World Journal of Social Sciences
Vol. 2. No. 5. August 2012 Special Issue. Pp. 58 – 78

Medical Service Facility of the Dhaka Medical College Hospital (DMCH): An Analysis

Sharmin Khan*

Medical services of a country depend on overall Health system of a country. This sector of Bangladesh is one of the very crucial situations. Objective of the study is to ascertain the status of the Health Service provided by the prime govt. medical college of Bangladesh. To conduct the study a total of 85 (Eighty Five) Interviews were carried out in DMCH through random selection of 4 groups of respondents out of which 17 Doctors and 25 Nurses from different departments, 18 patients and 25 ward boys of different wards of the hospital. Time period of the study is August 2011 to November 2011. Author observes that the number of areas in DMCH, where many policy implications are needed backed by an aggressive and quality planning of Operation Management in order to do the proper judgment to the reputation of Dhaka Medical College Hospital as the core institution for Medical Service provider to the peoples of the country. Author suggested that organizational establishment should be patient friendly and handle of patient ought to be done with utmost care if the hospital really wishes to be a service centre for the people.

Field of Research: Medical service, Health system, DMCH, Bangladesh

1. Introduction

"Medical Service" of the country is one of the very crucial need of the country and to ascertain the status of the Medical Service, we have selected the most renowned hospital of the Capital of Bangladesh-"Dhaka Medical College Hospital". The college as the source of creating the talented professionals in health service of the country, the hospital having the perception of Nucleus of Medical services of country among the population and the health service organization enjoying the highest government supports. We have intended to find out the overall management system for providing the health services by this prime government hospital of the Capital of Bangladesh.

According to http://en.wikipedia.org/wiki/Dhaka_Medical_College_and_Hospital Dhaka Medical College and Hospital (DMCH), established in 1946 during the British colonial rule, is a medical college in Bangladesh. It is situated at Bakshibazar area of Dhaka city. It is neighbored by University of Dhaka and Bangladesh University of Engineering and Technology. Since its establishment, Dhaka Medical College is continuously playing a pioneering role in dispersing medical education among young pupils. The hospital attached with the college provides affordable health care to a huge number of patients through its outdoor, indoor and emergency facilities.

---

*Executive Assistant, GMG Airlines, Bangladesh and Honorary Consulate of the Republic of Cyprus, Bangladesh, E-mail: sharminkhan41@yahoo.com, sharmin.khan@gmgairlines.com

How the system of Dhaka Medical College hospital works, whether there is any gap in the management system and if “yes”, what is the impact of lacking in the management system, the positive or negative outcome of the professional Management planning, were the intention of the study behind mind. As such the study has been undertaken to see whether the hospital provides proper services or not. Basic research question is whether the patients are getting due health care facilities in the hospital?

2. Literature Review

Andaleeb (2000) comments that since private hospitals are not subsidized and depend on income from clients (i.e. market incentives), they would be more motivated than public hospitals to provide quality services to patients to meet their needs more effectively and efficiently. This premise was supported. Patient perceptions of service quality and key demographic characteristics were also used to predict choice of public or private hospitals. The model, based on discriminant analysis, demonstrated satisfactory predictive power.

WHO (2007) observes that health problems today are no longer merely the responsibility of those working on health, but require positive action by those outside the health sector. International conflicts and national crises often lead to the disruption of social services which include health care. Globalization and decisions made regarding international trade have a direct impact on health, especially in terms of pharmaceuticals and the movement of health professionals. In many countries Ministries of Health often do not have the capacity to adequately influence important causes of ill-health outside the health sector.

http://www.ti-bangladesh.org/research/ES_DMCH.pdf observes that the Dhaka Medical College Hospital (DMCH) is the central point of public health services of all the government hospitals in Bangladesh. Everyday, on an average of 1,432 patients come to the outdoor and 450 to the emergency units of the hospital, while 184 patients are admitted to the indoor for further treatment. The patients are supposed to receive medical treatment at a lower cost as it is a government-run hospital. However, alleged that the patients are regularly deprived of the health facilities due to a number if irregularities and corrupt practices. Patients are attended at the outdoor between 8:30am to 1:30pm, however, 71% of the patients informed that they had to wait for the doctors for 78 minutes on an average. 35% of the outdoor patients were suggested by the doctors to visit the doctors’ private chamber. 29% of the outdoor patients gave average Tk.21 as bribe for visiting the doctors breaking the serial. Among the admitted patients, 20% of the patients alleged that doctors did not visit them regularly. There are numerous allegations against the nurses. 33% of the patients did not receive good behaviour and 16% of them did not get regular services from the nurses. 58% of the patients did not get the ward boys or cleaners in the time of need. The most conspicuous crisis is the shortage of beds. It was found that 70% of the patients got bed immediately after admission through bribes (creating artificial crisis first and then managed), 20% stayed on the floor and 10% shared beds with others for 5 days.The patients were asked to comment on the overall service quality of the hospital. According to the findings, 30% of the indoor and 19% of the outdoor patients were satisfied with the service, while 30% and 35% respectively were dissatisfied with the quality of service.

After getting admitted in the hospital the patients have to pay money to different people in the name of tips. It was found that 93% patients who used trolley paid Tk 42 as tips, 38% who were bandaged and got dressing paid Tk 53, 6% paid the sweeper Tk 13 to clean the floor around their bed, and 65% patient staying in the hospital for 15 days on average paid Tk 27 on average everyday to the ward boy. The visiting hour in the hospital is between 4 p.m. to 7 p.m. but 66% patients had visitors other than this hour by paying on average Tk 9 to the gatekeeper.

