

# **Citizens Trust in Public Institution: A Study of Service Delivery Institutions at Local Level in Bangladesh**



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## CONTENTS

	Page
Contents	i-vii
List of Tables	viii-ix
List of Figures	ix
List of boxes	ix-x
List of Abbreviations	xi-xii
Abstract	xiii
Acknowledgement	xvii
Dedication	xix
<b>Chapter- I Background and Context of the Study</b>	<b>1</b>
Introduction	1
What is this study about?	2
Statement of the problem	4
The notion of non-professionalism	5
Unresponsive services	7
Services at OPD & Consultation	7
Supply of medicines	8
Preventive medicine and campaign	8
Service delivery and referral system	9
The culture of corruption	10
Politicization of health professionals	12
Erosion of generalized trust in public sphere	13
Hypothesis of the study	14
Objectives of the study	14
Research questions	15
Why trust is important in general and for the purpose of the study?	15
Significance of the study	17
Scope of the study	18

Organization of the dissertation	19
Conclusion	19
<b>Chapter-II Health System in Bangladesh</b>	<b>21</b>
Introduction	21
Overview of Health Institutions in Bangladesh	22
Health Policy Reforms	24
Health Policy 2011	27
Primary Health Care	27
Primary Health Care delivery system in Bangladesh	30
The Upazila Health System	30
The Upazila Health Complex (UHC)	30
Health Care at Union level	33
Community Health Care Service	33
Brief account of the UHCs under study	35
Chokoria UHC, Cox's Bazar	35
Ali Kadam UHC, Bandarban	35
Sharia Kandi UHC, Bogra	36
Gabtali UHC, Bogra	36
Debiganj UHC, Panchagar	37
Pirganj UHC, Thakurgaon	37
UHC management and oversight	38
Achievement and challenges of PHC	39
Secondary and Tertiary Health Care	41
Urban Health Service	42
Health Expenditure	43
Service Delivery in UHC's under study	45
Service Delivery in UHCs' as reported in media	49
Primary Health Care-Observations drawn from selected studies	51
Conclusion	53

<b>Chapter-III Literature Review on Trust Research</b>	<b>55</b>
Introduction	55
Research on Trust	55
Focus on Culture	56
Variety in trust research	60
Societal level	61
Governance perspective	63
Micro and organizational perspective	66
Economic perspective	66
Trust research in health care	68
Methodological trends in studying trust	72
Challenges of trust research	74
Relevance of trust research	77
Trust research from governance perspective	77
Trust from the perspective of service delivery	81
Implication of trust in dealing with uncertainty and service delivery	82
Conclusion	86
<b>Chapter-IV Research Design and Methodology</b>	<b>89</b>
Introduction	89
Research design	90
The research plan	92
Study location	94
Sampling method and selection of cases	95
Pre-testing and field visits	96
Choice of methods in data collection	97
Collecting data using primary sources	97
Key informants and use of cases	99
Data processing	101
Data analysis	102

Validating the data	103
Methodological limitations of the study	104
Conclusion	105
<b>Chapter-V Theories and Concepts on Trust</b>	<b>106</b>
Introduction	106
Conceptions on trust	107
Theories on trust	109
Rational choice theory	109
The institutional approach to trust	112
Constituents of trust	114
Trust constructs	115
Expectations	116
Belief and willingness	116
Attitude	116
Classification of trust	117
Calculative trust	117
Value or norm based trust	118
Contract trust	118
Goodwill trust and competence trust	119
Identity based and deterrence trust	119
Knowledge based trust	119
Typology of trust	120
Trust at micro level	120
Institutional based trust	120
System trust	121
Societal trust	121
Trust, trustworthiness and institution	122
Ethical considerations	124
A review of trust variables	124
Trustworthiness	126

Reflected trustworthiness	127
Public institution and trust perspective	128
Relationships between institutions and trust	130
Conclusion	133
<b>Chapter-VI Conceptual and analytical framework of the study</b>	<b>134</b>
Introduction	134
Analytical framework	136
Demographic and Identity variables	137
Hypotheses drawn from dimensions of trust, and institutional variables	138
Conclusion	139
<b>Chapter-VII Quantitative and qualitative analysis of empirical data</b>	<b>141</b>
Description of the analytical chapters	141
Respondents profile	142
Upazila wise patients' profile	144
Citizens' trust perceptions on UHC	144
Demographic, identity variables and trust in UHC	150
Age	150
Gender	151
Household expenditure	152
Trend of illness of patients coming to UHC	153
Frequency of visits and trust on UHC	154
Distance to UHC and patients' trust	155
Patients' knowledge and formation of trust	157
Educational level and impact on trust	160
Occupation of patients and trust	161
Dimensions of trustworthiness	162
Are doctors at UHC committed?	162
Patients' perception on doctors' competence	163

Extent of cooperation	165
Nature of privacy and confidentiality extended to patients at UHC	166
Nature of rapport and communication established during patients treatment	168
Do the doctors provide compassionate care to the patients at UHC?	170
State of general level of satisfaction on service delivery at UHC	172
Institutional factors	173
Are services at UHC non-discriminatory?	173
Dependency on UHC	173
What is the state of nursing services at UHC?	174
Is integrity of doctors at UHC wanting?	176
Key findings from the survey	177
Are there variations across upazilas in terms of patients' trust in UHCs?	180
Regression Analysis	181
Qualitative Analysis	188
Does trust matter for treatment in UHC?	188
What is the level of commitment of doctors at UHC?	191
To what extent doctors at UHC are perceived to be competent?	193
Perceptions on doctors competence and service delivery	196
Doctors' competence and opportunism	197
Is patients' privacy at UHC is considered as a barrier for treatment?	200
To what extent doctors at UHC demonstrates compassion towards patients?	201
State of general level of satisfaction on quality of services at UHC	202
To what extent the services at UHC are fair and non-discriminatory?	204
Patients' overall dependence on the services of UHC	205
To what extent the nursing services at UHC are of quality?	206
To what extent doctors at UHC conform to institutional norms and practices?	208
Findings from the discussion	211

Inference drawn on the basis of triangulation	213
Conclusion	221
<b>Chapter- VIII Summary: Concluding Discussion and Implications</b>	<b>223</b>
Introduction	223
Revisiting the analytical framework of the study	224
Does trust matter for patients at UHC?	226
Response to citizens' health needs by service providers at UHC	229
Major trust arena and potential sources of opportunism affecting service delivery in UHC	229
Factors contributing to trust formation in the context of UHC	235
Challenges of PHC from the context of UHC	236
Inadequate capabilities and resources	237
Monitoring and compliance	237
Implications of the findings	238
Theoretical implications	238
Policy implications	243
Scope for further research	246
Revisiting the research questions and hypotheses	247
Course of actions on the basis of hypotheses	261
Revisiting the definition of trust	264
Epilogue	265
Bibliography	268
Appendix-1	280
Appendix-2	285
Appendix-3	286
Appendix-4	287
Appendix-5	288
Appendix-6	289
Appendix-7	291



### List of Tables

Table No.	Title	Page
2.1	Institutions and level of health services	24
2.2	Five Year Plans of Bangladesh	25
2.3	Distribution of health expenditure by function 2006-07	43
2.4	Comparative health expenditure of Bangladesh and other countries	44
2.5	OPD/IPD and emergency patients under the study area	46
2.6	ANC/ delivery services and maternal deaths in the study area	46
3.7	Trends in trust research	73
4.8	Distribution of respondents	96
4.9	Antecedents of key Informants	99
5.10	Trust variables advanced by different Authors	125
5.11	Pillars of institutions	131
7.12	Profile of respondents	142
7.13	Upazila wise patients' profile	144
7.14	Patients' conceptions of trust towards doctors at UHC	147
7.15	Patients' trust and frequency of visit cross-tabulation	155
7.16	Patients' trust and distance from home cross-tabulation	156
7.17	Patients' knowledge and household expenditure cross-tabulation	159
7.18	Patients' trust and education cross-tabulation	160
7.19	Patients' assessment of privacy across study upazilas	167
7.20	State of nurse availability across study upazilas	175
7.21	Patients' trust across upazilas	180

7.22	Variables, definitions and hypotheses	182
7.23	Regression model	184
7.24	Hypotheses and findings of the regression model	185
7.25	Health service delivery at Pirganj UHC, Pirganj, Thakurgaon	197
7.26	Departmental proceedings against medical officers at UHCs	209
8.27	Assumptions and findings of the regression model	227
8.28	Trust arena and potential sources of opportunism	230

### List of Figures

Figure No.	Title	Page
2.1	Health institutions at macro level	23
2.2	Distribution of health expenditure by type	44
2.3	Health expenditure in selected countries in 2008	45
6.4	Analytical framework	136
8.5	Revisiting the analytical framework	225

Box No.	List of Boxes	Page
2.1	Newspaper clip on health services at the periphery	49
7.2	A case of Barabil Union, Gangachara, Rangpur	189
7.3	Story of patient concerning trust in doctors	190
7.4	Case of a patient-Chairman, Pirganj sadar, Pirganj, Thakurgaon	192
7.5	Interview of a teacher at Pirganj High School	192
7.6	Interview of UHFPO, Gabtoli, Bogra	193
7.7	Case no. 4 A case of health intervention with negative impact	194

7.8	Case no.5 A case of survival	195
7.9	Case no. 6 Abdul Jabbar, Gabtoli, Bogra	199
7.10	Case no. 7 Amina Begum, Shariakandi, Bogra	200
7.11	Case no. 8 Syed Ali, Gabtoli, Bogra	201
7.12	Case no. 9 Rahima Begum, Gabtoli, Bogra	201
7.13	Interview no.3 Teacher at Gabtoli Primary School,Bogra	202
7.14	Interview no. 4 Anisul Haque, Debiganj, Panchagar	202
7.15	Interview no. 5 upazila vice-chairman, Debiganj, Panchagar	203
7.16	Interview no.6 UHFPO, Shariakandi, Bogra	203
7.17	Interview no.7 Dr.Syed Abu Jafar Musa, Director, DHS	203
7.18	Interview no.8 A teacher of Gabtoli, Bogra	204
7.19	Interview no. 9 Jobed Ali, Sharia kandi, Bogra	205
7.20	Interview no.10 Dr.Moazzem Hossain Sarkar, Quality Assurance Unit, DHS	207

## List of Abbreviations

ANC	Anti-Natal Care
BNC	Bangladesh Nursing Council
BMDC	Bangladesh Medical and Dental Council
BPC	Bangladesh Planning Commission
BPS	Bangladesh Pharmaceutical Society
CCS	Community Clinics
DDA	Directorate of Drug Administration
DGFP	Director General of Family Planning
DGHS	Director General of Health Services
DHS	Directorate of Health Services
EmOC	Emergency Obstetric Care
EPI	Extended Program on Immunization
ESP	Essential Service Package
FINT	First International Network on Trust
FMRP	Financial Management Reforms Project
FWV	Family Welfare Visitor
FYP	Five Year Plan
GDP	Gross Domestic Product
HPSP	Health and Population Sector Program
HPSS	Health Population Sector Strategy
HNPSP	Health, Nutrition & Population Sector Program
HPNSDP	Health , Population & Nutrition Sector Development Program
IPD	In-Patient Department
LGD	Local Government Division
MBBS	Bachelor of Medicine, Bachelor of Surgery
MDGs	Millennium Development Goals
MoHFW	Ministry of Home and Family Welfare
NGO	Non-Governmental Organization

OPD	Out Patient Department
PHC	Primary Health Care
PNC	Post Natal Care
RCT	Rational Choice Theory
SACMO	Sub Assistant Community Medical Officer
SFYP	Second Five Year Plan
SWAp	Sector Wide Approach
UHFWC	Union Health & Family Welfare Centre
UHFPO	Upazila Health & Family Planning Officer
UHC	Upazila Health Complex
UHS	Upazila Health System
WHO	World Health Organization

## **Abstract**

Trust is perceived as a vital element in social relationships and it occupies a central place in every human transaction. Trust is equally important in individual as well as organizational level for demonstration of desired commitment and also to safeguard parties from malfeasance. Trust has multiple meanings and definitions and an integrated approach to understanding trust still remains elusive. It is considered as an important variable in explaining public and political institutions for its claim for legitimacy and also from growing credence from the perspective of good governance. It explains how relations between and among actors and in institutions are initiated, developed and sustained.

The study on citizens' trust in public institution maps and analyzes patients' trust on Upazila Health Complex (UHC) - a public hospital poised for delivering primary health care at the upazila (sub-district) level in rural Bangladesh. The study also explores factors based on which patients' trust at UHC may be built and sustained. By adopting a cross sectional design, the survey was conducted in 6 upazilas of five districts within the territorial jurisdiction of three divisions of Bangladesh. The study employs a mixed approach combining both quantitative and qualitative methods to map patients' trust perception on doctors at UHC. The study attempts to answer three broad research questions. First, What is the state of generalized trust among the users of primary health services at upazila?, Second, identify the major trust arenas and potential sources of opportunism at UHC, and third, identify the factors which may contribute to trust formation for UHC and how it may affect service delivery?

Three sets of independent variables are identified on the basis of which the dependent variable i.e. patients' trust at UHC is assumed to be determined. The independent variables are i. socio-demographic variables which includes factors such as age, gender, education, ii. dimensions of trustworthiness such as commitment, competence, general level of satisfaction, cooperation, privacy, rapport, compassion etc. and iii. institutional variables such as institutional

norms, non-discriminatory services, integrity and professionalism, dependency for treatment and quality of nursing services. A structured questionnaire for data collection has been developed and patients in both out-patient department (OPD) and in-patient department (IPD) have been surveyed. Apart from the survey questionnaire, several cases of patients' are examined as case studies while several others were interviewed as key informants. The results from survey reveal that UHC enjoys very high patients' trust. There is generally a high dependency on UHC of patients who mostly come from rural setting within upazila under a low-income bracket. Better resourced and affluent citizens may often be skeptical about the quality of treatment at UHC and may seek alternative care at private clinics and hospital outside upazila. Though patients' trust on UHC as evident from the study is high, not all health related problems are possible to be treated at UHC. UHC is responsible for Primary Health Care (PHC). Patients having health complexities such as coronary or cardiovascular diseases cannot be handled in health emergency as there are no CCU at UHC and therefore cannot expect to get proper treatment at UHC, though UHCs offer referral services for further treatment. For treatment of common diseases, injuries, services for female patients such as ANC and PNC services are seen to be very effective at UHC. Patients' with emergency generally report to UHC for treatment, complex cases are referred to specialized care at secondary or tertiary level.

The findings with regard to patients' trust at UHC reveal that the generalized trust in UHC for treatment is very high. 91% of the patients report that they think that the doctors at UHC are committed to their services. 92% of the respondents think that the doctors at UHC are competent to provide treatment. About doctors' cooperation with the patients, 78% of the respondents agree that doctors are moderately cooperative in dealing with the patients. On compassionate care, 91% of the respondents think that the doctors at UHC provide compassionate services to the patients. 82% of the respondents responded that the quality of services at UHC is at moderate level, 84% of the respondents agree that the services of UHC are non-discriminatory. 98% of the respondents report that they are dependent on UHC for their treatment. Non-clinical matters pertaining to the

behavior and demeanor of doctors and nurses may often affect patients' trust building at UHC. However, on the basis of the above observations, it is inferred that generalized trust in UHC is high.

Findings from the regression model reveal that in the category of socio-demographic variables such as age, it shows inverse relationships with trust at UHC. Meaning older patients will have low trust compared to the relatively younger ones. No statistical significance between gender, monthly household expenditure and patients' trust on UHC is found. Patients' frequency of visits to UHC signifies their dependency and trust. Distance to UHC from patients' home has high significance in building patients' trust in UHC. Patients' educational attainment has no significance in patients' trusting behavior. Occupation of patients has no significance in determining patients' trust.

In dimensions of trust, three variables such as doctors' commitment, competence and general level of satisfaction is included in the model. No significance is found with doctors' commitment and patients trust on UHC. Doctors' competence and general level of satisfaction came out to be very significant. With regard to the institutional variables quality of nursing services and integrity are found to be very significant in building trust. Other two variables such as non-discriminatory services and patients' dependency have no significance with trust. Therefore, it may be seen that four variables such as doctors' competence, general level of satisfaction, quality of nursing services and integrity have been found to be useful in explaining the dependent variable i.e. citizens' trust on UHC.

