especially through Television.

Keywords: Health rights; Safe and continuous health service; Emergency health service; Confidentiality and privacy; Treatment; Health service records; Awareness

Introduction

Health is one of the basic rights of human by birth and it is the most important sector for any country. But it is the most unattended sector in a highly dense populated country like Bangladesh. It is a big challenge for a country with huge population to convert them into manpower which deserves to get supreme priority from all authority.

The right to health means that the State must ensure the environment in which everyone can be as healthy as possible by enjoying equal access to any kind of health services available in the country [1]. During the last fifteen years, an increasing number of European countries have adopted laws or other legal instruments respecting and protecting the rights of patients. This reflects the progressive recognition of the inherent dignity and of the equal and indisputable rights of all potential users of the health care system [2].

All the countries worldwide ratify universal health rights in their constitution but adoption and implementation still varies. In many countries "Clients Charter of Rights" is followed with a view to ensure health rights of the people [2]. Different sectors (Private and Government) must have their own health rights charter. The prevailing situation in Bangladesh is a bit different which looks as if there is no 'health rights' existing in the country, because we could find a very few number of charters in Dhaka (the Capital of Bangladesh) in some NGOs like 'Marie Stopes clinic', 'Manusher Jonno' etc.

In Bangladesh, a statistics says that in case of illness more than half of the urban people visit doctors, whereas near a quarter of rural people do that. Moreover, only about one tenth of people go to Government facilities and 27% go to private facilities, whereas majority of them go to unqualified services [3]. It is needless to say that poor people; especially the rural ones have limited access to the health services.

Compared to many other countries, Bangladesh has improved health infrastructure even in the peripheral areas rather than division/district localities. Nowadays the number of availability of Upazilla and

Thana health complexes with health resources are at satisfactory level as the government asserts, but utilization is very poor. Consequently, only privileged people utilize facilities whereas, general mass is left neglected. Moreover, people in Bangladesh seldom take legal action. So the providers never care about their accountability.

Considering the above issues on "Health Rights" this study was one of the initial researches to explore the awareness level of patients about their health rights in a public hospital. Our study was aimed to measure the awareness of the patients regarding their health rights through knowledge and attitude as awareness is reflected through these two.

Methods

Study Place and time

It was a descriptive cross-sectional study conducted between August to December 2010 at the outpatient department (OPD) of the Dhaka Medical College Hospital (DMCH), the tertiary care hospital of Bangladesh Government and also the largest Government health care center in Dhaka.

Sample calculation and collection

Considering this one as a pilot study, 230 individuals aged between 18 to 65 years were invited for the study through purposive sampling. Respondents who had other medical complications, or were hospitalized or were unable to answer were excluded from the study. Among them 200 (87%) subjects could complete all the investigations.

Data collection

The knowledge and attitude of the subjects towards health rights were assessed by 'interviewer-administered questionnaire' method [4-6]. Awareness was defined by the combined scoring of 'Knowledge' and 'Attitude'. A standard two part questionnaire, designed by the researchers was constructed in local language (Bangla). The first part of the questionnaire consisted of socio-demographic information and second part covered knowledge and attitude about health rights according to health rights charter [7].

Knowledge was assessed through questions related to understanding of 'rights to get'; 'correct information of provided health services', 'emergency, safe and continuous service', 'cordial environment, privacy, confidentiality' 'informed consent', 'legal steps'(in case of indulgence) and receiving 'copy of service records'.

Attitude was assessed by asking them about their eagerness to practice 'what they know', 'interest to choose health or family planning services', 'alertness for privacy & confidentiality', 'urge to get copy of health service records', 'spontaneity to complain authority in case of indulgence of rights'.

Likert scale scoring system has been used for the questions to measure the knowledge of the patient and attitude about their health rights [8,9]. There were 09 questions for 'knowledge' (with only 'yes' or 'no' option) and 09 questions for 'attitude' (with 'five' options to answer). Each acceptable answer carried '1' mark and '0' for unacceptable or wrong answer. For each subjects a sum score was calculated to label knowledge and attitude. Each of the questions about knowledge was scored first and arranged in an ascending order. Then the total scores were divided by three grades (as researcher wanted to classify the knowledge level in three types- poor, moderate and good). According to the quotient researcher made equal gap among the scores of the poor, moderate and good knowledge and synchronized it in ascending order. In the same way attitude level of the participants was calculated. Then the total score of each participant was summarized for the knowledge and attitude. Awareness level was calculated like the knowledge level as mentioned above.

The combined level of knowledge and attitude was classified according to each respondent's score and expressed as 'Awareness'. Poor knowledge and attitude corresponded to a score of (<Mean – 1 SD); average knowledge and attitude corresponded to a score between (Mean ± 1 SD); good knowledge and attitude corresponded to a score of (>Mean + 1 SD) [10]. Income was classified following the 2006 per capita Gross National Income (GNI) and World Bank (WB) criteria [11].