There are various kinds of mismanagements and corruption in diagnostic tests. In such cases the patients are harassed by the doctors, staffs and the middlemen. 65% of the indoor and 50% of the outdoor patients was instructed to undergo diagnostic tests from particular diagnostic centers. It should be mentioned here that doctors get commission of 30% to 50% from these centers. (Transparency International Bangladesh, A Diagnostic Study by Taslima Akter and Shahidul Islam, 2010).

The cooperation towards the illiterate people from DMCH is extremely bad, where in our medical service system it is of crucial importance. A man in his mid thirties standing in a queue, said,

“I have come to see a doctor for my eye, but didn’t know where the department was. No one at the ticket counter told me where to go. I asked at least eight different persons to find out the right section. I have been standing in this queue for 15 minutes now. After I submit the ticket, they will write down the name of the doctor who will see me.” (bangladeshnews.com.bd)

Ali and Medheker (2011) argue that health management can be improved through strategic formulation and implementation of the government policy. There is no other alternative but to take holistic approach to develop this sector. Medical tourism in Bangladesh may be developed for which it can be taken as a part of Vision 2021.This will help raise national income of Bangladesh.

Ali and Medheker (2012) comment that main push factors for Bangladeshis to travel to India for medical treatment were non-availability of specialised treatment, high cost, corruption, lack of medical expertise corruption and ethical practice in Bangladesh. Further, the pull factors were experienced doctors and physicians, good quality of nursing care (pre and post surgery), low cost of surgery, and state of the art medical technology, treatment and medical facilities in India, along with source of information from relatives, which concurs with the emerging medical tourism literature.

Among all the studies, most importantly, only the findings were stated but the reason associated with the findings were not clearly identified. In any findings, if we can try to get the root cause of the respective problems or set back then only we can reveal the gaps in performance management and can come up with a proper set of recommendations for the betterment of the overall scenario. The present study was carried out with the aim to find out the situation as well as to analyze and find out the related root cause that lead to this situation and thereafter address the management steps to overcome the situation in order to ensure a better health service towards the people.

3. Objectives of the Study

The study has been undertaken with following objectives:

i) To assess the present situation of a prime Govt. hospital i.e. DMCH of the country;
ii) To evaluate the service providers quality;
iii) To ascertain the receivers' situation of the country;
iv) To provide recommendations for betterment of the health services of the country.

4. Methodology of the Study

In order to perform the study we have selected 4 (Four) types of Respondents of DMCH to get the opinions and perception on the issues related to our Title of the study. 04 (Four) set of Questionnaires have been developed to interview the respondents of 04 (Four) category .Doctors, Nurses, Ward Boys and Patients were interviewed through physically at DMCH in order to acquire the primary data. However, the respondents have been collected randomly.

During the days of interviews various authenticated information have been collected from the Office of Administration as well as through talking to various people like senior doctors of Management Level, security, cleaner, attendance of patients and also observed the real life scenario waiting there, what helped us a lot in the study. We have also collected some previous works, published news and interviews relevant to our study and taken into account as Secondary data. Time period of the study is August 2011 to November 2011.

4.1 Data Analysis

A total of 85 (Eighty Five) Interviews were carried out in DMCH through random selection of 4 groups of respondents out of which 17 Doctors and 25 Nurses from different departments, 18 patients and 25 ward boys of different wards were there.

Few issues were there in the questionnaire related to service and quality, where opinions have taken from all 85 respondents. And some opinions were there which were collected only from Doctors and Nurses through random selection. Accumulation and analysis of all data have given us a clear picture of different operational aspects of DMCH.

All the respondents were adult and mixed up with Male & Female (except Nurses, all are female by default in our society).

All the Primary data has been analyzed through appropriate tool.

4.2 Hypothesis Testing

Null Hypothesis: DMCH provides good health care services.
Alternative Hypothesis: DMCH does not provide good health care services.

4.3 Limitations of the Study

The study has been done through selecting only one govt. hospital. Private hospital did not take under the study. Moreover, selections of the respondents were done randomly.

5. Present Status

Even being one of the basic right and an important indicator of Human Development Index (HDI), our Health sector has been suffering from capacity problems, shortage of necessary medical equipments, medicines, doctors and trained nurses. Every year government allocates large sums of money in the budget for health care, but it is not-sufficient from the demand perspective. There is wide documentation of corruption in the health care sector published in the both print and electronic media.

Due to the majority of population belonging to the lower economical group, our dependency on the Government Health Care system is very high. But there is widespread public perception about the low quality of health service delivery, be it provided by government, private or other non-state actors in Bangladesh. Several studies and surveys published has proven that the quality of healthcare has declined in Bangladesh with increasing cost backed by the non-availability of certain treatments, more waiting time, lack of cordial and caring doctors, scarcity of professional nursing staff, poor reliability on pathological and diagnostic tests etc.

Even the "Elite" Private Hospitals, where it matters "Money" only, the above limitations are evident. According to one patient's statement, "unethical or inhumane professional practices are a common practice in Bangladesh. A common complaint against the doctors in this country is that they often send their patients for unnecessary diagnostic tests to labs, thus pocketing 50-60% of the charge. Taking hostage of dead bodies for not clearing the hospitalisation costs by some of the hospitals is becoming quite common".

The scenarios in the government-supported hospitals are worse. Serious allegations such as swapping of a dead child with a newborn baby, not attending to patients in coma, absence of human touch and care from the hospital staff, and lack of ethical considerations etc. are causing damage to healthcare professional standards, goodwill and image of the hospital.