To sum up the findings of the research questions, the study found that the generalized trust on UHC is very high. Major trust arenas at UHC where patients' may base their trust judgment are availability and efficacy of medicines, continuity of specialists/consultant physicians, availability of hospital beds, quality of food, integrity of doctors, behavior and demeanor of doctors and nurses and lastly doctors' competence are identified as the major trust arenas and sources of opportunism at UHC. Lastly, the factors which may contribute to trust formation



at UHC and how it may affect service delivery are identified. Among the independent variables, doctors' competence, patients' general level of satisfaction, quality of nursing services and integrity of doctors becomes most significant factors contributing to patients' trust. These variables showed strong significance which may signify that these four variables explain patients' trust in UHC. Beyond these factors there may be other factors which may contribute to explain patients' trust at UHC.

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## Dedication

This work is dedicated to my late mother.

## Chapter-I: Background and Context of the Study

*“Trust is a social good to be protected just as much as the air we breathe or the water we drink. When it is damaged, the continuity of the whole suffers; and when it is destroyed, societies falter and collapse”- Bok (1979).*

### Introduction

The relevance of trust in social organizations and its ubiquitous role in evoking positive expectations in every social relationships and transactions are well acknowledged by scholars, researchers and practitioners today. Trust is therefore, considered as an essential element for organizations as well as for human interaction. Trust as seen through a positive lens may lead to beneficence rather than malfeasance in any transactions. Seligman notes that “the existence of trust is an essential component of all enduring social relationships” (1997:13). Putnam (1993) and Fukuyama (1995) in their seminal works have argued that trust - a derivative of social capital may promote civic cooperation and reciprocity which may lead to prosperity of a country. Fukuyama (1995:33) notes “social capital, the crucible of trust and critical to the health of an economy, rests on cultural roots”. According to this view, the main driver for economic prosperity is led by cultural attributes that promotes generalized trust. Therefore, trust is a vital ingredient for promoting honest, cooperative behavior in the society which may encourage reciprocity, shared understanding, cooperation and associationism to shape present and future possibilities. In absence of trust, “people end up cooperating under a system of formal rules and regulations, which have to be negotiated, agreed to, litigated and enforced, sometimes by coercive means... widespread distrust in a society, in other words, imposes a kind of tax” (Fukuyama 1995:27-28).

Trust is defined as “the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor

or control that other party” (Mayer et al. (2009: 85). Three elements deserve attention in this definition which may evoke trust i.e. positive expectations, conditions which may involve vulnerability and absence of outside monitoring. Trust meant by the above definition may promote generalized trust in the society. A distinction between generalized and particularized trust may be worthwhile to understand the scope and nature of each of these two categories of trust. Generalized trust may feature shared norms, regular, honest and cooperative behavior among individuals of a society. Generalized trust “is a measure of the scope of a community and based on both morals and collective experience. Generalized trust goes up and down, though it is basically stable” (Uslaner 2002:26). As opposed to generalized trust which rests on the premise of moral community, particularized trust rely on the premise and belief ‘whom to trust’ or to ‘bridging’(Putnam 2002:22) people who are different and may not have shared norms and values. In particularized trust the ‘moral community is rather restricted’ (Uslaner 2002:27). The stance for generalized trust is moralistic, while particularized trust may uphold positive views on in-groups and negative views on others or outside their known circles. When citizens’ trust is generally referred it is more to do with the generalized trust rather their particularized trust on any institution.

### **What is this study about?**

As it is now widely acknowledged that trust is an essential element in our social and organizational relationships in promoting honest and cooperative behavior among individuals of a society, it is also pertinent to raise questions as to the risks and negative effects which might occur in absence of it? What may occur to citizens’ when institutions experience and witness a gradual decline in generalized trust? What conditions promote and build generalized trust on institutions? This study makes an attempt to investigate these broad questions by studying citizens’ trust in public institution at upazila level in Bangladesh. Upazila provides many services of which primary health is an important one impacting most of the citizens’ lives. More specifically, this study investigates generalized trust of a public

institution namely Upazila Health Complex (UHC) which delivers primary health care to patients. It is argued that like the benefits in social organizations and human interactions generated by trust, health services may also be affected by the element and abundance in trust. Particularized trust may generate benefits for few whereas generalized trust may benefit many. Therefore, generalized trust on the institution may impact patients' health seeking behavior and treatment. "A person who trusts a health care provider is more likely to seek care, comply with treatment recommendations, and return for follow-up care than a person who has little trust in a specific provider or health care system. Trust is widely recognized as being central to the doctor-patient relationship. It is a concept that resonates strongly with both doctors and patients" (Thom et al. 2004:125,126).

This study attempts to explore patients' trust on doctors at Upazila Health Complex (UHC)<sup>1</sup> and identify factors towards trust formation at UHC. The concern of this study is to examine contribution of the factors in generating patients' trust in the delivery of primary health care. Institutional trust may depend on institutional norms and practices as well as individual efforts of the doctors, nurses and other health care providers working at UHC to deliver services.

Primary health care is the basic health care every community member of the society is entitled to have access to and considered as a basic right of individuals. It involves both clinical as well as preventive measures and care. UHC also renders services on maternal and reproductive health of women, general and adolescent health, communicable<sup>2</sup> and non-

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<sup>1</sup> Upazila Health Complex is the public health facility located at the Upazila responsible for delivery of preventive and clinical treatment and also for providing primary health care. Many UHC's have 50 bedded hospitals and offer both out-patient and in-patient services seven days a week.

<sup>2</sup> Communicable diseases<sup>2</sup> are those which can spread by contact or regarded as contagious. Non-communicable diseases<sup>3</sup> are more patient-specific and does not spread in others Communicable diseases can spread from one person to the other. Chicken pox, influenza, cold, Hepatitis A, measles, mumps, ringworm, conjunctivitis, diarrheal illness etc are some of the communicable diseases.

communicable<sup>3</sup> diseases etc. UHC have been seen as the unique health facility at the grassroots through which primary health care can be accessed by the citizens.

This chapter sets out the meaning of trust and more specifically conceptions on patients' trust in institutions and lays down the objectives, problematic and significance of the study at selected upazilas<sup>4</sup>.

### **Statement of the problem**

One of the key strategies of the Government is to make Primary Health Care (PHC) more accessible to the population and to improve the existing primary health service provisions by strengthening the Upazila Health System (UHS). UHS covers the services from community clinics at the ward<sup>5</sup> level to upazila level. The strengthening of UHS is intended to be done with the improvement of the union health and family welfare centers (UHFWC) and by making the union sub-centers fully functional. The community clinics (CCs) which have been a new set up in the health system is considered to be the first point of contact and entry to the health system. Nevertheless, UHC remains a leader as the only public institution at upazila to deliver primary health services to the rural population. Despite the impetus given on PHC involving the UHC as the main provider of health services at upazila level, service quality at UHC is seen to be lowly satisfactory to many. Several factors might be responsible contributing to unsatisfactory services. Non-professional attitude of the health care providers and politicization of the health system resulted in a professional divide. Wide scale absenteeism and shortages of medical officers and staff across UHC, supply mismatch of medicines, other supplies and appliances

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<sup>3</sup> Communicable diseases<sup>3</sup> are those which can spread by contact or regarded as contagious. Non-communicable diseases<sup>3</sup> are more patient-specific and does not spread in others Communicable diseases can spread from one person to the other. Chicken pox, influenza, cold, Hepatitis A, measles, mumps, ringworm, conjunctivitis, diarrheal illness etc are some of the communicable diseases.

<sup>4</sup> Upazila<sup>4</sup> is an administrative set up at sub-district level referred here as 'local level' and constitutes a population of a geographic region in rural Bangladesh. The population size of an upazila varies and may constitute approximately 300 to 350 thousand people.

<sup>5</sup> Wards are constituted by few villages. Each ward is represented by a member/councilor of a union council. Several wards may constitute a union which is the lowest unit within the local government system of the country.



coupled with a growing notion of better service in private care, might have left the UHC less reliable and trustworthy to the patients in general.

Citizens' trust in institutions may be based on the degree of responsiveness and satisfaction of the people on the fulfillment of their particular health needs. A higher level of trust may indicate citizens' greater reliance and satisfaction; correspondingly a low trust may suggest dissatisfaction or lower levels of satisfaction. Without trust an institution may become a source of dissatisfaction to its clients and may gradually lose its effectiveness and future sustainability. The element of trust in a public hospital not only involves competence of the doctors, availability of medicines and proper treatment but also on the fiduciary role of doctors where patients' welfare and care is specially given due importance and attention. Patients' care and satisfactory services are often embedded in the institutions good practices and stated in the mission statement. It is often manifested through its long tradition of providing services to the citizens. However, quality of care may depend on a number of factors. "Quality of care in government health facilities depend on a number of factors such as adequacy of staff and their attitude towards patients, supplies, drugs, waiting time, client satisfaction, management, technical efficiency, sufficient funds, physical infrastructure and operational rules"(Zahan et al.2012:51).

The problematic of the study concerning trust and service delivery in the context of primary health services at upazila may be discussed under five clusters as narrated below.

#### **a. The notion of non-professionalism**

The health service delivery system at UHC is managed in a manner which is marked by absence of appropriate professional norms and standards. For example, measures to adopt appropriate patient screening at the time of entry to UHC for treatment is far from being practiced. Concepts on patients' data base with patients ID, personal profile and disease profile,

treatment history etc. are non-existent at UHC which perhaps could help retrieve patient's treatment and make health care delivery system managed more scientifically. Outdoor services are often run by paramedics due to shortage of medical officers. This may also have contributed to the poor quality of health services and make it less credible to the public.

Negligence and delay of doctors in reporting to duty often causes delays in receiving treatment at UHC. There are a significant number of vacant positions arising out of unfilled positions in the Upazila Health Systems which hinders smooth delivery of health services. Besides, absenteeism of doctors at UHC is known to be endemic which has been observed by others studies e.g. Chaudhury and Hammer (2003). Lack of accountability, weak and ineffective compliance system has failed to bring any improvement in the health service delivery system. The tenure of qualified doctors and consultant physicians deputed at UHC is usually short as they often seek transfer from UHC to a more desirable place which has potential for private practicing.

While private practicing of doctors is permissible, it may be difficult to bifurcate treatment in public and private sphere since patients may seek treatment by the same doctor both at public hospital and during private practicing. This in a way encourages the doctors to pull patients more towards private practicing rather than giving energy for quality treatment at public hospital. There is also a dominant belief among the patients' in the superior quality of private treatment in clinics and hospitals than the service provisions of public facilities such as UHC, which may look less credible to them. Since, there are variations in the actual number of health care providers such as doctors, nurses and other staff across UHCs; this may also lead to variations in the health response to patients' needs.

The motivation of individual doctors in UHC may also hinder them from discharging their duties more sincerely. It is observed and also learnt from other studies that the living conditions at UHC are inadequate and demotivating for doctors. As mentioned by Zahan et al.(2012:57) " many

health professionals refuse a placement in rural setting due to various reasons". The administrative head of UHC, the UHFPO is appointed as a senior doctor. It may take several years of experience and seniority to become UHFPO. Slow promotion of UHFPO compared to the other officers at upazila also creates disincentive for giving proper leadership in forming effective teams for delivering services to the patients.

## **b. Unresponsive services**

### **i). Services at Outpatient Department (OPD) and consultation**

OPD services at UHC may begin with morning rush hour and may often be disrupted due to delays in arrival of the medical officers on duty. Patients coming to UHC are mostly poor and illiterate; many fail to communicate with the doctor effectively. Women and young children often line up the queue to get tickets for outdoor services. Patients load at OPD and shortage of doctors allows very little time for consultation with the doctors. During the rush hours, the attending doctors at OPD find 'less-than-a-minute' time to examine a patient properly. Patients often complain that they were not asked questions or allowed time to explain their ailments or physical discomfort when their turn comes to see the doctor. This may result in minimal patient contact time with the doctor. Besides non-availability of prescription medicines are quite common which also may make the OPD services less credible to the patients. Poor patients often fail to buy medicines which cannot be supplied by UHC. There is no provision through which poor patients can access those medicines not supplied by UHC for free or to have financial support to buy them from outside. Patients' having chronic health problem may take longer time for full or partial recovery. Delayed or longer time for recovery in health may send signal to many patients that doctors at UHC are not competent enough or failing to make proper diagnosis and treatment which may eventually turn the UHC to be less credible.

## **ii). Supply of medicines**

From patients' perspective availability of medicines in UHC may become a concern particularly to the poor as patients have limited information. Supply of medicines at UHC is delivered through the central procurement entity and channeled through respective Civil Surgeon offices. Only a limited variety of approximately 23 categories of medicines are currently supplied at UHC. Therefore, a doctor may prescribe a patient on the basis of available medicines in stock. It often results in the delivery of similar medicines to different patients on a number of different health problems. Though it is known that a particular medicine may work on a number of health indications, UHCs often provide same medicines to different patients which may at times give the patient a hint of non-care and poor quality of medicines which may be given as free. Some tablets come in large containers which is dispatched loose and wrapped in papers when given to a particular patient. Many patients also doubt the quality of medicines supplied through UHC when compared to similar medicines available outside and apprehend that loose drugs are cheap and would not cure. The doubts are often more acute when same drugs are given to patients to cure a number of diseases. Patients may have to buy medicines from outside which are not available at UHC. This may add financial burden to the poor patients. Complaints about disposal of drugs and medicines from UHC are not new. Illegal use and disposal of drugs and medicines may be conducted both by the patient as well as by the health care providers at UHC. There is also a sense of "inefficiency in resource use due to poor purchasing and distribution system" as observed by Barkat et al. (2011:28).

## **iii). Preventive medicine and campaign**

The success of using preventive medicines such as vaccination and immunization and health campaign has been huge in Bangladesh in achieving the MDGs 4 and 5 with reference to reduction in child mortality and maternal mortality. There are still challenges from the threats of communicable and growth in the non-communicable diseases. It is also

observed that non-communicable disease is on the rise in Bangladesh. Despite governmental health interventions access to health and treatment may become costly and often unaffordable to many. As observed by Haque (2011:52), “access to maternal care there is a high cost of services which needs to be borne from out of pocket expenses approximately from Tk.854 at the primary level”. The gains already achieved in the reduction in child and maternal mortality needs to be sustained. Other aspects of health such as health and nutrition have also been given renewed focus which needs to be pursued simultaneously for which awareness and campaign is needed. Vaccination or immunization programs are undertaken on the basis of national campaign reached out at door steps of villagers. The process requires adequacy and efficacy of the vaccines and timely administration to ensure that the services have been trust worthy and manifested by reduced or no symptoms of illness in a given population after they have been vaccinated. Shortage of medical professionals, lack of equipment and diagnostic facility, lack of clean and creating safe environment for safe delivery and post natal care are challenges for delivering reliable services to the citizens at UHC.

#### **iv). Service delivery and referral system**

No responsive services to the patients can be given unless there is a well functioning and structured referral system in the delivery stream. Referrals are procedures for redirecting a patient to the nearest and appropriate level of treatment center where the patient may expect appropriate or higher level of treatment. Referrals are made when diagnosis cannot be made or treatment cannot be given at a particular point. It usually takes a vertical direction. As indicated in the ESP operational plan (2011-2016), HPNSDP, “Primary Health Care centers need to maintain a close relationship between all levels of a health system. The linkage between primary health care services and first referral units upwards is crucial in providing health care for the people. Continuous collaboration between health care personnel at primary health care level and those of referral facilities is very essential”. But referral patients have difficulty in seeking priority treatment

and for admission to hospital and may have to remain in waiting unless a bed vacancy is available. There is a need for developing and streamline the referral system enabling upward and downward collaboration so that contact may be established prior to sending a patient to a hospital thereby facilitating later tracking and monitoring possible. The community clinics which began its journey in rural Bangladesh very recently stands out to be a health facility at arm's length to make health services accessible to all the people at the grassroots. A major task performed by the Community Clinics is the referral system to UHC. Community clinics are managed by newly recruited paramedics and lower level health professionals who can only deliver few medicines and antibiotics without the ability to screen a patient and diagnose professionally. Indiscriminate distribution of medicines may also result in misuse of drugs and improper administration. Referrals made by community clinics to UHC add very little value from treatment perspective as patients may come to UHC straight way without going to particular community clinic. Besides, the health care providers usually provide medicines on the basis of symptoms rather than doing any diagnosis. Therefore, patients are referred to UHC. In case of UHC, critical patients may be referred to secondary level of care at the district. In many cases patients are promptly sent to district hospital to avoid any chances of patient casualty and to avoid any possible backlash.