Statistical analysis

Percentages were used to describe the participation rates of respondent for health right awareness. Means and standard deviations (SD) were used for continuous variable. To summarize categorical data we used both the number and proportion for all the socio-demographic parameters of the study. Independent-sample t-tests (for continuous variables) and Pearson's chi-square test (for categorical variable) were done as to perform intergroup comparison to examine the difference in the covariates between two awareness groups (low and high) of respondents. The statistical tests were considered significant where p-values were ≤5%. All P-values presented were two-tailed. Data were analysed using SPSS version 11.5 (SPSS Inc. Chicago, IL).

Ethical approval

The ethical principle of the Helsinki Declaration was followed while informed verbal consent was obtained from all respondents after full explanation of the nature, purpose, and procedures used for the study (the interviewer read out the consent form and interviewee gave permission orally). Ethical approval was obtained from the ethics and research review committee of Bangladesh Diabetic Samity (BADAS-internationally recognized as Diabetic Association of Bangladesh).

Results

Majority of the respondents (36%) were from the age group 25-35, more than half of them were male (63%), 60.5% had primary and secondary level of education, 61% were service holders or doing business and 51% were city (Dhaka) dwellers. More than three quarters of the participants (84.5%) came from low and lower middle income group [(Bangladeshi Taka (BDT) ≤20,000 per month] as shown in Table 1.

Variables[1]	n	%
Age (years) (M ± SD)		
18-25	50	25
25-35	72	36
35-45	55	27.5
45 years and above	23	11.5

Gender		
Male	126	63
Female	74	37
Educational status		
Illiterate/signature/gonoshikha	29	14.5
Primary and secondary level	121	60.4
Graduate/Post graduate level	50	25
Occupation		
Businessman	46	23
Housewife	40	20
Service holder	76	38
Student and others	38	19
Place of habitat		
Slum dwellers	16	8
Rural	36	18
Outside of capital city	45	22.5
Capital city	103	51.5
Gross National Income (per capita, US$)		
Low income (≤905)	71	35.5
Lower-middle income (906–3595)	98	49
Upper-middle income (3596–11115)	31	15.5

[1]Values expressed as numbers and percentages in parentheses or mean ± SD, as appropriate; SD, standard deviation; US$1=80 Bangladeshi Taka (BDT)

Table 1: Socio-demographic characteristics of the respondents (n=200).

Most of the participants (58%) had no perception about health rights. An enormous discrepancy was observed among the respondents' knowledge and attitude (good knowledge 0.5% vs. good attitude 42%) regarding health rights. Majority of the male respondents (61.5%) had poor knowledge regarding health rights as well 34.5% female were in poor category. However compared to male, female showed better awareness about their rights (0.5% vs. 7.5% respectively) in 'moderate' group. in general 'good' level of knowledge was absent as only one male found to reach the good level of knowledge in our study (Table 2).

Age	Gender	Knowledge (n, %)			Attitude (n, %)		
		Poor	Moderate	Good	Poor	Moderate	Good
18-25	Male 18 (9.0)	18 (9.0)	-	-	1 (0.5)	10 (5.0)	7 (3.5)
	Female 32 (16.0)	28 (14.0)	4 (2.0)	-	4 (2.0)	15 (7.5)	13 (6.5)
25-35	Male 45 (22.5)	44 (22.0)	1 (0.5)	-	36 (18.0)	5 (2.5)	4 (2.0)
	Female 27 (13.5)	27 (13.5)	-	-	5 (2.5)	13 (6.5)	9 (4.5)
35-45	Male 43 (21.5)	42 (21.0)	-	1 (0.5)	1 (0.5)	18 (9.0)	24 (12.0)
	Female 12 (6.0)	12 (6.0)	-	-	2 (1.0)	7 (3.5)	3 (1.5)
45≤	Male 20 (10.0)	19 (9.5)	1 (0.5)	-	4 (2.0)	9 (4.5)	7 (3.5)
	Female 3 (1.5)	2 (1.0)	1 (0.5)	-	-	1 (0.5)	2 (1.0)
Total	Male 126 (63.0)	123 (61.5)	2 (1.0)	1 (0.5)	12 (6.0)	57 (28.5)	57 (28.5)
	Female 74 (37.0)	69 (34.5)	5 (2.5)	-	11 (5.5)	36 (18.0)	27 (13.5)
Grand Total	200	192 (96.0)	7 (3.5)	1 (0.5)	23 (11.5)	93 (46.5)	84 (42.0)
Values expressed as numbers and percentages							

Table 2: Distribution of knowledge and attitude according to age and gender.