Unethical malpractice and lack of human touch in pre and post surgery, lack of quality of healthcare service besides high cost, non availability of treatment, latest medical technology, malpractice and lack of specialist medical staff are some of the ways how the general people are deprived in the Health Sector.

Everyone in Bangladesh knows that medical doctors in public hospitals either own or have a contractual relationship with private clinics. For doctors, public service is a false identity. Their true identity is making money through their private practice or business. They appoint public hospital staff members as brokers to bring clients to private clinics instead of properly treating them in public hospitals. Even if people are treated in a public hospital,

they are forced by the doctor to visit private clinics for diagnosis purposes and in return doctors earn ‘commissions’.

Facilities available at the 1,700-bed Dhaka Medical College and Hospital (DMCH) are inadequate to meet the demand of patients who throng there every day for treatment. Experts say the hospital, running with one-third of the manpower it needs, is also making ill use of its available — though inadequate — infrastructure and logistics.

Experts say, the size of the hospital demands at least triple the manpower it possesses at present. There has been no recruitment at the hospital since 2004 and the existing number of staff is on the decline because of retirements.
There are, however, some professors, associate and assistant professors and honorary physicians, other than the staff, who are attached with the medical college and are considered visiting experts at the hospital.

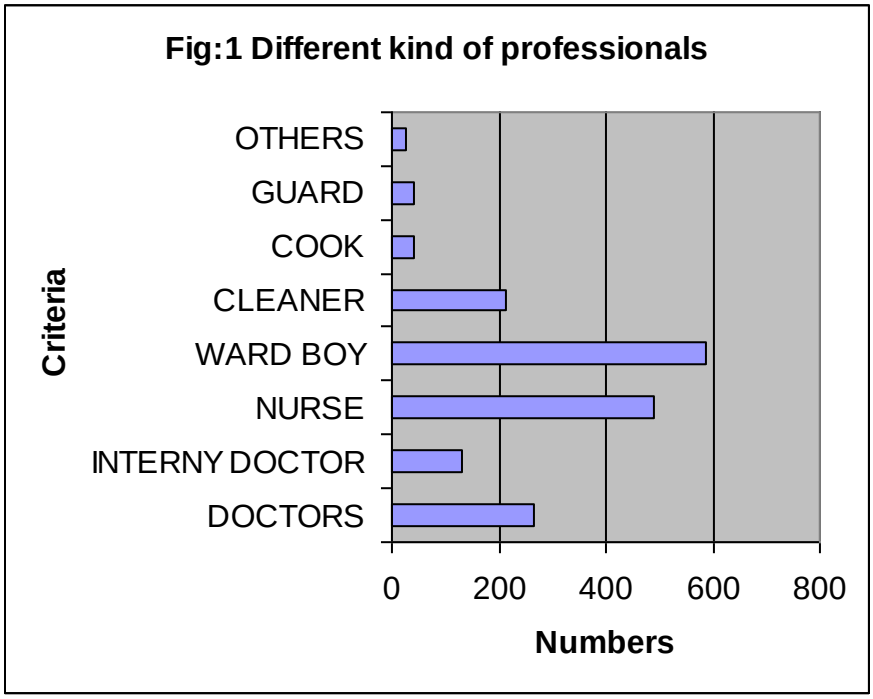
In practice, this inadequacy of the hospital leads to its rundown service. The picture after 2:30 pm is totally different from that of the morning hours. The professors, associate and assistant professors are on duty only between 8:00 am to 2:30 pm. So though the hospital admits patients round the clock, those who come in the afternoon do not get the expert attention they need.

It is alleged that a group of brokers exploit the situation by extorting money from poor patients, promising to get them seats in return. It was found an elderly patient from Sylhet lying in a corridor behind the outdoor department waiting for a broker to get him a bed. The patient, in his mid-sixties, said that he had been waiting there for two days since someone promised to get him admitted. The miscreant had even taken away the man’s prescription from the outdoor department. The hospital authority has taken no further steps than putting up posters saying ‘Beware of brokers’ on its wall to tackle the situation.

The weak governance in health sector by the Government i.e. the lack in the Operation Management is the root cause of this overall situation. Doctors are involved with politics which creates unhealthy atmosphere. Third class and fourth class employees are involved in corruption with the help of God fathers.

6. Analysis of Findings

From the official registrar of the hospital, the numbers of different kind of professionals are found, which is shown in Figure:1:



Out of 85 respondents of the study, Doctors were 20%, Nurse and Ward Boy were as per target with 25 nos. of each and Patients were 18 nos., giving a more or less expected level of even distribution of the respondents are given in TABLE: A in the appendix.

Among the Patients majority are coming from outside Dhaka, where the medical service has a remarkable limitations in compare to the service facility exist in the capital (TABLE: B) in the appendix. In addition, most of the patients have come to DMCH with the perception of availability of the "Better Treatment" in the capital though a remarkable percentage has come as their local doctors suggested so (TABLE: C) in the appendix.