### **c. The culture of corruption**

Corruptions in the delivery of health care may take many forms which may affect service delivery and satisfaction of patients. Zahan et al. (2012:57) observes that for effective health care delivery system, there should be good governance. Good governance is particularly important for ensuring discipline in the health facility, ensure proper drug management, and ensure that there is no unauthorized absenteeism for delivering responsive health care (Lewis, 2006). Absence of good governance may encourage corrupt practices in the institution which may affect service delivery. The problem of corruption in health services may be evidenced in the form of bribery, negligence of duties, nepotism, embezzlement or deception. Corruption at the level of UHC may take several forms such as

unauthorized absence from duty and drawing salary, abuse of power and benefitting from unofficial gains such as from award of contracts or procurement etc. The nature of corruption in relation to medicine at UHC may also take the following form as found in the study conducted by Zahan et al. (2012:55) on community clinics.

“Most community members expressed that the leakage of medicine was present within the system. One businessman described that the medicine of the facility was being sold by the staff to local pharmacies. A woman from the focus group also mentioned that she thought she saw the same medicine from the facility being sold in nearby pharmacy. The medical officer said the yearly budget for medicine was Tk. 75000 (approx. US\$1000). The health centre received medicine worth Tk.60000 from the UHC. There was a lag of medicine worth Tk. 15000 for which the pharmacist explained that medicines are supplied in every four months interval which was rarely the case. When the supplies are exhausted, fresh supplies are asked for from UHC”.

The study done by Akter and Islam (2006), FMRP (2007), Hossain and Osmani (2007) also indicate corrupt practices of officials and staff with regard to medicines at the public health facilities. Besides medicines, procurement and supply of food and other materials may also pose as sources of opportunism at UHC which may lead to corrupt practices.

Allegations of poor quality of food supplied for patients at the hospital may often result from supply of poor quality of food by the supplier. Effective supervision for ensuring proper quality of food is often not possible by the officials at UHC. Chowdhury et al. (2010:252) in highlighting the problems of health care facilities in Bangladesh notes:

“Facilities are supposed to provide services free of charge, in reality they are not free for patients. Often the patients are forced to purchase drugs and supplies and to make various other kinds of unofficial and informal payments. Absenteeism of doctors is rife in public facilities. There is strong evidence that public and private services tend to be provided on the same premises and during office hours”. Other studies indicate, “doctors devote less time to their non-private patients than they ought to” (Akter and Islam 2006, FMRP 2006).

Other instances of corrupt practices at UHC may involve issuance of false medical certificate for assault victims in exchange of money; pilferage of resources allocated for campaign and health awareness. Absence of effective supervision, non-residency of key officials at UHC and lack of

proper monitoring from districts often encourage corrupt practices in UHC to perpetuate.

#### **d) Politicization of health professionals**

Factional politics marked by party affiliation and lineage and demonstrated loyalty has engulfed the health profession in public sphere since long. One of the dysfunctional consequences of such factional politics is marked by a disregard of merit principle and professionalism in the health services. Internal movement such as placement and transfer, career progression of health professionals is often based on political considerations. This may adversely affect the motivation and commitment of those who try to remain apolitical in their professional careers. As a consequence, politicization may reward incompetence and drive out professionalism from health services making it non-responsive to citizens' health needs. Political loyalty and lineage gets prominence over professionalism and competence which may disregard accountability and patronize inefficiency and corruption. In such an environment, patients' care and quality of service gets minimal attention. Rather one may get irritated and even humiliated for raising voices against any non-conforming behavior and attitudes of health care providers.

Placement of doctors to key or preferred work stations are influenced by political decisions. The professional associations such as BMA<sup>6</sup> also play key role in such influence system. Many positions of medical officers or doctors at upazila remain vacant due to political tadbir or due to managed-transfer to a preferred location which may result in a denial of services to citizens'.

#### **e). Erosion of generalized trust in public sphere**

Though there has been impressive improvement in the access and quality in PHC resulting in a number of positive health outcomes, likewise, there has also been simultaneous erosion of trust in the quality of treatment and

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<sup>6</sup> Bangladesh Medical Association (BMA) is the national associations of the physicians (<http://www.bma.org.bd>)



services impacting patients' health care and wellbeing. Greed of doctors, absence of effective regulatory oversight has encouraged opportunistic behavior and contributed to the erosion of patient's trust to a great extent. Decay in generalized trust in the society has also forced the public to take a negative view of public institutions as being ineffective and of poor quality. This has also given the public a notion to take private hospitals in a superior frame of mind compared to public facilities such as UHC. In absence of adequate treatment facility in public hospitals, private hospitals though generally expensive compared to public hospitals, are claimed to be better resourced and capable of offering quality treatment. Even then, private services also suffer from public trust as they may extort money exorbitantly and resort to certain actions not in conformity with sound medical practices.

Lack of proper services drives patients out of public hospitals to private chambers of doctors where they may be subjected to immense monetary hardship and harassment. Patients' are often compelled to such a situation where no fiduciary responsibility or assurance of any credible services to the patients is available. Under this situation, patients' trust to doctors for treatment tends to suffer. Patients' therefore may try to look for someone who would be more trustworthy as a physician. Patients therefore look for doctors whom they know or have good professional repute. Patients' trust or distrust is based on their experience when they encounter doctors and nurses for treatment. Compassionate care and attaching professional norms to treatment may lead to high trust which may assure a patient to expect proper treatment while negligence or irregular presence of doctors in duty may create patients' distrust on the institution as well as negative attitudes towards the doctors.

As discussed above, the health service delivery at UHC may feature several dysfunctional norms and practices which may produce low radius of trust and may result in negligence, poor quality of care with low self-esteem of doctors and nurses hindering proper team work at UHC. Factional politics in the health system may undermine apolitical professionals who

might lose enthusiasm to render responsive services.

### **Hypothesis of the study**

With a culture in the society which may breed a low radius of trust within individuals and groups, non-responsiveness on the part of the service providers towards citizens may be a common observed phenomenon. Politicization of health administration coupled with weak governance, pervasive corruption and dominance of tadbir-based decision making in placement and transfer with lack of accountability have eroded institutional norms with a gradual decline in generalized trust in Bangladesh. Erosion of generalized trust on public institutions such as UHC, may negatively affect health seeking behavior forcing people to take recourse to alternative health care. Greed and opportunistic behavior of doctors, non-caring attitudes to patients may erode patients' trust and may drag people to seek more caring and effective health services outside.

### **Objectives of the Study**

As high trust in institution may produce beneficial outcomes impacting citizens' lives; the concern of the study is to gauge citizens' trust in UHC and its effects on health service delivery. Several factors may lead to trust building in UHC as trust building may largely depend on the collective actions undertaken by individual doctors and nurses. UHC remains as a major primary health care provider in rural Bangladesh. The quality and delivery of health services at UHC may often be affected by shortages of medical professionals arising out of large number of unfilled positions as well as unauthorized absence of doctors which may remain unabated. Therefore, providing free and effective primary healthcare accessed by a large number of rural populations remains a key challenge for UHC.

### **The key objectives of the study are:**

- To map the level of citizens' trust in Upazila Health Complex (UHC)

in Bangladesh.

- To examine those factors that may affect trust building in the delivery of health services at UHC.
- To identify the factors that promote patient's trust in the delivery of primary health care.

### **Research questions**

The study attempts to find answers to the following research questions.

- What is the state of generalized trust among the users of primary health services at upazila ?
- Identify the major trust arena and potential sources of opportunism in service delivery at UHC.
- What factors may contribute to trust formation for UHC and how it may affect service delivery?

### **Why trust is important in general and for the purpose of this study?**

In a society where cooperation, reciprocity and trusting behavior of people is commonly expected, displayed or reciprocated, life may become quite easy and simple. Trust is seen "as essential for stable relationships, vital for the maintenance of cooperation, fundamental for any exchange and necessary for even the most routine of everyday interactions" (Miztal 1996:12). Trust "encourages sociability, participation in various associations and allows for greater intimacy of interpersonal contacts" (Sztompka 1999:105). "When the culture of trust is present, transaction costs are significantly lowered and chances for cooperation increased" (Offe 1996:10). Therefore, trust eases the process of human interaction from simple day to day on the spot transaction to complex nature of transaction which may have later affects or have long term consequences.

The study of trust is particularly important from the perspective of citizens while they may seek primary health care. "Trust is an important value in

health care as the person who is sick seeks the help of the health care provider to heal illness. This treatment seeking behavior entails a level of trust in the provider” (Goipchandran et al. 2013:1). The study of trust is important from two perspectives: firstly, the issue of “patients’ vulnerability and the expectation of cure, secondly, the issue of power differential between the doctor and the patients which brings in the potential for exploitation of the patient by the doctor. Therefore, vulnerability, power differential and exploitation from opportunistic behavior bring in the issue of trust with regard to health care. More particularly, “trust involves the question of proper diagnosis, appropriate treatment, non-exploitation and genuine interest in the welfare of the patient” (Gopichandran 2013:1). Therefore, the study of trust is particularly important from service delivery point of view.

From policy perspectives lack of institutional trust may indicate weaknesses in the delivery system and provide policy directions to strengthen primary health care (PHC) to meet access and quality. From policy perspective, coverage of vaccination program may be considered important, but from citizens’ perspective, ensuring quality and efficacy of vaccines with ease of access may be more relevant. From service delivery point of view, a trustworthy service delivery system is a precondition if the Upazila Health System (UHS) is to be strengthened to expand and ensure quality of primary health care. Unless the deliverables such as medicines supplied are considered safe and bears good quality and services made accountable, citizens’ trust may be wanting. Policy implementation and reforms agenda in primary health care may remain incomplete and remote if citizens’ trust perspective is completely ignored or missed out from policy. Rationalization of resources in UHC to match ever increasing demand for health needs to be calibrated with trustworthiness of people. Unless trust in UHC is built and maintained spontaneously the facilities provided in UHC may remain underutilized with patients seeking treatment elsewhere.

Upazila Health Complex (UHC) has been made the locus for the expanded health delivery system at the grassroots where majority of the rural people

lives. The quality of health services such as proper screening of patients, providing compassionate care must be extended to make the health service delivery system meaningful and credible to the people. The study would therefore; map citizens' trust towards the health system at the grassroots. Despite many weaknesses, the services delivered by UHC are widely used by the ordinary citizens. Trust may be considered central to treatment in health care and therefore the study bears much importance in understanding service delivery at UHC.

### **Significance of the study**

Studying citizens' trust in UHC may be significant from several perspectives. Studies suggest that patients' trust has been relevant in the treatment of patient and their recovery. Though trust has been considered as the cornerstone and foundation of clinical health care, it is not known to what extent the services of UHC appear trustworthy to the patients. Further to this no such study on primary health care with focus on trust was conducted earlier in UHC to assess generalized trust of patients. As a result, citizens' trust perspective on treatment and care has been largely overlooked or not properly emphasized in the health agenda.

Attaining patients' trust in PHC has not received explicit attention and focus in the health policy of Bangladesh. Health policy focused more on access and coverage of the population with emphasis on quality and equity issue. However, equity in treatment and care of the poor and rich has been uneven and more tilted towards the better offs according to some studies. The study of patients' trust may be significant from policy perspective to identify the factors causing breaches of trust in health care and help formulate appropriate policy response.

From development perspective, the role of trust could be critical in determining the development agenda on health and wellbeing of people. Health service delivery without trust may turn out to be less satisfactory and health interventions undertaken for the improvement of health and well

being of citizen's may become ineffective. The Health, Population and Nutrition Sector Development Program (HPNSDP) (2011-2016) under the Ministry of Health and Family Welfare aim to bring about improvement in the health services. One of the key elements of such improvement of health services is targeted for the improvement of primary health care through the Upazila Health Systems which includes the UHC, Community Clinics and Union Health and Family Welfare Centers and Union Sub-centers. Much of the success in the delivery of PHC lies in the proper coordination and collaboration and in the smooth functioning of the vertical referral systems for responsive treatment of patients. Therefore, this study bears significance from the development perspective where the findings of the study may bring new insights and understanding for development interventions in primary health care and service delivery.

The main contribution of the study would be to explore the state of generalized trust in the delivery of primary health care services at UHC in Bangladesh and its implications to health policy. The study also aims to provide inputs for policy makers to focus on factors which may build citizens' trust in UHC and may influence policy agenda.

### **Scope of the study**

The scope of this study is limited to the assessment of patients' trust in UHC with a focus on primary health care. The study confines itself to map citizens' trust in UHC and examine whether trust matters for primary health care.

### **Organization of the dissertation**

This dissertation includes eight chapters in all. The first chapter includes introduction, statement of the problem, hypothesis and objectives of the study, research questions, significance and scope of the study. The second chapter provides an introduction to the health system of Bangladesh focusing on primary health care with a discussion on health policy. The

third chapter is dedicated to the review of literature on trust research, challenges and relevance of trust research. The fourth chapter deals with research design and methodology of the study, research design, data collection and analysis. The fifth chapter discusses the relevant theories and concepts of trust. The sixth chapter presents the conceptual and analytical framework. Chapter seven presents the quantitative and qualitative analysis of empirical data. Lastly, chapter eight of the study presents, summary, concluding discussions and implications.

## **Conclusion**

This chapter presents the main concern of the study i.e. patients' trust in UHC. Patients' trust is considered vital from treatment perspective. This chapter sets the context and background and highlights its study relevance from several perspectives. Though patients trust and treatment is known to be dependent on each other, no such studies focusing on UHC in Bangladesh has been conducted in the past. The reason for this may be attributed to the recent research interest in studying trust in organization theory and more particularly in studying patients' trust in public institutions. Therefore unlike some advanced countries where trust research has advanced fairly well, studying trust particularly in health care in Bangladesh may be considered as a new area of research and to some extent considered being in a nascent stage. In the case of policy, trust may be considered as an overlooked area of research. As trust has different dimensions, its formation and manifestation, its linkage to treatment may have socio-economic and psychological underpinnings. However, the study of citizens' trust may warrant systematic study to have a deeper understanding on patients' trust at UHC. High trust may suggest more satisfactory services in health outcomes and consequently a low trust may suggest non-satisfactory services with consequent low health outcomes.

The study of trust is limited to UHC and measure patients' perception with regard to treatment and care. A more detailed account on the health

system, health policy and service delivery at UHC is presented in the next chapter.



## Chapter-II: Health System in Bangladesh

*“Trust is most realistic when a relationship has a history of reliability, advocacy, beneficence and goodwill” R. L. Jackson (unpublished manuscript)*

### Introduction

Health is considered as a basic need and right of every citizen with the provisioning of medical care to improve material and cultural standard of living of the people. Ensuring Primary Health Care (PHC) to all the citizens appears as a major challenge given the limited resources of the government and ensuring responsive services. Appropriate financing, management and governance of the health system are prerequisites for delivering quality primary health care. The government is committed for further development of this sector. Persistent pro-poor policy of the government in social sectors perhaps contributed to the long term outcomes in many human development indicators such as increase of life expectancy of people by over 50% from about 45 years in the 70s to over 65 years currently(Health Watch 2011:1). Considerable progress has been achieved in the health indicators over the last decade over expansion of coverage of essential services and with the increase in the allocation in overall GDP for health sector from 2.7% in 1990 to 3.5% in 2010(Bangladesh Health Watch Report 2011).

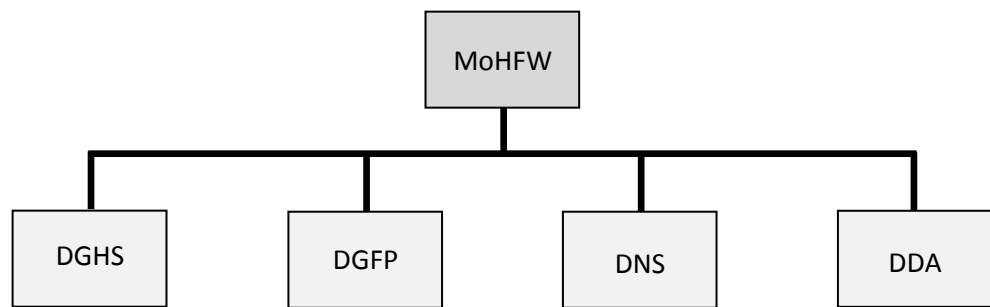
Many challenges still remain in maintaining access and quality of service delivery in primary health care. There are further concerns in the reduction of incidences of some communicable and non-communicable diseases. The United Nations Human Development Report 2013, identifies some concerns and challenges to health in Bangladesh such as underweight in children under the age of 5, (which accounts for 41% in during 2006-2010), infant mortality rate, (which is recorded 38 death per 1000 live births while in Norway it is recorded 3 in 2010). Death due to malaria, (is recorded at 1,8 per 100000 people per year in 2008), cardio vascular diseases and diabetes, (which estimated at 418 per 1000 people in 2008), availability of

doctors, (which is currently at 0.3 per 1000 people in 2005-2010, in Norway it is 4.1, in India it was 0.6, in Pakistan it is 0.8 in 2005-2010).