More than half of the participants were highly aware (59%) of their health rights as it was measured by the combined score of their knowledge and attitude

Awareness on health rights and the socio demographic variables (except age and gender, p=0.192 and p=0.199 respectively) were found significantly associated (p<0.05). Respondents with elevated awareness were largely from the age groups of '25-35' and '35-45' years. Respondents' educational qualification was significantly associated with awareness (p=0.002). Better level of awareness was found mostly among males (39.5%), service holders (25.5%) and lower middle income group (27.5%). Response pattern showed there is an association between media accessibility and awareness level of the respondents about their health rights. The association between media accessibility and health right awareness was positively and significantly correlated (p=0.034). Respondents with access to watch television were with maximum level of awareness (13.6%). On contrast respondents without any media accessibility were least aware (Table 3).

Characteristics	Awareness (n=200)		p-value
	Low (n, %)	High (n, %)	
Overall response pattern	82 (41)	118 (59)	
Age			
18-25	20 (10.1)	29 (14.6)	
25-35	36 (18.1)	36 (18.1)	0.192
35-45	19 (9.5)	36 (18.1)	
45 yrs and above	6 (3.0)	17 (8.5)	
Gender			
Male	47 (23.6)	79 (39.5)	
Female	34 (17.1)	39 (19.5)	0.199
Education			
Illiterate/ signature/gonoshikha	26 (10.66)	3 (1.77)	
Primary and secondary level	60 (24.60)	61 (35.99)	0.002
Graduate/Post graduate level	14 (7.0)	36 (21.24)	
Occupation			
Business	21 (10.5)	25 (12.5)	
Housewife	25 (12.5)	15 (7.5)	0.003
Service	25 (12.5)	51 (25.5)	
Student and others	15 (7.5)	23 (11.5)	
Family monthly income			
Low income	35 (17.5)	36 (18.0)	
Lower middle income	43 (21.5)	55 (27.5)	0.004
Upper-middle income	4 (2.0)	27 (13.5)	
Place of habitat			
Slum dwellers	13 (6.5)	4 (2.0)	
Rural	22 (11.0)	14 (7.0)	<0.001
Outside of capital city	19 (9.5)	26 (13.0)	
Capital city	28 (14.0)	75 (37.5)	
Media accessibility			
News Paper	7 (3.5)	14 (7.0)	
Radio	8 (4.0)	5 (2.5)	
Television	24 (11.9)	27 (13.6)	0.034
Internet	-	7 (3.5)	
All	20 (10.0)	46 (23.0)	
None	24 (12.0)	18 (9.0)	

Results are expressed as number (%), p<0.05 was considered as level of significance

Table 3: Association between 'awareness on health rights' and 'socio-demographic factors' among study participants.

Discussion

This study showed that more than half of the study participants were highly aware of their health rights. But education, occupation, income and dwelling place might be the important factors. The result was interesting but not unexpected. As the awareness level was measured by the combined score of participants' knowledge and attitude, where 'attitude' scored affirmative as usual in all points and reflected in the response. Several studies have already showed that 'knowledge' affects 'attitude' [12] and 'attitude' affects 'practice' or 'awareness' [13]. However, here we observed knowledge did not affect attitude, probably as they were evaluated using separate questions. Some research papers showed that the people of Bangladesh have lost their faith in health services of their homeland and were not satisfied [14]. This may happen when the patients are aware of their health rights, educated enough to judge the services and can express their lack of satisfaction. As the majority of population was aware of the health rights with positive relation with education and income, our study supports that statement.

It is generally believed that in a developing country like Bangladesh, females are lagging behind compared to males in all spheres of life. Since males get better privilege in our country so are expected to be better aware than females.

People from city and around had better access to all types of promotional activities including health, which might have helped them to score more in awareness scale. Higher education is always counted as an important factor for awareness. This study also supported the fact. Study from Iran also revealed the same perception [15].

Another attention-grabbing finding of the study was to find that people understand the meaning of 'Health Right' as 'Family Planning'. The reason behind this may be the extensive promotion of "family planning program", which is documented to be one of the most successful health promotional activities by the Government. Attitude concerning confidentiality, privacy and informed consent was found strongly positive. The reason behind this may be the cultural and religious stance of Bangladeshi people.

The main limitation of this study was the small sample size as the survey was cross sectional and conducted in a single urban hospital. Study findings raise further concern to involve majority of people living in rural areas and having less access to information.

So far to our knowledge the study is the first one to find out the level of awareness among the patients regarding Health Care. This work also explored the availability of Health Charters in different health care setups including government and private sector. Government hospitals are more preferred by our low and middle income population and Dhaka Medical College Hospital is the top most selected one in Dhaka for all kind of health services. So, it is always overloaded and too tough to run research work there. Performing research in this hospital was a strong point for the study.

Conclusion

From the study findings, with great encouragement of a positive outlook, this study indicates that people have assenting attitude regarding most of the health rights, may be lacking of good knowledge. Still the inclining awareness level which is positively related to education, income and media accessibly expresses optimistic expectation for researchers, health professional and policymakers to take more initiatives for health promotion focusing health right using mass media specially television.

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