Though DMCH had launched the "Ambulance Service", but the targeted people is not aware about that facility and the patients coming from outside Dhaka, who need the facility most, are not aware at all about the facility. Only one-fourth of the patients know that DMCH has this facility. Three-fourth of the patients have either the wrong awareness or no awareness about ambulance service in TABLE 1:

Table 1: Awareness about Ambulance Service

Respondent – Patient : [18]

Coming from	Wrong Awareness (No		Lack of Awareness		Positive Awareness		Total 29%	
Dhaka	1	25%	1	10%	1	25%	3	16.7%
Outside Dhaka	3	75%	9	90%	3	75%	15	83.3%
Total	4	22%	10	56%	4	22%	18	100%

Source: Collected by Author

The emergency service observed “Better” by the maximum of the patients TABLE 2 though there is a question that whether the patients came to emergency were at a situation to observe the service? Because in many cases, the patient’s attendance gave different opinions. But 89% of these attendance confirmed about the availability of the doctors at emergency. The complaints at the outdoor department of DMCH are almost endless. The sufferings of patients seeking treatment here begin with the absence of any help desk here. Patients buy an outdoor ticket with more than the value of Govt. defined rate. After that they wander about, as they are often clueless about which department or direction to go to. This is particularly a huge problem for the illiterate patients who don’t understand which nook or corner of the hospital to go to.

Table 2: Opinion on Emergency Service at DMCH

Respondent – Patient : [18]

Coming from	Good 8		Average 9		Bad 17		Total 29%	
Dhaka	1	50%	1	50%	0	0%	2	11%
Outside Dhaka	10	63%	4	25%	2	13%	16	89%
Total	11	67%	5	28%	2	11%	18	100%

Source: Collected by Author

No professional like guard or ward boys are co-operating to the patients who are fully in dark about the location of different wards, where to go. From the patients and their attendance and to some extent from the nurses also it has been found that the ward boys are mostly unavailable in their duties and nobody has any control over them. It can be better explained through the length of the service analysis as found in the study (TABLE 3).

Table 3: Associations of Professionals with DMCH

Respondent – Doctor, Nurse, Ward Boy : [67]

Professional	0 – 5 years 8		5 – 10 years 9		10 years + 17		Total 29%	
Nurse	3	12%	4	16%	18	72%	25	37%
Ward Boy	0	0%	13	52%	12	48%	25	37%
Total	19	30%	18	27%	30	45%	67	100%

Source: Collected by Author

100% of the Ward Boys are working with DMCH more than 5 years. There is no transfer issue for them and the DMCH has become their home where no administrative control over them exists. Even the maximum length of their services or experiences are only with DMCH, meaning they have started here and DMCH become their home and for them job security is 100%, what is evident in TABLE 4.

Table 4: Maximum Associations with DMCH

Respondent – Nurse, Ward Boy : [50]

% of service length with DMCH	Nurse 9		Ward Boy 17		Total 29%	
0% - 25% of service length	4	16%	0	0%	4	8%
26% - 50% of service length	1	4%	0	0%	1	2%
50% - 75% of service length	4	16%	0	0%	4	8%
75% - 100% of service length	16	64%	25	100%	41	82%
Total	25	100%	25	100%	50	100%

Source: Collected by Author

Perceived Opinion on different aspects of medical services have been collected in the study, where (i) Hygienic Environment, (ii) Diagnostic facility, (iii) Visiting Hour Management, (iv) Equity of Services toward patients coming from different economy classes and (v) Supply of Medication, have been classified as of “Average” Level in DMCH. Here (i) Services of Doctors and (ii) Services of Nurses have been found quite “Good”. Remarkable percentage of opinions are “Bad” regarding (i) Hygienic Environment, (ii) Visiting Hour Management and (iii) Quality of Food Supply indicate the extremely Bad management of the system. (TABLE 5 [A] – [H]) in below.

Table 5: Perceptions on Different Services of DMCH

Respondent – Doctor, Nurse, Ward Boy, Patient : [85]

[A] SERVICE : Hygienic environment

Respondent Type	GOOD 8		AVERAGE 9		BAD 17		TOTAL	
Doctor	2	15%	13	22%	2	17%	17	20%
Nurse	4	31%	15	25%	6	50%	25	29%
Ward Boy	3	23%	22	37%	0	0%	25	29%
Patient	4	31%	10	17%	4	33%	18	21%
Total	13	15%	60	71%	12	14%	85	100%

Source: Collected by Author

[B] SERVICE : Doctor's visit to the patients

Respondent Type	GOOD 8		AVERAGE 9		BAD 17		TOTAL	
Doctor	17	29%	0	0%	0	0%	17	20%
Nurse	12	20%	13	52%	0	0%	25	29%
Ward Boy	21	36%	4	16%	0	0%	25	29%
Patient	9	15%	8	32%	1	100%	18	21%
Total	19	69%	25	29%	1	1%	85	100%

Source: Collected by Author

[C] SERVICE: Services of Nurses

Respondent Type	GOOD 8		AVERAGE 9		BAD 17		TOTAL	
Doctor	12	23%	5	21%	0	0%	17	20%
Nurse	17	32%	8	33%	0	0%	25	29%
Ward Boy	24	45%	0	0%	1	13%	25	29%
Patient	0	0%	11	46%	7	88%	18	21%
Total	53	62%	24	28%	8	9%	85	100%

Source: Collected by Author

[D] SERVICE : Diagnostic Facility

Respondent Type	GOOD 8		AVERAGE 9		BAD 17		TOTAL	
DOCTORS	11	37%	6	11%	0	0%	17	20%
NURSES	13	43%	12	23%	0	0%	25	29%
WARD BOYS	3	10%	22	42%	0	0%	25	29%
PATIENTS	3	10%	13	25%	2	100%	18	21%
TOTAL	30	35%	53	62%	2	2%	85	100%