Other challenges with regard to health system include 'bringing efficiency and ensuring good governance. From citizens' perspective the element of efficiency concerns how the resources are used and whether equity issue is observed' (Health Watch 2011:1). The government aims to raise average life expectancy to 72 years by 2021 and providing easy access to reproductive health service delivery system to reduce birth rate. Introduction of telemedicine services, service provisioning through approximately 12557 community clinics, access to health services have been widely expanded to the grassroots. In order to minimize the out of pocket expenses of patients for medicine and treatment, introduction of telemedicine and health insurance programs, improving the quality of medical education are under active consideration of the government. The government also strives to enhance the skills of health care providers at public institutions and healthcare regulatory agencies to ensure professional discipline and quality in the practicing doctors.

### **Overview of Health Institutions in Bangladesh**

The health system of Bangladesh is organized under the Ministry of Health and Family Welfare (MoHFW) with its key role in policy formulation and overseeing its proper implementation. As indicated in the Allocation of Business among Ministries and Division, 1996, Government of Bangladesh, the ministry formulates policy on medical and health services including promotive, preventive, curative and rehabilitative aspects, matters relating to public health, control of epidemics and prevention of infectious and contagious diseases, matters relating to hospitals and dispensaries, extended program of immunization etc. The Ministry as the apex policy making body is over all responsible for policy, planning and decision making at macro level.

**Figure 2.1: Health Institutions at Macro Level**

The ministry is organized with subordinate offices called directorates. The directorates are Directorate General of Health Services (DGHS), the Directorate General of Family Planning (DGFP), Directorate of Nursing Services (DNS) and Directorate of Drug Administration (DDA).

Apart from the above administrative set up, there are regulatory bodies such as the Bangladesh Medical and Dental Council (BMDC), Bangladesh Nursing Council (BNC) and Bangladesh Pharmaceutical Society (BPS) which are also mandated to provide academic accreditation, quality control in curriculum and also registration for practicing doctors and nurses.

The DGHS as an institution is responsible for the implementation of the policy decisions of the MoHFW with regard to health service delivery to all. At the national level the Director General is aided by additional director generals, directors, line directors responsible for implementing operational plans of HPNSDP, and other subordinate staff. At the regional level i.e. in the divisions, there are directors of health responsible for overall supervision of health in the divisions. There are also directors for different national institutes, directors of medical college hospitals, at the district level the civil surgeon is the administrative head and responsible for implementing, administering and managing health services within the district, he also supervises the Upazila Health Systems (UHS) within his jurisdiction. In some districts he is also responsible for district hospitals. In the district, there is also a position of Superintendent who is responsible for district hospitals. The Upazila Health System is supervised and managed by the Upazila Health and Family Planning Officer. The UHFPO is the administrative head of the Upazila Health Complex (UHC). Under the UHC,

there are union sub-centers at union level and community clinics at ward level managed by medical officers and health care providers. Under the supervision and control of the UHC, health inspectors and assistant health inspectors manage and supervise the health programs at union level and below.

**Table 2.1: Institutions and Level of Health Services**

Level	Institutions		Health Services
National	National Institutions	Specialized	Super Specialized care (cancer hospital, cardiovascular diseases, infectious diseases, eye hospital etc)
Regional	Regional Hospitals	Teaching	Tertiary Health Care (medical College hospitals, referral institutions for the district)
District	District Hospitals		Secondary Health Care (district level hospitals)
Upazila/UHCs	Upazila Health Complex		Primary Health Care, Child and maternal health, promotive and clinical care with inpatient facility
Union Sub Centers	Union level		Limited inpatient care available in limited upazilas, otherwise union sub-centers provide outdoor services
Community clinics	Community level		Child and maternal care, family planning, no inpatient facility is available

### Health Policy and Reforms

Bangladesh did not have a health policy until 2000 and the current policy which was adopted in 2011. In absence of a coherent health policy, the programmatic implementation was guided by sector wide approach through two broad programs Health and Population Sector Program (HPSP) (1998-2003) and Health, Nutrition and Population Sector Program (HNPS) (2003-2010). Prior to the sector-wide approaches, health sector interventions were carried out mainly by the successive Five Year Plans since independence. In each of the Five year plans, focus in health sector

was primarily made towards provisioning primary health care, though the modalities of service delivery shifted from time to time. Broadly speaking the health policy reforms in Bangladesh captured the major buzzwords such as 'integrated and comprehensive service', 'pro-poor service', 'vertical approach', 'door to door' and 'one stop service', 'cost-effective essential service package' etc.(Sabina et al. 2011:17).

Chowdhury et al. (2010:210-213) makes a stock of the major thrusts in health sector in successive Five Year Plans and assesses the achievement of the health sector from rights-based approach.

**Table 2.2: Five Year Plans of Bangladesh**

<b>Five Year Plans</b>	<b>Major Focus</b>
The First Five Year Plan (1973-78)	Bring health services to all, building necessary rural health infrastructure at Thana level for maternal and child health services at Thana Health Complexes (THCs) and Rural Health Centers (RHCs) at union level.
The Second Five Year Plan (1980-85)	Recognized the need for private sector and NGOs in providing health care services and made Primary Health Care as the main focus of health sector activities ensuring minimum level of health care for all.
The Third Five Year Plan (1985-90)	Emphasized maternal and child health care (MCH) as a means of population control, and integrated the health and population sector. More focus was given to Expanded program of Immunization (EPI), vitamin A distribution and control of diarrhea.
The Fourth Five Year Plan (1990-95)	Focus was given to Primary Health Care (PHC) and Mother and Child Health(MCH)
The Fifth Five Year Plan (1997-2002)	Sector Wide Approach to health sector was introduced in the form of Health and Population Sector Strategy(HPSS) and made operational in the name of Health and Population Sector Program(HPSP)

\* There was a lag of two years in between the Fourth and Five Year plans.  
Source: Chowdhury et al. (2010: 210-213)

As indicated above, Bangladesh witnessed successive health sector reforms initially through the Five Year Plans (in absence of any coherent health policy) and later through the Health and Population Sector Strategy (SPSS) and sector wide approaches (Swap). The drivers for early reforms

since independence were often led by contextual realities and donor policies. For example, in order to curb population growth initial reforms were targeted towards family planning which was largely supply driven and incentive based. Through the Second Five Year Plan (SFYP) the shift in reform took place in favor of having comprehensive community-based primary health care focusing on children, expanded program of immunization. The SFYP also recognized and encouraged the participation of NGOs to share the responsibilities to deliver health services to the rural people. The early 90s witnessed major policy and structural reforms in health sector. The shift was triggered more towards expanding comprehensive services from family planning which resulted in adopting and pursuing sector wide approach (SWAp) through the introduction of Health and Population Sector Program (HPSP) in 1998. The major thrust of HPSP was to improve the health of women and children and the poor. The SWAp emphasized on horizontally segregated project-based approach, unified the health and family planning wings of the Ministry of Health and Family Welfare at upazila level, introduction of Essential Service Package (ESP), introduction of community clinics replacing the door step approach. HPSP was succeeded by Health, Nutrition and Population Sector Program (HNPS) in 2003 incorporated nutrition in the program targeting the poor households with increased allocations of resources.

Sabina et al. (2011: 21) while making an analysis of health sector policy and reforms observes that “though equitable coverage of services has been emphasized in policy and successive reforms, but very little has been done through guidelines how these services would be financed and how to maximize uses of allocated resources. More focus was given on quick and visible health results rather than long term health outcomes. With regard to ownership and leadership in policy formulation and reform, dominance of donor’s is observed to be prominent”. It is further observed that “sector reforms serve the interests of donors more than national interests. With regard to channeling resources, the allocation of 60- 65% of the total resources towards upazila and lower administrative levels could not be

made by the Ministry of Health and Family Welfare (MoHFW)” (Sabina et al. 2011:21).

### **Health Policy 2011**

One of the objectives of the current Health Policy of Bangladesh (2011) is to deliver patient-centered primary and emergency health services to all citizens which meets quality, easy accessibility and equity. Other objectives include prevention and control of diseases by encouraging people to access health care services as a matter of their civic entitlement and human dignity. The goals of the policy is to bring health services to all for improving their quality of lives, ensuring quality and easily accessible health care to the lowest quintile of the society, bring gender parity in health care, improve maternal and child health and ensure maternity services at every village for further reducing infant and maternal mortality and strengthen family planning and reproductive health services.

Therefore, improving access and quality in the service provision, strengthening the rural health services to ensure quality, using information technology, control of communicable and non-communicable diseases, reduction in infant mortality, incorporating food and nutrition in health service delivery, building human resources and attaching ethical aspects in treatment are some of the major highlights of the health policy.

### **Primary Health Care**

Primary health care is defined as “the essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community though their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination, It forms an integral part of the country’s health system and of the social and economic development of the community bringing health care as close as possible to where people live

and work and constitutes the first element of a continuing health care process.”(Alma Ata Declaration (1978). . The Alma Ata Conference adopts eight principles in its declaration which embed the premise of primary health care of all nations. In the declaration it is recognized that primary health care involves complete physical, mental and social well being and considered as a fundamental human right. It is government’s responsibility to ensure health of the people which can be fulfilled only by the provision of adequate health and social measures. PHC is based on the following principles such as a).social equity i.e. more equitable distribution of health resources and preferential treatment of those in greatest need, b). community involvement i.e. active participation by the community in their own health, c). appropriate technology which is scientifically sound, adapted to local needs, acceptable to the community and can be maintained, and d). multi-sectoral approach which cannot be met by health sector alone requires coordinated action at all levels. PHC therefore involves citizens’ education, awareness and information about prevailing health problems, promotion of food supply and nutrition, ensuring safe water and basic sanitation, maternal and child health care and family planning, immunization against infectious diseases, prevention and control of endemic diseases, treatment of minor ailments and injuries and provision of essential drugs etc(Source Book, HNPS, MoHFW 2005:32).

Imbued with the spirits of Alma Ata declaration and also from the health milestones to be achieved by 2015 under the MDGs, the health policy reflects major health strategies of the government and recognizes key challenges to PHC. In the health policy providing quality, easily accessible and equitable health care to citizens particularly the poor has been given due focus. As such primary health care has been extended to the grassroots down to the community level in the form of ‘community centres’ which is the first point of health contact at community level with upward referral linkage. Through the establishment of some 12,557 community clinics where each clinic caters for every 6000 people in villages, primary health care in Bangladesh is broadly based on direct provision by the government.



Health and nutrition programs as part of PHC is further integrated according to the health policy. Further to this, family planning and reproductive health programs is also integrated with primary health care with Essential Service Package (ESP) such as child health services, limited maternal health care, family planning, control of communicable diseases and behavior change program services at one stop service basis. ESP services are designed to deliver from upazila health complexes and community clinics so that a “member of a household can access services in one single visit rather than going to different places at different times for their health needs(Chowdhury et al. 2010:211). The Health and Population Sector Program (HPSP) under the MoHFW targeted the rural poor and bring them under health coverage with appropriate budgetary allocation. Through HPSP, “60% of the national health budget for ESP to be delivered for PHC at upazila level and below” (Sabina et al.2010:18). For providing quality primary health care, qualified and well trained doctors and other health team members will be ensured at all levels. e-health and tele-medicine will be expanded to augment the effectiveness of primary health care. Surveillance and monitoring of diseases caused due to natural disaster and climatic changes will be strengthened for prevention of diseases and also for maintaining public health.

Reduction in infant and maternal mortality rate, reduction of communicable diseases, and non-communicable diseases, emergence of new and recurrence of diseases, natural disaster, maintaining food and nutrition continue to be regarded as major challenges faced by primary health care. With regard to management and governance of primary health care, development and management of human resources such as qualified doctors and nurses, their placement, retention as part of their career plans, filling in the unfilled positions of doctors and nurses keeping in view of future requirements pose further challenges in providing primary health care.

## **Primary Health Care Delivery System in Bangladesh**

Primary Health Care in Bangladesh was largely 'clinic-centric and relied on domiciliary services. Earlier approaches to primary health care were oriented towards providing comprehensive services through clinics and field workers. With successive health sector reforms and with the introduction of ESP and Community clinics, "domiciliary services have been replaced which was the most preferred mode of reaching services to the grassroots in the pre-HPSP period" (Chowdhury et al.2010:212). Primary health care is now managed by a three-tiered upazila health management system. In the hierarchy of the UHS, Upazila Health Complex is the main institutional hub providing clinical, promotive and preventive health care. The next step below the UHC is Union Sub-centers located at union level, next below in the hierarchy are the community clinics which also provide vertical referral system. The UHC, union sub-centers and the community clinics therefore, constitute the institutional infrastructure through which primary health care is delivered and health needs of vast of the majority of the rural people are met.

### **The Upazila Health System (UHS)**

#### **a.The Upazila Health Complex (UHC)**

UHC is an apex health institution at upazila responsible for delivering primary health care services to the rural population of Bangladesh. It provides both curative, promotive services to the citizens at upazila. It also provides maintenance and restoration services on a limited basis to the patients in need. A UHC may serve a population ranging from 2, 00,000 to 450000 and comprise a 31- 50 bedded hospital to render both indoor and outdoor services to patients. Besides, UHCs also provides limited diagnostic facility, x-ray and ambulance services to be dispensed on payment. There are 459 government hospitals at upazila which provide limited inpatient services such as comprehensive emergency obstetric care services(EOC), gynecology, anesthesia, nursing and basic laboratory

services( Khan 2011:38). Apart from the routine OPD and IPD services, Upazila Health Complexes provide the following services:

- Introduction of E-health services: mobile phone health services have been introduced at upazila level. Mobile phone services are intended to give patients health advice from UHC.
- Health services at the field level: Ward or village levels field workers such as health assistants and assistant health assistants, health inspectors, family planning inspectors and family welfare assistants provide necessary assistance to control and eliminate diseases such as diarrhea, malaria, filaria and tuberculosis. Health assistants help mitigate sudden outbreak of epidemic and diseases such as diarrhea, dengue, swine flu and SARS etc. as they work closely with the patients at the community level and provide information on detection of cases and prompt referral.
- Extended Program on Immunization (EPI): One of the major role of the UHC is to implement the immunization program as a matter of Universal Health Coverage (UHC). EPI program covers vaccination for preventable diseases such as diphtheria, whooping cough, tetanus, TB, measles, hepatitis B and eradication of polio.
- Reproductive health program: Services on reproductive and maternal health care is being provided in all UHCs. Under this program, maternal health vouchers and safe delivery services through skilled health personnel is being provided in selected UHCs. Besides emergency obstetric care (EmOC) services are provided to 132 upazila(MoF:2012).
- Piloting health insurance program: In order to remove financial hurdles for health access by the poor government has lunched piloting of health insurance program in selected upazilas. People below poverty line are targeted and considered eligible for health cards. Health cards will enable poor patients to have access to treatment and medicines free of cost at UHCs(Bangladesh Economic Review 2014).

About its services, majority users of UHC are local residents of upazila. Bangladesh Health Facility Survey 2009 conducted by World Bank (2010) on 80 upazila health complexes revealed that 64% of the UHCs surveyed were clean, 55% of the patients reported that waiting time for treatment or consultation with doctors was not long, 72% of the health providers showed respect and 56% of the patients reported that they were satisfied with the services they received. However, according to this survey, only 63% of the positions of the physicians and 70% of the nurses were filled out of the total sanctioned positions. With regard to the services, another study (MoHFW:2013) which was conducted to assess the level of benefits to the poor and vulnerable, it was found that accessing care is found inequitable as poor patients wait longer and pay more for services. The services are inefficient as scarce resources are often used indiscriminately; benefits to the poorest quintile exceed those of the richest as facilities are mostly used by poor. It is also found from that study that doctors at health centers' do not explain either the timing or the appropriate dosage of the medicines and also do not advise patients with dos and don'ts of a medical problem. It was also found that the prescription of drugs generally done on the basis of availability of stocks regardless of medical problems of the patients.

Further improvement in the service delivery in PHC could be challenging without ensuring the availability of all required human resources at UHC i.e. doctors and nurses. Further to this, the state of public health care could remain unsatisfactory and inefficient unless health budget is raised sufficiently. In 2010, the total health care expenditure is estimated at \$17.4 in per capita terms (Bangladesh Health watch Report 2011:86). According to Barkat (2010), in order to meet WHO standard and norms, per capita expenditure on PHC in Bangladesh should be raised at US\$24.

## **b. Health Care at Union Level**

At union<sup>7</sup> level, Union Sub-centers and Union Health and Family Welfare Centers (UHFWC) have been long established which also offer primary health services to rural people. There are 18 hospitals having 20 bed facility and 13 hospitals with 10 bed facility at union level. A total of 1275 union sub-centers only provide outpatient services and do not have any facility for inpatient care. There are 87 union health and family welfare centre's which also caters for outpatient services only.

Union level health centers operate on a particular time in a day. Many such centers remain inoperative in absence of doctors. At present only 23 union level hospitals with bed capacity of 10-20 are in operation with a total capacity of 410 beds. At the union level there are approximately 1382 union sub centers and 87 health and family welfare centers under DGHS. Apart from this, under DGFP there are 3719 health and family welfare centers. The UHFWC's are managed by Sub-Assistant Community Medical Officer (SACMO) and Family Welfare Visitor (FWV). Though these facilities have basic infrastructure, it needs to be upgraded with proper resources and manpower to provide reliable outreach services such as providing basic diagnostic facilities, first aid, carrying out minor operations, normal delivery of pregnant women and providing effective referral system.

## **c. Community Health Care Service (CHCS)**

Community clinics are the lowest-level static health facility with a total of 12584 functioning at the ward level and operated by health care providers (Health Bulletin, MoHFW 2014:29). In addition to the health care providers, each community clinic is also assisted by existing domiciliary staff members of DGHS and DGFP three days a week. Community clinics are one stop service centers at the ward level providing basic health care

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<sup>7</sup> Union is the lowest local government unit in Bangladesh having an elected system of governance headed by a Chairman and nine elected members. A union includes nine wards. Currently there are 4549 Unions in Bangladesh (LGD).

package to the citizens. It provides a host of services such as maternal and neo-natal health care, reproductive health and family planning services, immunization, nutrition education, micronutrient supplementation, health education and counseling, communicable disease control, treatment for minor ailments and first aid, identification of illness and referral system to higher level health centers.

Community clinics provide free medical services for each 6000 people of a given area and managed by a 15 to 17 member management committee constituted by local community members where at least 4 members are required to be female. The management committee is further assisted by 15-17 volunteers. The community clinics are also brought under internet connectivity through a laptop and wireless modem to collect and transmit local health related data, provide tele- medicine and ICT based health solution to the community people. There is also a steady growth of budgetary allocation for community clinics in the last few years which shows a growth of BDT 0.07 million in 2009-2010 to BDT 0.11 million in 2011-2013. Availability of essential drugs has also been increased from 25 (2009-2010) to 30 (in 2011-2012). Numbers of service recipients have also grown sharply since inception in 2009 and rose to 15 million patients all over the country (Health Bulletin, DGHS, MoHFW 2014).

Community clinics are considered as the first entry and contact point to the health referral system within the UHS. Patients are referred to UHC from community clinics after initial diagnosis by the health care provider. Given the shortages of health workforce for providing inpatient care such as doctors and nurses in UHC, referred patients to UHC may not receive prioritized services unless the patient needs urgent medical attention. Referred patients may also find themselves in already crowded in- patient care units where they may have to wait in a makeshift bed on the floor until a vacancy is made. Therefore, more upward referrals from community clinics could crowd out IPD at UHC. During outbreak of epidemic more number of patients could become a challenge from management perspective and to provide treatment with limited human resources.

## **Brief Account of the UHC's under Study**

The study was conducted in six upazilas namely, Chokoria, Ali Kadam, Gabtoli, Shariakandi, Debiganj and Pirganj upazila under five districts of Bangladesh. Rationale for selection of these upazilas may be viewed in chapter-IV in study location. A brief account of the UHC's on health services and health statistics is given below:

**Chakoria UHC:** Chakaria is a upazila under the district of Cox's Bazar and located in the south eastern corner of the country. The upazila has 79103 households with a population of 500507. It has 18 unions. It has 50 bedded hospital, 2 union sub centers and 15 union health and family welfare centers and 18 community clinics. There are 5 private clinics or health facilities in the upazila.90% of the households have access to safe drinking water and 82% have sanitary toilets. Currently there are 21 sanctioned positions in the UHC out of which 8 positions are vacant (Health Bulletin 2012). The UHC is seen to possess one x-ray machine and few surgical and anesthesiology equipment. Common diseases include diarrhea and gastroenteritis, peptic ulcer, pneumonia, injuries, respiratory infections, poisoning, malaria, nephritic syndrome etc. Rate of vaccination of children is 86.5%. Total patient days in UHC are 22741, bed occupancy in hospital is 129% and average length of hospital stay of patients is 2.57 numbers of days. Hospital death rate is recorded at 0.12% (January-December 2013).

**Ali Kadam UHC:** Ali Kadam UHC is located in the hill district of Bandarban. The population is sparsely located and stands to 46798. A total of 8197 households inhabit the 2 unions of the upazila. The total sanctioned post of doctors in UHC is 11 out of which 8 positions are lying vacant.48% of the populations have access to safe drinking water and 74% have access to sanitary toilets. In UHC out of sanctioned 11 positions of doctors, 8 positions were vacant. No radiology equipment and anesthesiology/surgical equipment were available (Health Bulletin of 2012, 2013).

Total patients days in 365 days stands to 5892 and bed occupancy in the UHC hospital is reported to be 48%. Average length of stay in the hospital i.e number of days per patient is 1.81 days. Hospital death rate is recorded at 2.31 % ( Health Bulletin 2012). Common diseases reported include diarrhea and gastroenteritis, pneumonia, malaria, gastric ulcer, asthma, urinary tract infection, poisoning, sudden infant death syndrome etc.

**Shariakandi UHC:** Shariakandi UHC is located in the district of Bogra. The upazila has a history of displaced population owing to the river erosion from the mighty river Jamuna. The population of the upazila is 246136. The number of households recorded stands to 54100. There are only 12 unions under this upazila. With regard to the official strength of the UHC, 15 positions remained vacant out of a total 21 positions. Only 1 radiology equipment i.e. x-ray, and several other anesthesiology/surgical equipment is available in the 50 bedded hospitals (Health Bulletin of 2012, 2013). 95% of the populations have access to safe drinking water and 82% have access to sanitary toilets. Total patients days in 365 days stands to 18883 and bed occupancy in the UHC hospital stands to 103.29%. Average length of stay of patients in the hospital i.e. number of days per patient was 4.31 days. Hospital death rate was recorded at 0.33 % (Health Bulletin 2012). Common diseases include gastroenteritis and colitis, pneumonia, typhoid, sexual assault, peptic ulcer, anemia, urinary tract infection, asthma, chronic pulmonary disease etc

**Gabtali UHC:** Gabtali UHC is also located in the district of Bogra. The population of the upazila is estimated at 324627 with 83188 households. There are only 11 unions under this upazila. In UHC out of sanctioned 21 positions of doctors, number of vacancies is reported to be 15. X-ray, surgical equipment are reported to be available in the 50 bedded hospitals (Health Bulletin of 2012, 2013).98% of the populations have access to safe drinking water and 90% have access to sanitary toilets. Total patients days in 365 days stands to 128693 and bed occupancy in the UHC hospital stands to 70.10%. Average length of stay of patients in the hospital i.e. number of days per patient is 3.30 days. Hospital death rate is recorded at



0.10 % (Health Bulletin 2012). Common diseases include gastroenteritis and colitis, fever, obstructive pulmonary disease with lower respiratory infection, road accidents, urinary tract infection, poisoning cases, hypertension, asthma etc.

**Debiganj UHC:** Debiganj UHC is located in the top north western district of Panchagarh. The population of the upazila is 223060. The number of households recorded stands to 48960. There are only 10 unions under this upazila. In UHC out of sanctioned 20 positions of doctors, number of vacancies was reported to be 17. Only 1 radiology equipment i.e. x-ray, and several other anesthesiology/surgical equipment such as anesthesia machine with ventilator, autoclave, sucker machine, sterilizer etc. are available in the 50 bedded hospital (Health Bulletin of 2012, 2013). 95% of the populations have access to safe drinking water and 72% have access to sanitary toilets. Total patients days in 365 days stands to 14909 and bed occupancy in the UHC hospital stands to 100%. Average length of stay of patients in the hospital i.e. number of days per patient is 3 days. Hospital death rate is recorded at 1.00 % (Health Bulletin 2012). Common diseases and other health problems include assault cases by sharp objects, gastroenteritis and colitis, viral fever, road accident cases, mixed asthma, bacterial pneumonia, sandfly fever, medical abortion etc.

**Pirganj UHC:** Pirganj UHC is located in the top north western district of Thakurgaon. The population of the uapzila is 259023. The number of households recorded stands to 53572. There are only 10 unions under this upazila. In UHC out of sanctioned 9 positions of doctors, number of vacancies stand to 5. Only 1 radiology equipment i.e. x-ray, 1 dental x-ray unit and several other anesthesiology/surgical equipment such as anesthesia machine without ventilator, autoclave, diathermy machine, sucker machine, sterilizer etc. are available in the 50 bedded hospital( Health Bulletin of 2012, 2013). 97% of the populations have access to safe drinking water and 75% have access to sanitary toilets. Total patients days in 365 days stands to 17084 and bed occupancy in the UHC hospital stands to 93.61%. Average length of stay of patients in the hospital i.e.

number of days per patient is 1.90 days. Hospital death rate is recorded at 0.55 % (Health Bulletin 2012). Common diseases include assault cases, diarrhea and gastroenteritis, road accident cases, hypertensive heart disease, pneumonia, poisoning cases, asthma, anxiety disorder, unspecified abortion, incomplete and complicated cases by genital and pelvic infection etc.

As evident from the above description, most of the UHC's have shortage of doctors. There are also commonalities in terms of diseases across upazilas. Of the commonly recorded diseases includes patients suffering from diarrhea, road accidents, enteric fever, poisoning cases, pneumonia, hypertension, bronchial asthma, peptic ulcer and anemia. Assault cases are common to all upazilas and may arise out of litigations owing to land or rivalry between parties. The coverage of safe drinking water is yet to be 100%, nevertheless, it has certainly made positive contribution towards reducing the incidence of water borne diseases. Sanitation coverage across upazilas is far below 100% in many upazilas which pose a concern for public health.

### **UHC Management and Oversight**

In order to provide quality health services and for proper hospital management at UHC, the government has constituted local committee in each upazila to be known as 'Upazila Hospital Management Committee' chaired by the local member of the parliament. Formation of this committee provides space for community participation and also ensuring more accountable and responsive services to the people. The hospital management committee is required to meet regularly once in a month. The hospital management committee is a forum for discussing issues such as quality of treatment, availability of drugs and physicians and nurses, improvement in the quality of care and community participation. However, such meetings are irregularly held and often become more ritualistic and could serve very little in the overall improvement of PHC. Many issues are

discussed with little follow up such as filling in the vacant positions of the doctors and nurses and also bringing overall improvement in patient care. Monitoring from the DGHS is done through regular reporting from UHC and for the MIS at DGHS. However, field visits and monitoring from DGHS or MoHFW at a regular basis may strengthen upazila hospital management committee and bring vitality to UHC for more responsive and quality service delivery.

### **Achievements and Challenges of PHC**

Providing PHC to citizens' as a basic human right and maintenance of the basic delivery of health services needs sustained effort and commitment of the government. For improvement in the quality of treatment and care, appropriate level of financing is also a prerequisite. The gains of health services in PHC are visible through the attainment of various milestones articulated in the MDGs and other human development indicators. The Millennium Development Goals 4, 5 and 6 concerns health related goals. MDG-4 is about reducing child mortality below targeted level by 2015. MDG-5 is about improvement of maternal health which also includes reduction in maternal mortality, reproductive health, nutrition and births attended by skilled health attendants, antenatal and post natal care. Huque (2011:52) observes that, "while access to family planning is increasing, access to three other pillars of safe motherhood namely, antenatal care, clean and safe delivery, and essential obstetric care remain largely unfulfilled, therefore, great challenge lies to meet MDG-5". MDG-6 is about combating HIV/AIDS, malaria and other diseases. Prevalence of HIV/AIDS is less than 0.1 % and deaths due to malaria has also significantly reduced due proper diagnosis and proper treatment. With regard to tuberculosis, it is still a cause of concern as prevalence rate needs to be further cut down by the year 2015.

UNDP(2013) highlights the recent progress in health sector of Bangladesh in reducing child and infant mortality to a desirable level meeting which

must have been the outcome of a series of proactive actions such as immunization coverage, control of diarrheal diseases and vitamin A supplementation and awareness building. Efforts must be sustained for covering the new born babies. Along with this poverty and inequality in the society must also be contained to benefit from the gains of PHC. According to Bangladesh Progress Report 2013(BPC) in meeting the Goal 4,MDG, under -5 mortality rate per 1000 live births, Bangladesh has already crossed the target of 48 by 2015 which is 53(2011). Progress in the reduction in infant mortality rate has been made to 43(2011) against target of 31 per 1000 live births. In Goal 5, in improving maternal health, Bangladesh has exceeded the target of 143 per 100000 live births to 194(2010). Progress on proportion of births by skilled health personnel is however low 31.7(2011) compared to the target of 50 by 2015. Likewise contraceptive prevalence rate needs to be improved to make progress from 61.2% (2011) to 72% in 2015. Other areas where more progress is needed is anti natal care for at least one visits and at least four visits. For combating HIV/AIDS and malaria which comes under Goal 6, HIV prevalence among population is halted(0.1%, 2011), progress in the reduction of prevalence of malaria per 100000 population is below the target(270.84 against 310.8 by 2015).Prevalence of TB per 100000 is still high 411 against the target of 320 by 2015.

Other improvements in the human development indicators such as reduction in population growth rate, life expectancy at birth has increased by 50% from 45 years in the early 1970s to over 65 years currently, more longevity of women than men, improvement in reproductive health and nutrition are positive signs of human health and wellbeing. Spread of communicable diseases caused by HIV, avian flu and other viruses pose new challenges to health. In addition non-communicable diseases such as cardio vascular disease, diabetes etc. are on the rise.

As observed by Chowdhury et al. (2011:1) for achieving universal health coverage, financing the health system is a big challenge. The current allocation of 60% of the health budget goes to PHC at the level of UHS

through the ESP services. Using the allocated resources equitably and in an efficient manner must be maintained if the components of PHC are required to be maintained. As far as nutrition is concerned, nearly half of pregnant women suffer from malnutrition and anemia. Malnutrition is also seen to be high in children, adolescent and girls. Another point of concern is the cost of treatment which comes out of the pocket expenses of the patients. Currently out of pocket expenses in Bangladesh are high and account for 60% of the medical expenses (Rannan-Eliya 2010). The out of pocket expenses put huge financial burden on poor patients which drive around 3.8% of the population or 5.7 million people into poverty each year (Chowdhury et al.2011:1). As far as equity in PHC is concerned, health care expenditure at different levels shows that 27% of the primary level health care allocation go the richest quintile and 21% to the poorest quintile(Haque et al.2011:28). Therefore, more needs to be done for bringing equity in PHC and keeping the out of pocket expenses low for treatment.

The health workforce which faces severe shortages also needs systematic recruitment based on current and future vacancies. The number of doctors/nurses/dentist per 10000 populations is only 7.7 whereas it is 12.5 and 14.6 and 21.9 for Pakistan, India and Sri Lanka respectively. In order to achieve the MDGs, WHO's estimate for 10000 population is 23 doctors. The current nurse - doctor ratio which is 0.4 i.e. 2.5 times more doctors than nurses need to be matched with regional or international standards. This means the shortages of nurses is four times higher than the shortages of doctors according to WHO's estimate (Health Watch 2013:4, Vol.1, Issue 1).