Source: Collected by Author

[E] SERVICE: Supply of Medication

Respondent Type	GOOD 8		AVERAGE 9		BAD 17		TOTAL	
Doctor	8	29%	9	6%	0	0%	17	20%
Nurse	15	54%	8	16%	2	14%	25	29%
Ward Boy	2	7%	21	16%	2	14%	25	29%
Patient	3	11%	5	52%	10	71%	18	21%
Total	28	33%	43	27%	14	16%	85	100%

Source: Collected by Author

[F] SERVICE : Visiting Hour Management

Respondent Type	GOOD 8		AVERAGE 9		BAD 17		TOTAL	
Doctor	2	11%	5	12%	10	40%	17	20%
Nurse	2	11%	19	45%	4	16%	25	29%
Ward Boy	12	67%	7	17%	6	24%	25	29%
Patient	2	11%	11	26%	5	20%	18	21%
Total	18	21%	42	49%	25	29%	85	100%

Source: Collected by Author

[G] SERVICE: Equity of service among different economy classes

Respondent Type	GOOD 8		AVERAGE 9		BAD 17		TOTAL	
Doctor	14	47%	2	4%	1	14%	17	20%
Nurse	8	27%	14	29%	3	43%	25	29%
Ward Boy	3	10%	21	44%	1	14%	25	29%
Patient	5	17%	11	23%	2	29%	18	21%
Total	30	35%	48	56%	7	8%	85	100%

Source: Collected by Author

[H] SERVICE: Quality of Food supplied to patient

Respondent Type	GOOD 8		AVERAGE 9		BAD 17		TOTAL	
Doctor	6	14%	8	22%	3	50%	17	20%
Nurse	10	23%	13	36%	2	33%	25	29%
Ward Boy	24	56%	1	3%	0	0%	25	29%
Patient	3	7%	14	39%	1	17%	18	21%
Total	43	51%	36	42%	6	7%	85	100%

Source: Collected by Author

However, overall observations considering all types of respondents together, the scenario shown is comparatively far better. Because, if the “Patient” group is looked at separately in service areas of DMCH, it is evident from the above tables that in all the service areas of DMCH, service status are much worse. And from this it can be concluded that the patients are not getting their expected Medical Services whereas almost all the patients have come here with the perception of getting “Better Services” from DMCH but now facing the reality. No restriction in entry and extremely bad visitor maintenance system and as a consequence poor hygienic environment has become the alarming issue. 72% of the total respondents (including doctors, nurses, ward boys, patients) are not satisfied with the Hygienic environment (TABLE 5[A]).

Poor Medicine inventory is a well accepted common issue for DMCH. 57% have made the comment about the poor inventory of medication supply (TABLE 5[E]) in appendix. All patients were supposed to be provided required medicines free from the hospital but were not. Medicines included antibiotics, analgesics, syringe, catheter, blood, and so forth. Medicine was usually bought when patients were admitted at night. The medicine required for treatment is ordered by the on-duty physician but it takes several hours for the hospital management to process the order. Thus, no free medicine is available immediately. To start the treatment, the on-duty physician requests the patient's relatives to buy the medicine, which is purchased from nearby private pharmacies.

Interviews found that the Food is provided by the hospital but of poor quality or totally lacking (liquid food such as soup or horlicks had to be bought for patients who had undergone surgery since these were not provided by the hospital). Relatives usually stayed with the patient in the hospital because of lack of ayahs (cleaning ladies) or nurses to provide necessary services. Thus, food was usually bought from a vendor or brought from home for both patient and relatives. According to the hospital chart, a patient gets eight slices of bread with one boiled egg, one banana, 30 grams of sugar and two ounce of jelly at breakfast, 225gm rice, 95gm fish or meat, 45gm pulse, 200gm vegetables and a banana at lunch, and 225gm rice, two eggs, 40gm pulse, 200gm vegetables and a banana at dinner. Patients say less than 150gm coarse rice, three or four pieces of bread, less than 35gm fish or meat, substandard jelly and very small and green bananas were supplied. But a consultant of Gynecology said, “The patients now look happy with the food quality. Previously, they could not eat the supplied substandard food.”

Though the services of ward boys are extremely poor and most of the times are unavailable, but Tips (bakshish) become the permanent tradition to be made to the ward boys, ayahs and guards. Ayahs are given tips for routine services such as pushing the patient's trolley to and from the labour/operation room, preparing patient before delivery/surgery, etc. Guards at the gates were tipped each time a relative came to visit the patient during non-visitor hours. However, ayahs, ward boys and guards are salaried hospital employees and are supposed to provide these services free of charge. The patients were reluctant when talking about the tips probably because they were still hospitalized and depended on these employees for access to certain services.

A very clear picture has been revealed in this study about the areas of improvement in DMCH, which is the most important outcome of the study and data analysis on it providing the essential recommendations and Policy implications of this study. TABLE 6 is given below:

Table 6: Areas of Improvement for Operations Management in DMCH

Respondent – Doctor, Nurse : [42]

Areas of Improvement	Doctor 9		Nurse 17		Total 29%	
NUMBER OF BED	11	26%	7	17%	18	43%
NUMBER OF NURSES	13	31%	24	57%	37	88%
DIAGNOSTIC FACILITY	4	10%	2	5%	6	14%
ATTENDANCE RESTRICTION	7	17%	14	33%	21	50%
HYGIENE MANAGEMENT	11	26%	8	19%	19	45%
VISITING HOUR MANAGEMENT	4	10%	5	12%	9	21%
RESEARCH AND MEDICAL AUDIT	2	5%	0	0%	2	5%
EMERGENCY FACILITY IN EVERY WARD	4	10%	0	0%	4	10%
ADMINISTRATION	4	10%	9	21%	13	31%
FOOD QUALITY	1	2%	1	2%	2	5%
MEDICINE INVENTORY	9	21%	11	26%	20	48%
NUMBER OF DOCTORS	2	5%	0	0%	2	5%
SECURITY	1	2%	8	19%	9	21%

Source: Collected by Author

The scarcity of Nurses appeared as the most crucial and most alarming demand for DMCH. The situation is no better with support staff with often a single staff nurse in each ward to look after 40 to 60 patients. While interviewing, some nurses shared a view – “Due to poor remuneration and facilities a number of trained senior nurses are going abroad due

to high demand of nurses in other countries." 88% of the respondents claimed the shortage of Nurses as the area of highest attention to be given (TABLE 6).

Restriction on attendance and visiting hour management have been found as the 2nd and third important area to be improved (TABLE 6) and all the respondent's comments were unique in the issue. It is very much visible that the failure of the Management system has destroyed the total environment of the hospital and turned like a market place. Due to this non-restriction, it is merely impossible to maintain the hygienic environment of the hospital which is a absolute mandatory.

Seat crisis i.e. shortage of Beds are the next one to be mentioned. Under the 'Expansion and Modernization of Dhaka Medical College Hospital' project from 1994 up to 2003 and then again through several attempt the number of beds were subsequently increased through an administrative order providing only drugs and Medical and Surgical Requirements (MSR). It did not increase the manpower, infrastructure and or other ancillary facilities of the hospital, which experts point out, jeopardized the very purpose of the increase in beds. The majority of the patients who throng DMCH belong to the middle and lower middle classes who cannot afford treatment at the city's many private hospitals. Though the number of beds at DMCH has been increased, it still stands short of meeting the increasing demand. This excessive burden puts pressure on the quality of treatment provided. One-third of the patients at DMCH are not able to get beds but are admitted and forced to seek treatment from floor beddings all year round.

Visitors walk past these patients lying on the floors, exposing them to dust and dirt and increasing the risk of infection. There also remains a concern for minimum privacy.

It's often even alleged that patients are sometimes released before cure to make room for more critically ill ones.

A patient complained that ultimately when they do go to a doctor, it's often of little help. Most of the times gossiping or the political discussion is going on in the doctors' room.

> *"The doctors even don't want to hear our problems and begin to write down prescription before we have finished talking," he said referring to the Medical Officers (MO) at the outdoor department.*
>
> *"It feels like they are more happy to just get us out of their rooms," another patient said with adding, "After 2 pm any doctor will be rarely found in the hospital."*
>
> *One of the doctor countered this allegation by saying, "a Medical Officer has to attend to around 200 patients every day between 8:00 am and 2:30 pm. How much time do you think that gives him for each patient? Only 1.5 minutes on an average? What kind of service is possible within this short time?"*

Experts say that a hospital providing 24-hour service must have at least three shifts, as it is not possible for any person to work round the clock. At present the DMCH staff

capability means that only the needs of a single shift are met, on paper. In reality these employees are scattered to work round the clock at the hospital.

In practice, this inadequacy of the hospital leads to its rundown service. The picture after 2:30 pm is totally different from that of the morning hours. The professors, associate and assistant professors are on duty only between 8:00 am to 2:30 pm.

The situation of the hospital reached to the peak of it's worst point during the religious holidays like Eid. The period of Interview was immediately after Eid. Many of the hospital beds were seen empty as patients left the hospital in large numbers.

"We are releasing the patients who are out of danger and almost recovered from their ailment. In many cases patients themselves requested for early release on the occasion of Eid," said one of the Doctor.

He admitted that more than half of the doctors and nurses would be on leave for additional two to three days after govt. declared holidays. He, however, said hospital staffs living in the city were granted leave on condition of rushing to the hospital in case of emergency, while the regular emergency service would operate as usual. He failed to give the exact number of doctors and nurses going on leave during the festival.

The mass discharge mostly affected the patients who came from remote places and are yet to be recovered completely or awaiting operation after the Eid.

"My elder brother has been discharged though he still requires treatment. Doctors have asked us to come after the Eid," said one of attendants of patients, who came from a district far away from Dhaka nine days ago after his brother, suffered a brain stroke. And he was discharged two days ago but could not be taken out of the hospital as he was too weak to bear a travel through the dilapidated road to their district."

During the Eid festival all sort of admissions are on hold for 7-days. Though there were enough vacant beds but irrespective of the seriousness all the patients have to lay down in the verandah as admission is on hold. Bureaucracy is much stronger than the value of a life and this is the reality of our medical services.

There are cabins available for the economically solvent patients (Tk.500 per day) but due the level of regular patients, all the cabins remain empty whereas there is scarcity of beds in wards. If the Management has the intension to provide real medical health service, they should think of the necessity of these cabins or increase of the general beds for the mass people.