### **Secondary and Tertiary Health Care**

At the secondary and tertiary level, health services are provided by district level hospitals. District level hospitals have been upgraded and staffed by professionals and consultant physicians. Apart from the public hospitals, there has been an impressive growth in private hospitals and diagnostic

centers in the district though many of these facilities may often fall behind the required standard. Many patients in the districts are drawn from the upazila referral systems. In the divisional level public medical college hospitals and specialized hospitals with capacity of 250-1700 beds provide specialized services while private clinics and hospitals offer diagnostic facilities and specialized services to the patients. The district level hospitals and the divisional level medical college hospitals serve as the referral centers where more advanced treatment is available. Bhuiya et al. (2009) observes that with liberalization of private investment in health sector in the 80s, it resulted in proliferation of private inpatient care facilities in urban areas catering the affluent people and the rural poor are mostly dependent on the public hospital and rural people are in disadvantaged position to use the secondary and tertiary care in the districts and towns (Roh 2007; Folland et al.2007).

### **Urban Health Service**

The term 'urban' is referred to signify an urban population residing in the capital city and divisional towns which also includes residents of metropolitan towns and municipalities. It is estimated that currently 27% of the population lives in urban areas and 29% of the population lives in divisional towns while 309 municipality towns have 31% of the population. Dhaka city singly accounts for approximately 40% of the population. Preventive health and curative care within the urban health services is the responsibility of the City Corporations and municipalities of the country. Such services have remained very insignificant given its quality and availability of alternative health care facility in private sectors. Therefore, private health service providers also provide curative and preventive health care including tertiary and specialized services to the urban populations. Several urban dispensaries under the DGHS provide primary health care to the urban poor. Along with this several NGOs provide primary and specialized health services to the urban population. Urban health services by public sector have been overtaken by private health providers as public provision are largely inadequate and lack quality.

## Health Expenditure

There has been an increasing trend in the health care expenditure from 1999 to 2008 from 2.7% to more than 3.5 % of GDP(WHO:2010). In per capita terms health care expenditure has increased from \$8.7 to \$ 17.4 during this period. From the users perspectives there are out of pocket costs and opportunity cost on the part of the citizens' for visiting the facility. Non-medical expenses are costs which include travel and food for hospital attendants borne by the users as out of pocket expenses. Maternal health voucher program in 44 upazilas provides a pilot case for demand side financing the average cost per voucher is estimated at \$41.The voucher program is costly as it provides incentives to both provider and consumers (Huque 2011:86).

The major heads of public sector health expenditure both by function and type in Bangladesh are presented in the following tables:

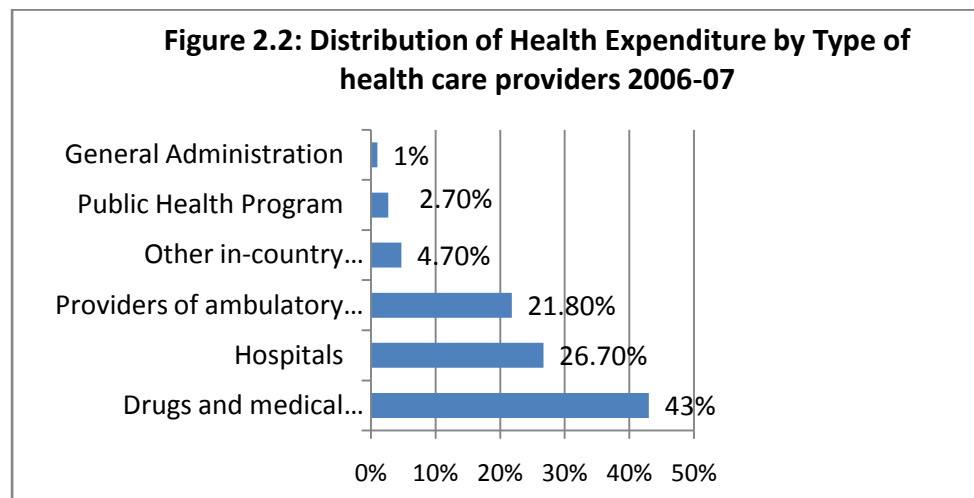
**Table 2.3: Distribution of Health Expenditure by Function (2006-07)**

Heads of Expenditure	(%) the health budget
Capital Investment	18
Medical education and training	4
Curative care	33
Medicines and medical goods	14
Preventive services	27
Health administration	4
Total	100

(Health Bulletin 2012, DGHS, MoHFW)

In the above table curative care and preventive services comprised the major health expenditure followed by medicines and medical goods in 2006/07. Health expenditure for primary health care and tertiary care in FY 1996/97 was 38% and 37% respectively, however the share of expenditure at upazila and below increased to 62% in 1999/2000. The target of funding 60-65% for primary health care could not be met and only 49% funding was possible in 2003/04(Huque et al. 2011:26). ESP services therefore were constrained severely from resource allocations which might have impacted

health service delivery at upazila.



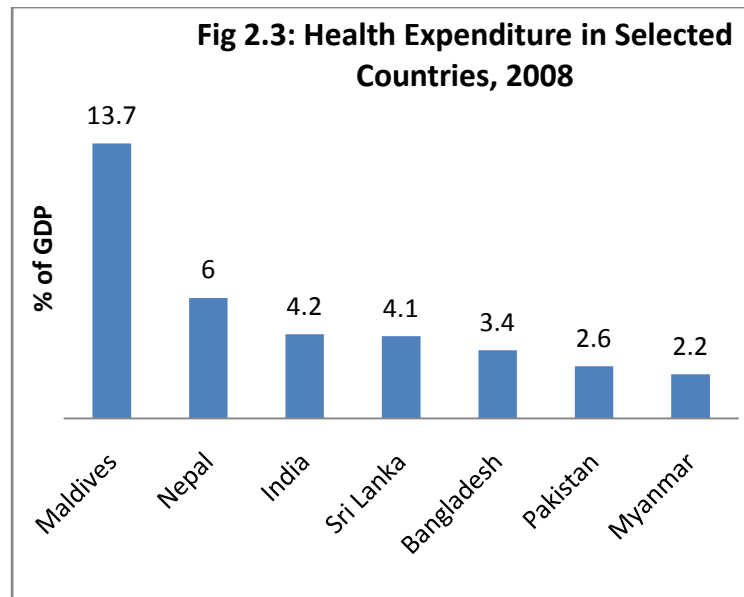
According to the above table major heads of health expenditure on drugs and medical goods retailers constitute 43%, hospitals 26.70% and providers of ambulatory services 21.80%. While a comparison is made on health expenditure with some neighboring countries, it is seen that Sri Lanka, Nepal and Pakistan has higher percentages of public expenditure on health than Bangladesh. Likewise per capita health expenditure in Bangladesh is far too low when compared with Sri Lanka and India.

**Table 2.4: Comparative Health expenditure of Bangladesh and other countries**

Country	Fiscal Year	Per Capita Health Expenditure in US\$	Total Health Expenditure as % of GDP	Public Expenditure as % of total health expenditure
Bangladesh	2006-07	16	3.6	26
Bangladesh	2005-06	14	3.3	27
India	2005-06	29	3.6	25
Nepal	2005-06	17	5.1	30
Pakistan	2005-06	19	2.6	32
Sri Lanka	2005-06	57	4.2	49

Source: Health Bulletin 2012. DHMS, Bangladesh





Source: WHO Department of Health Statistics and Informatics, World Health Statistics 2011

### **Service Delivery in the UHCs under Study**

Success in coverage and maintenance of PHC can be lauded with limitations in manpower and resources of UHC. Services of UHCs may still be considered satisfactory to a majority of users at upazila. Part of the success of UHC lies and attributed to the consistent government policy towards achieving primary health care. As evident from the United Nations Human Development Report 2013, 69% of the users of services expressed satisfaction with health care quality during the period of 2007- 2009. The services of primary health care have further improved in terms of accessibility and coverage. The following tables give a picture of patients visiting UHCs for primary health care and emergency services in six upazilas for 2012 and 2013.

**Table 2.5: OPD/IPD and Emergency Patients under the Study Area**

Year	Name of Upazila	Indoor patients/ number of patients			Outdoor/emergency patients		
		Male	Female	Total	Male	Female	Total
Jan-Dec 2012	Chakaria	4179	3058	7237	27823	30473	58296
	Ali Kadam	1662	1567	3229	21655	39642	46798
	Shariakandi	1745	2066	3811	25197	45035	246136
	Gabtali	1431	1834	3265	32352	45822	324627
	Debiganj	1047	2930	3977	23978	27361	51339
	Pirganj	2346	5540	7886	14805	28113	42918
Jan-Dec 2013	Chakaria	3850	4151	4493	24590	30389	54979
	Ali Kadam	1456	1533	2989	19852	24942	44794
	Shariakandi	1374	1881	3255	16250	21840	38090
	Gabtali	1317	1513	2830	10301	24355	34656
	Debiganj	1375	2938	4313	17106	21649	38755
	Pirganj	2859	6231	9090	18414	33887	52301

Source: Health Bulletin 2012, 2013, Ministry of Health and Family Welfare

From the above table, it may be seen that large number of patients visited OPD compared to IPD. It may also be seen that female patients who visited OPD during the year 2012-2013 far exceed the number of male patients. The reason for more female visits may be due to their own treatment and also for the purpose of treatment of their young children. Doctors at UHC are required to examine large number of patients during the hours of examining out-patients. During epidemic the number of patients in need of urgent medical attention might also increase.

**Table 2.6: ANC, Delivery Services and Maternal Deaths in the Study Area**

Year	Name of Upazila	ANC Services		
		ANC recipients	Total deliveries	Maternal deaths
Jan-Dec 2012	Chakoria	20059	12173	11
	Ali Kadam	919	89	0
	ShariaKandi	2783	2692	0
	Gabtali	4212	3291	0
	Debiganj	12136	5154	5
	Pirganj	13322	1583	7
Jan-Dec 2013	Chakaria	4496	13465	8
	Ali Kadam	40	211	3
	Sharia Kandi	3939	3452	0
	Gabtali	5276	4816	0
	Debiganj	699	4314	8
	Pirganj	3259	3207	13

(Source: Health Bulletin 2012, 2013, Ministry of Health and Family Welfare)

In the above table, Chakoria UHC provided the largest number of ANC services in the EmOC unit of the UHC in 2012. The total number of deliveries stood to 12173. In 2013, the total number of ANC service recipients is reduced to 4496, but the number of deliveries stood to 13465. One explanation for reduced ANC service may be increased care at home and also greater awareness of the patients. But for safe delivery there is greater reliance on the EmOC unit of UHC as evident from the number of deliveries in a particular year. However, maternal deaths are still a cause of concern for many UHCs. Maternal deaths are recorded highest in Priganj UHC in the year 2013. The reason for more maternal deaths may be due to the complications during delivery and from failure to take ANC services from UHC.

General cleanliness of the male and female ward of UHCs often remains in poor condition and inside the ward the environment and surrounding air may appear stuffy. Each patient particularly the old and weak are often accompanied by family members in the hospital for help either to bring in some medicines from outside or guide the patient to toilet at night. Hospital foods are free for patients. It is reported that per day approximately Tk100 (one hundred) is allotted for supply of three meals a day to the patient. Food catering is usually tendered and lowest bidder is awarded work order for supply of food. Food supplied at hospital is of inferior quality which encourages many patients to bring food from home. At the OPD patients' crowd may appear to be heavy during the morning hours of the day. Doctors at OPD often hurry while examining patients as they may have to examine all the patients during the fixed hours at OPD. Medicines prescribed at OPD are available but many medicines, injections have to be bought from outside. The medicines which are given free to the patients are supplied from the central depot through the district civil surgeon office. For investigation such as pathological tests of blood, patients are required to pay certain amount of money. Many hospitals have x-ray facility but remain inoperative in absence of technicians. Citizen's charter is generally displayed in front of the main entrance of the UHC but the objectives of displaying it is hardly met since it is hung far above the viewing height of an

average person and also rarely noticed or understood by the patients.

Patients' dissatisfaction on treatment and complaints on the quality of services, general cleanliness and delivery of food at the hospitals may often be seen common to all the upazilas, A major reason for this may arise out of the system such as a centralized system for primary health care or a decentralized system through which communes or county in the advanced countries deliver primary health care. In Bangladesh primary health care is essentially managed and controlled by a centralized top down system under the Director General of Health Services, under the Ministry of Health and Family Welfare. As a centralized system, like many other institutions which deliver services, health services may also suffer from proper monitoring and accountability which may affect service delivery. Service delivery in UHC can often be impaired by excess work load taken by available medical professionals in proxy of others or working extra to meet the patient load and also from the pressures arising out of the unfilled positions. The impact of these on patients may be visible in reduced time for consultation and examination, delays in medical response etc. The potential patient's rely on UHC for the delivery of low cost medical services and treatment by government registered and qualified professionals. In UHC, the competence of the health professionals is hardly challenged by the users. This can have two explanations such as users of the services mostly come from poor background and often illiterate. They perceive UHC as a government institution and rely on the doctors on prima-facie judgment. Despite its limitations and some failing services at some point, it often succeeds in providing responsive medical services at UHC. In case of complex nature of the health problem, the patient is firstly managed to a stable situation and then referred to an appropriate higher level of medical services. For urgent medical response, UHC also offer ambulatory services to the patients when situation demands. The medicines supplied at UHC are free and they come in distinct trade mark to readily reveal that they are government supplies and cannot be sold outside.

## Service delivery at UHC as reported in media

A recent report in the daily Bangla newspaper, '*Amader Shomoy*' dated 04 February 2013 with a caption *Eker Jonno Dawsher Bhoganti*' ( *Sufferings of many for the cause of one*) very aptly captures the often- failing health services at rural Bangladesh. The report is produced below in verbatim in Box-1.

### Box: 2.1: Recent Newspaper Clips on Health Service at the Periphery

The news relates to Sonargaon Upazila Health complex which is located in a sub-urban district Narayanganj close to Dhaka. The plight of the patients begins with formation of a cue for the collection of a ticket for outdoor services. The person in charge of the issuance of ticket for outdoor services was reported to be a mali(gardener) of the upazila nursery since no staff from UHC was posted. The Upazila includes one municipality and 10 unions with a population of approximately 5 laks. Outdoor services of the UHC remains available upto 2 pm but it is alleged to be closed by 12 noon each day. Yesterday which was Sunday, no doctor was available till 11am, rooms for medical officers in room no 101, 102, 105 and 111 in charge of outdoor services remained empty. Mr.Chunnu reports with a ticket for consulting medical officer at room 105 for treatment of his minor son Ashik, but found no one there. Several other patients namely Hoshne Ara from the village of Ratonpur, Hasina Begum, blind folk singer Abdul Barek all reported that they had been waiting for more than an hour with fever and headache but no doctor was found to be available. Much later Dr. Jasia Jannat arrived in her office who told waiting patients that she was in a meeting in Dhaka. Dr.Salauddin, Dr. Mofizuddin, Dr. Daharul wre also not seen in their duties till noon. Medical emergency services are often attended by assistant medical officer Mahfuzur Rahman and Harunur Rashid. Most of the doctors commutes from Dhaka on some days and leaves office after putting their signatures. The T.H.O Dr. Md.Lokman Mia was absent on account of a meeting at Narayanganj district. Resident Medical Officer Dr.Joynal Abedin was also on leave on that day. Dr.Subhi Sadik, medical officer is also reported to be irregular in Upazila Health Complex owing to his connection with the political higher ups. The above accounts only portray failing health services to the poor at Upazila.

Source: *Amader Shomoy*' dated 04 February 2013 with a caption *Eker Jonno Dawsher Bhoganti*' (*Sufferings of many for the cause of one*).

Unauthorized absence of doctor at upazila has been an old problem. Unauthorized absence from duty coupled with large number of vacant positions of doctors across the country have made the PHC at UHC more

fragile and fragmented. Many medical officers, consultant physicians despite their postings at a particular upazila manage to alter their postings either to stay in situ or seek transfer to their desired places of postings. For example, in Gabtoli Upazila of Bogra district in December 2012, 16 positions out of 24 sanctioned posts of doctors and professional staff for a 50 bedded hospital remained vacant. Likewise at Debigonj Upazila, under Panchagar district for 50 bedded hospital in the month of November 2012, 18 positions out of 20 sanctioned positions of doctors and professionals remained vacant. These figures of vacant positions UHC's remain fairly common in all upazilas located either in a periphery or in a backward region. This resulted in overcrowding of doctors in UHCs close to Dhaka and big cities.