About the service towards the poor patients, who have no financial capability to get the medical service, the responses received are not very clear. Some identified this area as excellent service areas where poor patients are getting everything free (Table 7):

Table 7: Services towards Poor Patients at DMCH

Respondent – Doctor, Nurse, Ward Boy : [67]

% of service length with DMCH	Doctors 9		Nurse		Ward Boy		TOTAL	
FREE BED, FOOD	1	6%	1	4%			2	3%
FREE BED, FOOD, DRUGS & DIAGNOSIS	7	41%	8	32%	5	20%	20	30%
FREE DIAGNOSIS & TREATMENT FROM POOR FUND	3	18%					3	4%
SOCIAL WELFARE DEPARTMENT RENDER SERVICE	2	12%	7	28%	3	12%	12	18%
SMALL CHARGES TAKEN FROM POOR PATIENTS	4	24%	2	8%	7	28%	13	19%
INSUFFICIENT	0		7	28%	8	32%	15	22%
NO RESPONSE	0				2	8%	2	3%
TOTAL	17		25		25		67	

Source: Collected by Author

.

Almost equal percentage of respondents stated this area as an activity of “Poor Fund” or “Social Welfare Department”, however 22% of the respondent clearly stated that the service providing towards the poor patients are not sufficient enough (Table 7) .

Most of the Patients have given positive answers about the economic service of DMCH in both Cabin cost and Expense on Cost perspective, whereas deviations found in the responses of professionals. It can be explained in a way that as majority of the patients here have come from outside Dhaka and having very little perception about their level of expectation of service versus the expenses. This is shown in appendix.

The rural areas, where there is severe scarcity of medical services specially for any critical medical problem have almost no service, the expenses are more over there due to dominating few medical service centers. However, 60% of nurses termed the cabin cost as an expensive one and 52% of them also termed the Expense on Service relation as a slightly expensive one and 20% of the nurses think it is expensive. But majority of the respondents have termed the expenses as economic and considerable percentage of respondents see the services versus costs perceptions as standard (Table 8 a and Table 8 B).

Table 8 (A): Perceptions on Expenses – Cabin Cost

Respondent – Doctor, Nurse, Ward Boy, Patient : [85]

Respondent Type	Economic 8		Standard 9		Slightly Expensive		Expensive		TOTAL
Doctor	15	88%	1	6%	1	6%			17
Nurse	4	16%			6	24%	15	60%	25
Ward Boy	18	72%	7	28%					25
Patient	17	94%	1	6%					18
Total	54	64%	9	11%	7	8%	15	18%	85

Source: Collected by Author

Table 8(B): Perceptions on Expenses – Cost on Services

Respondent – Doctor, Nurse, Ward Boy, Patient : [85]

Respondent Type	Economic 8		Standard 9		Slightly Expensive		Expensive		TOTAL
Doctor	12	71%	5	29%					17
Nurse	6	24%	1	4%	13	52%	5	20%	25
Ward Boy	3	12%	22	88%					25
Patient	17	94%	1	6%					18
Total	38	45%	29	34%	13	15%	5	6%	85

Source: Collected by Author

7. Concluding Remarks and Recommendations

Along with the study and its analysis, it has been clearly understood that the number of areas in DMCH where many policy implications are needed backed by a aggressive and quality planning of Operations Management. This is to be done in order to maintain the quality assurance of Dhaka Medical College Hospital as a core institution for Medical Service provider to the peoples of the country. From the filed survey it proves that DMCH does not provide good services for which we accept alternative hypothesis. Actually the basic research question of the study indicates poorer healthcare services. The policy makers should consider Ali and Medheker's (2011) suggestions. They should try to emphasis development of the govt. hospitals so that patients can get better treatment facilities.

The Visiting Hour of the Patients and the number of allowable attendants to be strictly controlled in order protect the safe - hygienic - secured environment of the hospital. There is administrative failure in the total system of the operation. Actually findings of the Transparency International Ltd., Bangladesh (http://www.ti-bangladesh.org/research/ES_DMCH.pdf) is totally true.

The number of nurses is in alarming situation to provide the proper medical services towards the patients. Only one or two nurses were observed per ward and many patients addressed the issue that Doctors are communicating to their illiterate attendances to brief them how and when, what medicine to be given to patients. The number of nurses ought to be increased substantially in DMCH.

The poor inventory of medicine is of crucial importance in order to provide the right treatment and health services. Moreover corruption has been critically identified and reported many times in the news media, which need to be addressed strongly. Actually WHO (2007) observations that health problems today are no longer merely the responsibility of those working on health, but require positive action by those outside the health sector should be seriously considered by the policy makers. Otherwise people of the country will no other alternative to go outside the country for treatment purposes.

The crises in the number of Beds are acute, whereas numbers of cabins are keeping idle in DMCH. The economic classes of the patients who are coming to DMCH from different districts do not need luxury of cabins rather a normal bed.

During vacation, admission is totally being stopped. Serious patients are lying down outside, though the there are beds available in wards. There are no alternative supportive plans to provide the services to the patients during long holidays which can not be think of in this modern world and in the hospital which is perceived as the centre and idle of the medical services in the country.

Introduction of Help desk, round-the clock duty roaster of support staffs, controlling of corruption are the other areas to look at. Even there are huge unemployment problem in our country and in govt. organization, rotational transfer happens, but in DMCH most of the ward boys are working since long and involved in other activities rather than their professional services.

Administrative bureaucracy as well as rampant corruption, politics among doctors, negligence of duties to be eliminated and more human friendly behavior are required for the service organizations like DMCH if it really wants to be a service centre for the people.

References

Ahmed, M, 2000, “Promoting Public-Private Partnership in Health and Education: The Case of Bangladesh” in Yidan Wang ed ‘Public-Private Partnerships in The Social Sector: Issues and Country Experiences in Asia and the Pacific’, Asian Development Bank Institute. pp. 219-290.