A more stark position of health services at upazila is captured by a daily news paper, *Dainik Amader Shomoy* dated 21 May 2013 with a red caption, "*Beton Gramey, Thaken Dhakai*" (meaning lives in Dhaka while salaried at rural work station). It was reported that more than half of the 10 thousand sanctioned positions of doctors in 64 Upazila Health Systems are lying vacant. For example Tetulia Upazila complex runs only with 3 working doctors out of 27 sanctioned positions. In Teknaf Upazila 19 positions are currently vacant against 29 sanctioned positions. The prevalence of large number of vacant positions at the upazila level is a common systematic problem across Bangladesh causing many sufferings to the rural population. Politicization of the medical professionals and weak mechanism for compliance and discipline has resulted in such huge number of vacant positions at upazila level. Vacant positions of doctors at Upazila Health Complex and union sub-centres in upazilas can be seen at Appendix-6.

The large number of unfilled positions of doctors at upazila gives a very dismal look of the primary health care at upazila when the government commits itself to further strengthen the UHS. Shortage of manpower and retention of specialists or consultant physicians are key challenges in the delivery of primary health care. Many patients are forced to undertake costly treatment in nearby towns or cities. But majority of the patients have

no choice to seek alternative treatment beyond UHC at nearby towns due to higher cost of treatment. Vacant positions are seen to be large in number in the difficult and remote upazilas. For example, Dhaka and neighboring upazilas tend to have high concentration meaning no vacancies. Despite its shortage of manpower, many upazilas are forced to deliver responsive health services with limited staff for providing treatment. Though there is dissatisfaction and complaints of services of some sort, many local people have no choice but to accept whatever is available to them. Those who can afford costly treatment avail private services at clinics. Treatment in private clinics could also be infested by ‘dalals’<sup>8</sup> who recruit patients for clinics. Treatment in private clinics is therefore costly and may also cause harassment and cheating.

### **Primary Health Care-observations drawn from selected studies**

UHC is responsible for delivering primary health care to the citizens’ at the level of upazila. The UHC set up comprises a small team of doctors and nurses where vacancies of doctors are high due to unfilled positions. Besides absenteeism of doctors is also common to many UHC which also constrain service delivery. Absenteeism in UHC is quite significant as indicated in a survey in 2003 mentioned by Chowdhury et al.(2010). They further observed that the public health service ranks the lowest among all types of service providers in terms of satisfaction to the users (GoB 2005). As noted, the major concerns for the users of health services were the non-availability of drugs and medical supplies and quality of in-patient food. The other concerns related to service delivery was lack of cleanliness and unhygienic conditions, privacy and waiting time for patient. It is further noted that the service users from higher socio-economic status were likely to experience better responsiveness from doctors/ service providers and receive better quality of treatment. In another study as cited by Chowdhury

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<sup>8</sup> The literal meaning of ‘dalal’ is a broker. ‘Dalals’ in case of hospitals are people who may act as a broker to recruit patients for private gains. Many private clinics or doctors, diagnostic centers take the help of dalals for recruiting more patients. Dalals in other cases may often appear to be fraudulent and may extort money from people in lieu of some promised work bypassing formal official channels.

et al. (2010), it was reported that although the poor utilized government services more frequently, they also found the services as bad more often compared to the non-poor-30 per cent and 36 per cent respectively(WHO 2002).

With regard to providing quality time to patients, doctors at UHC do not often render their professional services properly. As observed by Chowdhury (2010), “doctors often claim and indulge in private practices beyond their office hours and outside official premises, but there are strong evidence that public and private services tend to be provided on the same premises and during office hours” (Osman 2004). Referring to Akhtar and Islam (2006), Chowdhury et al. (2010) concludes that field studies suggest that the doctors devote less time to their non-private patients that they ought to. Availability of drugs and medicines’ are also considered as hindrances to satisfactory health service delivery. It is observed that drugs and equipment is a serious hindrance to effective service delivery. Referring to a review of HPSP, it was revealed that only one in every five persons using government health services was found to receive all the prescribed medicines (CIET 2001). The ESP provided by community clinics also proved to be unsatisfactory. Chowdhury et al. (2010) notes that costly medicines and equipment are sold off by corrupt officials and staff. Referring to an official review, they observe that the provision for drugs at lower levels of health system has long been insufficient and declining (IRT 2009). Chowdhury et al. (2010) thus concludes that all these problems has reflected in a poor rate of utilization of public health facilities.

In another study of beneficiary survey conducted by the World Bank(2012), revealed that ‘87% of the beneficiaries indicated that they have visited the health centers in the last six months and the main services sought in the health facilities were treatment for common disease, various illnesses affecting children, emergency health care, complications during delivery and side effects of family planning methods. 89% of the patients reported that they were provided service by MBBS doctors at the facility and the rest by para-professionals or Family Welfare Visitors. The mean waiting time of



the patients was 31 minutes and 49% of the patient reported that privacy was maintained during examination. 90% of the patients reported service provider's behavior as satisfactory/fairly satisfactory, while 3% reported service provider's behavior as very unsatisfactory. Supply and availability of drugs along with the regular presence of the physicians need to be ensured along with the required equipments according to the majority of the patients. According to the survey, 80% were of the opinion that services have improved over the years.

Despite many of its challenges and weaknesses UHC is considered as the only reliable health facility at arm's length at upazila. The qualified doctors at the UHC provide the patients with necessary services through consultation and treatment. In the event of complicated cases patients are referred to secondary or tertiary care. Though relatively pricy, patients may also seek alternative private health care beyond UHC as private services are often taken to be prompt, efficient and the services satisfactory.

## **Conclusion**

This chapter introduces the health system of the country particularly the management and service delivery of PHC. It also highlights the health policy reforms and health policy with regard to PHC. Health is considered as one of the basic needs and considered as individual rights of all citizens. Progress in health in Bangladesh is evidenced by the progresses made in MDGs and human development indicators such as reduction in infant and child mortality, reduction in maternal mortality, access to primary health care, longevity of life, improved sanitation and access to safe drinking water. Many challenges still remain concerning coverage, equity and quality of primary health care particularly to the poor. The current health policy has adopted a pro-poor approach to bring primary health care accessible to all the citizens. The question of quality and sustainability will largely depend on adequate health financing which also appears as a major challenge. Large number of vacant positions in health institutions at UHC and union levels along with unauthorized absenteeism of doctors is seen as a major barrier to effective and quality health service delivery.

Failure to provide effective and quality service at UHC may adversely affect citizens' trust on UHC. The health policy and the current sector development strategy HPNSDP has adopted a SWAp and involves elements of health, population control and improvement of nutritional status of citizens. The policy also aims to pursue a decentralized model of health governance with appropriate manpower. This will require policy continuity and persistent efforts to fulfill the target of MDGs by 2015 and also for achieving UHC within a reasonable shorter time. The following chapter presents literature review on trust to trace the variety of trust research that has been conducted and more particularly trust research pertaining to health.

## Chapter- III: Literature review on trust research

*“Trust is a vulnerable and fragile commodity, vaunted in the marketplace, acknowledged in every profession, yet perniciously difficult to quantify”.* David H. Thom et al. (2004).

### Introduction

This chapter reviews relevant literature to trace research trends in trust research and discuss its relevance from different perspectives. As observed by Li (2012), there has been an explosive growth in trust research in recent times. This is attributed to the essential and ubiquitous role of trust in organizations and every social relationship. This chapter aims to highlight the contributions of scholars in trust research and discuss implications of trust in governance and in the delivery of health services. It also attempts to identify major challenges and future trends in undertaking trust research such as methods of measurement and identification of explanatory factors based on which patients may base their trust on health service delivery at upazila level. Upazila Health Complex (UHC) - a public health service delivery institution at upazila is responsible for providing PHC to the citizens.

### Research on trust

Polish Sociologist Piotr Sztompka (1999) observes, the beginning of trust research is witnessed by the gradual and important fragments of evolving research traditions. He holds the view that it has been treated as a topic of autonomous theoretical interest. “The idea of trust has had a centuries-long intellectual career”(Silver 1985:52). On a more recent account on advancement in trust literature, Li(2011) notes, that there has been many articles devoted to the topic of trust by many journals related to organization and management since 1990s and this trend has been accelerated in recent years. Dietz et al. (2010:3) observes that “trust has been studied from a number of disciplines which includes psychology,

sociology, economics, political science and moral philosophy. As such trust research has witnessed different approach, conceptualization and different level of engagement". As evident from the First International Network on Trust (FINT), there has been a huge growth of researchers on trust across disciplines and countries. Li (2011) refers to ABI/INFORM Business Database developed by Pro Quest, a U.S.A based global repository of research publications which traces as many as 456 trust-related articles published in different scholarly journals until the end of 1979. Li (2011) further traces the growth in publications of trust related articles since the 80s. Accordingly, in the 80s' a total of 395 articles, from 1990 to 1994, a total of 411 articles, from 1995 to 1999 a total of 824 articles, from 2000 to 2004 a total of 1440 articles, from 2005 to 2009, a total of 1732 articles, and in 2010 a total of 359 articles were published. This trend suggests interest and consistent growth in the field of trust research devoted to the study of government, parliament, organizations, judicial systems and social relationships as well.

Sztompka (1999:2) notes that literature on trust research takes two broad research streams- i). focusing on the psychological aspects such as motivation, reasons, intentions, attitudes and moving towards a socio-psychological theory of action. The work of William I. Thomas (1981) and Florian Znaniecki (1964) in advancing theories of social action, ii). focusing on cultural meaning i.e. rules, values, norms, symbols and moving towards a culturist theory of action. The work of George H. Mead who advanced his theory of act (Mead 1964), Talcott Parsons (1937) who emphasized on normative orientation of action. Therefore, according to Sztompka (1999) the socio-psychological theory and the other culturist theory broadly has shaped the major streams of trust literature.

### **The focus on culture**

Sztompka (1999) notes that trust research has been inspired and enriched by the intellectual contributions made by the several classical and neo-classical scholars of sociology. Most of these scholars have emphasized on

the softer cultural values that acted as the basis of social action. Sztompka (1999:3) argues that “culture supplies action with axiological, normative and cognitive orientation which becomes a determining force for releasing, facilitating, enabling, arresting, constraining or preventing action”. Therefore, according to this view culture contributes to trust formation in the society, promoting social bonds. Sztompka (1999) further refers to morality with reference to the roles of individuals which may be based on proper, obligatory relationships invoking values for prescribed behavior. The bias for culture in formation of trust is also attributed by the notion of ‘moral community which is based on ethical habits and reciprocal moral obligations internalized by the members of the society’ (Fukuyama 1995:7), Sztompka (1999:5) holds that, moral community is reflected at the individual level in personal identity, by way of which an individual feels obliged to trust, to be loyal and shows solidarity to others’.

Sztompka(1999:6) refers to Durkheim’s doctrine of “social facts” (Durkheim 1964), Alexis de Tocqueville’s(1945) idea of “habits of the heart” for providing the intellectual roots of the culturist turn in sociology focusing on social collectivities i.e. society and on the individuals as social actors. Sztompka (1999) notices that the focus has shifted more towards the individual actions and how they behave individually and collectively in social contexts which can be interpreted from two perspectives. One is the hard utilitarian and instrumental perspective and the other ‘soft’ humanistic and meaningful image of action. One dimension sees individual action from rational, calculative, profit maximizing and the other dimension is based on normative judgments, emotional, traditional based on solidarity and identities.

Sztompka (1999) discerned two streams of research one the socio-psychological theory of action and the other culturist theory of action based on rules, values, norms, symbols etc. Thomas (1981) and Znaniecki (1964) has been identified as early proponents in the first category and Mead (1964) has been identified as the proponent of the second category. Along with this stream of ideas, Parsons (1968) normative orientation of action

provides similar undertone like the culturist theory of action. Sztopka (1999) refers to several other theorists and their ideas such as Pierre Bourdieu's "habitus" and Jeffrey Alexander's notion of "polarized discourses" as examples of cultural embeddedness of action.

In line with the classical themes of 'soft' cultural intangibles and 'soft' moral bonds new streams of research along with several theoretical concepts have emerged. Firstly, Sztopka (1999) points out to the numerous studies on 'civic culture' influenced and initiated by the work of Almond and Verba (1965). In explaining the political life, they took note of soft factors, values, beliefs, competences related to politics. Sztopka (1999:7) refers to the second idea the concept of 'civil society' which came in the wake of pro-democratic movement and anti-communist revolutions in East-Central Europe in the 80's was elaborately used by scholars (Keane 1988; Cohen and Arato 1992; Alexander 1992,1998; Seligman 1992; Kumar 1993). The third idea is the concept of "cultural capital" coined by Pierre Bourdieu when he studied the French educational system to find out the cause of social hierarchies, inequalities, elitist tendencies. Cultural capital was defined as 'institutionalized widely shared, high status, cultural signals (attitudes, preferences, formal knowledge, behaviors, goods and credentials used for cultural and social exclusion. Cultural exclusion refers to exclusion from jobs and resources while, social exclusion refers to the exclusion from high status groups".

The fourth idea is the concept of 'social capital' suggested by Robert Putnam (1995) used in the study of economic backwardness of Southern Italy. According to Putnam, features of social life-networks, norms and trust enable participants to act together more effectively to pursue shared objectives.

Fifthly, the idea as suggested by Inglehart (1998) in cross-national comparative research into dominant value orientation is the notion of "postmaterialist values" which is the shift of individual's choice from 'hard'

economic interests toward 'soft' cultural concerns and commitments such as the new social movements ecological, feminist movements.

Lastly, Sztopka suggest the concept of "civilizational competence" which he refers to the complex set of cultural predispositions embracing a readiness for political participation and self government, work discipline, entrepreneurial spirit, educational aspiration, technological skills, ethical principles, esthetic sensibilities necessary for full deployment and consolidation in democratic polity.

The concepts such as 'civic culture', 'civil society', 'cultural capital', 'social capital' , 'post-materialist values' and 'civilizational competence' have emphasized on the soft cultural intangibles which create loyalty, commitment, shared belief , norms, attitudes of people in the society and thus lays down the fabric of trust. A culture of trust in the society is demonstrated by voluntarism, reciprocity, spontaneity, shared expectations and beliefs among people builds generalized trust. People would generally have a broad radius of trust in the society when they may have shared understanding, belief and commitment towards each other. In a society where individuals pursue and compete for narrow interest and preferred orientation towards each other it may produce shorter radius of trust where loyalties and commitment may belong to groups and identities. This may encourage particularized trust and undermine generalized trust.

Thus the relationship between trust and culture is inseparable. 'Culture' according to Dietz et al. (2010), 'is understood as both a guide to behavior and a product of that behavior'. Johnson and Cullen (2002) provided a more general framework showing national culture which bases trust and trust related behavior. Zaheer and Zaheer (2006) indicates trust research across culture can be seen from 'etic' (cultural-general) and 'emic'(cultural-specific) perspective. According to 'etic' trust presupposes universal social phenomena which can be measured across culture. According to 'emic' perspective, considerable differences lie across culture and levels, degree, nature and objects of trust". Sztopka (1999:16) reckons the work of

several contributors on trust research in the 80s. Barber (1983) who reviewed the manifestations of trust in various institutional and professional domains of modern society and proposed a useful typology of trust and fiduciary trust. The work of Eisenstadt et al. (1984) discovered trust as a core ingredient in patron-client relationships. Gambetta (1988) in association with other researchers examined trust and distrust in different settings, from different perspectives and in exclusive communities such as Mafia. Coleman (1990) in social theory devoted much to the concept and issue of trust from the perspective of rational choice theory. Several other scholars based on Coleman's theory such as (Hardin 1991, 1993, 1996), Giddens, Beck and Lash expanded the theory on trust who saw it as a feature of late modernity and in the context of risk and uncertainty. Fukuyama's (1995) 'the end of history' provided a comprehensive account of trust and culture by comparing China, Japan and other South Asian societies and showed the relevance of trust as an indispensable ingredient of any viable economic system. Sztompka (1999) also notes the work of Seligman (1997) for the interpretation of trust as a specifically modern phenomenon linked with the division of labour, differentiation and pluralization of roles and consequent indeterminacy and negotiability of the role expectations.

### **Variety in trust research**

As noted by Sztompka (1999:2) there has been a shift in the image of action marked by behaviorism, rational choice theory viewed in its calculative utilitarian terms to a more soft, humanistic meaningful image of action marked by normative value orientations, social bonds, loyalties etc. This has also led to a shift in the focus and research interest in the field of trust research. Trust research ranges from trust in government to organizational theory and research. As noted by Kramer (2009:1), "trust emerged in the 1990s as a subject deemed important and worthy of study in its own right". Trust as a subject received serious attention and centrality in organizational sciences. Likewise, Kramer observes that there were also serious efforts to link trust to political institutions (March and Olsen 1989).