Ahmed, SM , Alayne MA , Chowdhury, M and Bhuiya, A , 2000, “Gender, socioeconomic development and health-seeking behaviour in Bangladesh”, *Social science & medi*cine, pp. 361

Ahsan, MB 2001, “Cross talk The night of the lost nose-pins” http://thedailystar.net/dailystarnews/200111/16/n1111602.htm#BODY3 in The Daily Star. Dhaka.

Ali, MM and Medhekar ,A, 2011," A *Medical tourism to India*: An analysis", *The Financial Express, Bangladesh* 29 April

Ali, MM and Medhekar ,A,2012, "A Cross-Border Trade in Healthcare services: Bangladesh to India " ,*Presidency University Journal,*Vol.1,No.1.

Andaleeb,SS,2000, "Public and private hospitals in Bangladesh: service quality and predictors of hospital choice", HEALTH POLICY AND PLANNING, Oxford University Press , Vol. 15,No.1,pp. 95–102 .

Ara, F , 2008. Public-Private Partnership in Providing Primary Health Care Services in Urban Bangladesh. Unpublished Master Thesis submitted as partial fulfillment of M.Phil Degree in the University of Bergen, Norway.

Asian Development Bank (ADB), 2005, Report and Recommendation of the President to the Board of Directors on a Proposed Loan and Asian Development Fund Grant to the People's Republic of Bangladesh for the Second Urban Primary Health Care Project. RRP: BAN 36296. May.

bdnews24.com/kt/shs/nir/1905h

Chaudhury N, Hammer JS, 2003, " Ghost Doctors: Absenteeism in Bangladesh health facilities" Dhaka, World Bank; pp:1-44.

DGHS 2001, Bangladesh Health Bulletin 1998-99. Dhaka, Directorate-General of Health Services

Haque, YA and Clarke, JM, 2002," The Women Friendly Hospital Initiative in Bangladesh Setting: Standards for the care of Women Subject to Violence", *Gynecology & Obstetrics* ,Vol.78

http://en.wikipedia.org/wiki/Dhaka_Medical_College_and_Hospital

http://www.ti-bangladesh.org/research/ES_DMCH.pdf

Islam, KM , 2007, Impact of Health Sector Reform on State and Society in Bangladesh. Published online PhD Thesis. archiv.ub.uni- heidelberg.de /volltextserver /volltexte /2007/7862 /pdf/Table_of_content_final_with_cover_page.pdf.

Jahan, R and Salehin, M ,2006, 'Health Care for Rural People of Bangladesh: Overview of Some Governance Issues' in Salahuddin M. Aminuzzaman eds 'Governance and Development: Bangladesh and Regional Experiences'. Shrabon Prokashoni, Dhaka.

Khan, MR 1988,Evaluation of Primary Health Care and Family Planning Facilities and Their Limitations Specially in the Rural Areas of Bangladesh. Dhaka: Bangladesh Institute of Development Studies.

Lee , K , Drager, N & Dodgson, R , 2000, Global Health Governance: A Conceptual Review. World Health Organization (WHO) & Centre on Global Change & Health Department of Health & Development, London School of Hygiene.

Lewis, W A, 1955, *The Theory of Economic Growth*, Allen and Unwin, London.

Osman, FA , 2004, *Policy Making in Bangladesh: A Study of the Health Policy Process. Bangladesh*, A H Development Publishing House.

Perry, HB 1999. *Quest For a Healthy Bangladesh : A Vision for the Twenty-First Century. Bangladesh ,* The University Press Limited (UPL).

Rights in Action (RIA) & Overseas Development Institute (ODI), 2007,*Voice for Accountability: Citizens, the State and Realistic Governance,* The UK.

Rahman MR 1999, Political economy of health in Bangladesh, unpublished M.Phil dissertation. In Centre for Social Medicine and Community Health. New Delhi., Jawaharlal Nehru University .

Rahman RM,,Hashem F, 2000," The state of health determinants in Bangladesh", *International Journal of Sociology and Social Policy*, pp.33-54.

Sobhan, R et al., 1998, 'Governance of Public Health in Bangladesh' in *Crisis in Governance : A Review of Bangladesh's Development 1997*.Dhaka, Centre for Policy Dialogue and University Press Limited.

The Daily Prothom Alo, 2008. 22 November 11

The Daily Star, 2004, "Non-governmental organizations getting bigger health care role", Dhaka, June 8

The Daily Star, 2008 24. November

The New Nation ,2002, "Health care demands more attention", editorial. Dhaka, September 17.

World Bank 2002*, Health Facility Waste Management Study in Bangladesh. Dhaka*

World Health Organization (WHO), 2007, WHO Country Cooperation Strategy 2008-2013: Bangladesh. Country Office In Bangladesh.

Appendix

Table A: Distribution of Respondents

Respondent – Doctor, Nurse, Ward Boy, Patient : [85]

Type of Respondents	Male	Female	Total	
Doctor	8	9	17	20%
Nurse	0	25	25	29%
Ward Boy	25	0	25	29%
Patient	18	0	18	21%
Total	51	34	85	100%
	60%	40%		

Source: Collected by Author

Table B: Locality of the Patients Coming From

Respondent – Patient : [18]

Type of Respondents	From Dhaka	From Outside Dhaka	Total	
Patient	3 (17%)	15 (83%)	18	100%

Source: Collected by Author

Table C: Reason to Choose DMCH

Respondent – Patient : [18]

Coming from	Economic		Better Treatment		Referred by doctor		Total 29%	
Patients	1	6%	13	72%	4	22%	18	100%

Source: Collected by Author