## **Societal level**

Putnam's (1993) study on 'social capital' featuring social organizations which facilitates cooperation and civic engagement. Key to the concept of social capital is the element of interpersonal trust which may be built over time. Putnam's work on the economic backwardness of Southern Italy led him to conclude that social capital as networks of spontaneous, voluntary associations pervaded with trust. Participation of members of these associations and their trust towards each other were seen as mutually dependent, trust emerges from their associational lives at the same time it further facilitates spontaneous recruitment and creation of new associations was a testimony that trust plays as a critical factor in civic engagement and the emergence of stable, cooperative regimes. After Putnam's work, Fukuyama's (1995) impressive survey of empirical findings documents that trust matters for organizations and for society more particularly in the economic development of South-East Asia. The works of Sztopka's (1999) and Putnam (2000) further solidify the significance of trust for organizations and society. Putnam (2001) in his popular book 'Bowling Alone: The Collapse and Revival of American Community' have observed how bowling leagues in American society have declined significantly in the last few decades of the twentieth century. He observes that civic engagements such as visiting clubs, attending picnics, going to churches declined over the years. The reasons for such decline were the modern lifestyle pursued by the Americans which limits their socialization time with the members of the society. Besides, television and travel time in between work place and home also contributed to the gradual decline in the membership in association and civic life which may erode social capital.

Hardin (2008) referred to the age of distrust while highlighted the significance of trust and declining trust in many advanced countries. Referring to the work of Swedish economist Axel Leijonhufvud (1995) who described the social life of French village life in Bodo in the tenth century over a thousand years ago, Hardin(2008) argued that life in Bodo was simple, everybody used to know each other probably for life time,

inhabitants consumed everything Bodo used to produce. Therefore, trust became a natural product for people of Bodo. Today in modern times in almost in all societies lives have been changed radically from what it used to be for the Bodos. In trusting strangers, or for securing business transactions in modern lives, institutional rules, procedures now have taken place to guarantee and protect business interest.

Ferrin and Gillespie (2010:48) while referring to trust differences across national-societal cultures identified fifty-six relevant studies which relate to the level of trust, the determinants of trust, the consequences of trust, the role of trust and the meaning of trust. They refer to the World Values Survey (WVS) (1990 and 1995-1997 waves) (Delhey and Newton, 2005) which is considered as the most comprehensive empirical study on national-societal cultural differences in trust levels. According to WVS countries such as Norway, Western European countries, Japan, China, India, South Korea, USA, Canada and Australia scored >50 as high trust countries where the national average scores ranged from a high of 65% (Norway) to 3% (Brazil). Low or no-trust countries include Eastern European, South American and African countries. Using WVS in twenty nine economies, Knack and Keefer (1997) also found similar results where trust level score ranged from Norway (61%) to Brazil (7%).

Sapsford and Abbott (2006) carried out Living Conditions, Lifestyle and Health survey to assess generalized trust in some Central Asian countries which includes Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia and Ukrain. The findings of the study i.e. 'agreement that most of the people can be trusted' showed Kyrgyzstan (70% agree) to Russia (50%) to Moldova (29%). According to Ferrin and Gillespie (2010:49), the variation in the trust score is attributed to the differences in "local cultural norms, political and social conditions, rate of political and economic change and economic recovery". According to the cross-country studies based on WVS, though both USA and Japan are classified as high trust countries, but evidence suggest that the generalized trust is higher in American society than Japan (Ferrin and Gillespie 2010:50). Yamagishi

and Yamagishi (1994) refers to the emancipation theory of trust which explains the trust differences between Japan and American society. Japanese society features collectivist norms which prevent trust from developing beyond group boundaries.

### **Governance perspective**

The study by Mishler et al.(2001) in 'Understanding the State of Trust in Regime Support, Democratic Values and Political Involvement in Russia' is based on a nationwide survey of Russian citizens held in 2001. The study examines the role of cultural theory and institutional theory in building trust in the workings of a democratic system in Russia. With the transition to democracy from an authoritarian regime, the case of Russia became an interesting one to measure institutional and political consequences of trust. The study on trust focused on the President of Russia, Army, Governor of region, Federal Security of Service, Constitutional Court, Police, Duma member in the district, Duma member at large, Political parties, interpersonal trust etc. The result shows that institutional trust in the President is confounded with personal trust on the President Putin more than twice the trust level on Boris Yeltsin in 1998 when he was the President. The preference for a democracy was as high as 76% Russians say positive about democratic governance.

A series of articles and publications on government performance and trust, quality and trust in government, comparing trust in government across countries provide evidence for the continued interest in trust research on governance. The works of Bouckaert and Maddens (2002), Roosbroek (2006), Bouckaert and Walle (2001), Hardin(2013), Mollering (2013) contribute powerful insights to the literature on trust research. The Study on "Trust in Public Institutions in South Africa" edited by Askvik and Bak (2005) is a compilation of articles based on empirical research on South African public institutions such as the legislature, ministries and her position in regional context. The empirical study suggest that after a long history of racial oppression during apartheid, there was much hope and

expectation in the post-apartheid period that the democratic government would be able to cope and meet the growing demands of the people. However, the concluding analysis from the study suggests that trust dwindles amid gaps between expectation of the people and failure in the delivery of services. The research compilations of this book focused trust in public institutions and not on individual trust in personal lives. In six chapters the researchers focused on the functioning and the role of the Parliament in building trust in politics and among citizens. Other researchers looked into the role of the Standing Committees of the Parliament on oversight on the executive particularly the institutionalized distrust with the structures and mechanisms which undermines oversight on executive by the legislature and ensure accountability. Research on the workings of the local government also highlighted the weak and low prevalence of social capital which undermined the workings of democratic structures. Low collection of taxes by the local authorities is suggestive of low compliance of citizens to pay their taxes. The papers by Gibson and Froestad(2005) highlighted the ritual and cultural brokerage and eventual creation of trust relationship within a Health information system. The research papers and contribution made by scholars highlighted the role of cultural and institutional trust in post-apartheid South Africa.

In another study by Askvik (2011) with a title, “The significance of Institutional Trust for Governance in Bangladesh” it is argued how institutional trust is viewed to be waning for major institutions on the one hand, and how on the other ordinary citizen’s perceive them as trustworthy which he terms as a governance paradox. By using Kim’s (2005) model of institutional trustworthiness such as notion of ‘credible commitments’, ‘benevolence’, ‘honesty’, ‘competency’ and ‘fairness’, Askvik (2011) went on asking to what extent public institutions do respect and enforce the law and observe their own rules and regulations. He referred White (1999) when she argued Bangladesh stand out as an example of weak state. Citing the World Bank’s ‘Doing Business Report (2010)’ as far as enforcement of contracts and property rights are concerned, Bangladesh stands out to be weak which creates distrust in public institutions. He also

points out the limited independence of the administration which is frequently interrupted and influenced by the politicians. He argued that in Bangladesh benevolence may be wanting as observed by many that civil servants are self-serving and pursue their own interest. In terms of honesty, he concludes that withholding of information, prevalence of corrupt practices seriously restrict citizen's propensity to trust public institutions in Bangladesh. Whether public institutions in Bangladesh are generally competent, he argues that competence of the officials is very much compromised by having non-merit based recruitment and career advancement resulting in institutional incapacity. As far as fairness is concerned, he observed that unequal treatment of people based on their economic and social status is very common. Economic and social power can lead to better and quicker services and inequalities are built in to legal system with resultant non-enforcement of legal actions by the institutions. He concludes by saying that the observed trustworthiness of public and political institutions in Bangladesh appears as rather low.

The study conducted by Jamil et al. (2010) on 'Citizen's Trust in Public and Political Institutions in Nepal' provides insights to the trust level of public institutions and political system of Nepal. The study shows that people in general are happy with the present life situation and are positive towards life in a political world marred by high level of uncertainty, violent clashes and political polarizations. It concludes that generalized trust is low in Nepal and across institutions there are variations in the level of trust judgment. Among the popular institutions enjoying high trust are the schools, colleges, universities, hospitals and mass media. The less popular institutions in Nepal include the judiciary, police, civil service, the army. Among civil society organizations, trade unions are very popular than NGOs. The central government and the Parliament also seen to be less trustworthy compared to other institutions in Nepal.

### **Micro and organizational perspective**

In this perspective trust has been seen as a leadership function. It is believed for leadership effectiveness trust is an essential ingredient. The micro level of trust involves trust in leaders which can either be character-based and relationship-based trust. A third perspective is the institution or system based trust which has been discerned serves as a powerful means to deal with perceived vulnerability. In this sense, institutions through its routines lead to predictable outcomes and protect the interest of the actors. Since trust is seen to be linked to positive attitude, organizational relationships and compliance, the micro level study on trust research has received prominence from organizational point of view. The works of Dirks (2006) regarding trust in leaders, McKnight and Chervany (2006) on reflections on an initial trust-building model provides rich insights on studying trust from a micro level perspective. Mayer et al.(1995)provided a model for trust in leaders based on integrity, capability or benevolence. In organizational trust, several concepts have been synonymously used such as cooperation, confidence and predictability. Several scholars such as Hovland, Janis, and Kelly (1953), Good (1988), Liberman (1981) have contributed to the organizational trust literature. Many others such as Boyle and Bonacich (1970), Butler(1991), Cook and Wall (1980), Dasgupta (1988) Kee and Knox(1970), Liberman (1981), Ring and Van de Ven (1992) have contributed to the factors of trust antecedents such as competence, fairness, integrity, ability, moral integrity etc. Gargiulo and Ertug (2006) have contributed to the behavioral consequences and benefits of organizational trust. They argue that trust facilitates lower level of monitoring and vigilance and safeguards in organization. It promotes within members of the organization greater level of commitment and lastly, trust promotes expansion in scale and scope of exchange between parties.

### **Economic perspective**

The study of trust from economic perspective is also viewed as transaction cost economics. The basis of transaction cost economics is

calculativeness. The other perspective on which transaction cost economics is based is the notion of bounded rationality and opportunism. Bounded rationality is the limits to act rationally and opportunism is the manifestation of self-serving behavior of individual actors. Trust is also seen to have role in reducing transaction costs and improving performance. Dyer and Chu (2006:207) notes that “trust is seen as a valuable economic asset as it lowers transaction costs and allow for greater flexibility to changing markets conditions”. Some scholars also argue that national economic efficiency is highly correlated with a high trust institutional environment (North 1990, Fukuyama1995). Fukuyama (1995:7) argues that “the economic success of a nation, as well as its ability to compete, is conditioned by the level of trust inherent in the society”. Fukuyama (1995:62) further notes that there are three broad paths to sociability. First, the basis of family and kinship, the second is the voluntary associations outside kinship and third, the state which give rise to distinct business enterprises. From family and kinship family business has evolved, from associations outside family professionally managed corporations has evolved and from state enterprises the state-owned or sponsored enterprises has evolved. In case where the primary basis of sociability is the family or kinship, in such society it is difficult to create large durable economic organizations and therefore they depend on state support and patronization. The other form of socialization where the basis is voluntary associations they can create large economic organizations and they do not wait to seek state support. Fukuyama (1995) observes that family orientation is manifested in China, Italy, France and Korea and associations beyond family are seen to do business in Japan and Germany. As business grows, it becomes difficult to operate by way of which the business either is reduced or give up control and become a passive shareholder. Therefore, the cultural norms where associations go beyond family, growth of large organizations based on corporate culture were possible. According to Fukuyama (1995), social capital and liberal democracy are closely related where underlying assumptions of the society are based on trust and sociability which may promote businesses.

From the literature review stated above, trust is not only pertinent in studying micro level phenomenon but it has wide relevance and practice in studying governments and institutions. In other cases studying trust is also seen to be of relevance in organizational settings such as organizational change (Hope-Hailey et al. 2010), international cooperation (Ripley et al.2010), business relationships (Mollering et al.2010). There are still ambiguities with regard to a single definition of trust. There is ample evidence now that trust generates cooperation and voluntarism. Trust also varies across culture and the study conducted by Fukuyama (1995) shows positive relationships of trust and economic development. With the complexities of modern life what Hardin(2008) calls 'the age of distrust', the relevance and importance of trust has become more pertinent in social and business transactions as technology and innovations take place and necessity to protect interest and guard against risk, the role of trust cannot be ignored.

### **Trust research in health care**

Like culture and sociology, the concept of trust has also been very relevant to health care and more particularly in doctor-patient relationships. Thom et al.(2004) observes that trust is a central element to the doctor-patient relationship. It is a concept that touches both the doctor and patient equally as far as their specific needs are concerned. Since the publication of the first study on measuring patients' trust in their physicians by Russell Caterinicchio in 1979, there has been a marked interest on studying patients trust. Since then measuring patients trust has been a new research area. Several measures have been developed to map patient's trust. Both quantitative and qualitative approaches have been used to measure patients trust. For measuring patients trust technical competency, interpersonal competency and agency (fidelity, loyalty and fiduciary duty) have been suggested. In association with technical competency, a physician requires interpersonal competency to understand the patient's needs and preferences to communicate effectively and build a working relationship for carrying out treatment. They have found strong correlations



between patients' trust and physicians or care providers for satisfactory services and showed that trust has a correlation ship with treatment adherence meaning taking prescribed medications and following doctor's recommendation. The study of trust by Thom (1999) suggests that trust is also a strong predictor of continuity with providers. In one of the studies as observed by Thom et al. (2004:126) that in comparison to satisfaction trust is more strongly associated with adherence and continuity of enrollment when trust and satisfaction were placed in the same multivariate model.

Thom et al. (2004) suggested whether it is feasible to measure patient trust or can patient trust be changed? They after reviewing literature located five measures of patient trust in physicians ranging from eight to eleven items in length. It is observed that patient trust is a state not a trait and it is subject to change. Patients trust appears to be specific to a particular physician and patients can also have different levels of trust in different physicians. In measuring physician's behavior and trust, they observed that competency, communication, caring, honesty and partnering are important ingredients for trust formation in patients. They further note psychologist and sociologists position to identify factors that promote interpersonal trust such as i) greater perceived mutual interests, ii) clear communication, iii) a history of fulfilled trust, iv) less perceived difference in power with the person being trusted v) acceptance of personal disclosure and vi) an expectation of a longer term relationship.

The study by Kao and et al. (1998) in their survey of 292 patients of physicians aged 18 years in Atlanta, Georgia concludes that patients' trust in their physician is related to having a choice of physicians, having a longer relationships with their physicians and trusting their managed care organizations. The study of Rowe et al. (2009) observed that most studies emphasize that trust in patients depend on relationship factors more than patient characteristics (Clanan & Sanford, 2004; Goold & Klipp, 2002; Tarrant, Stokes, & Baker, 2003; Thom, Ribisl, Stewart, & Luke,1999) although others have found among older, less educated patients(Anderson & Dedrick,1990; Balkrishnan, Dugan, Carnacho, & Hall, 2003; Freburger,

Callahan, Currey, & Anderson, 2003, Mainous, Baker, Love, Pereira Gray, & Gill,2001; Tarrant et al., 2003).

A number of other studies suggests trust can be built if patient views are respected and taken seriously and information is openly shared with patients (Arksey & Sloper,1999; Burkitt Wright, Holcombe, & Salmon,2004, Henman, Butow, Brown, Boyle, & Tattersall, 2002; Joffe, Manocchia, Weeks, & Cleary,2003;Johansson & Winkvist,2002; Mazor et al.,2004; Mechanic & Meyer,2000; Trojan & Young,1993; Walker,1998; Wilson, Morse, & Penrod,1998; Zadoroznyj, 2001). They further observed that interpersonal skills that lead to trust are as important as clinical skills (Burkitt Wright et al., 2004; Cooper-Patrick et al., 1997; Goold & Kilpp, 2002; Henman et al., 2002; Lee-Treweek, 2002; Lings et al., 2003; McKneally & Martin, 2000; Thom, Kravitz, Bell, Krupat, & Azari, 2002). According to Rowe et al., (2009) therapeutic communication skills are of primary importance in the development of trust in the clinician-patient relationship which may also aid in limiting patient anxiety and improving overall patient satisfaction. In the conclusion; it is argued that in building collaborative trust in patients who are reluctant to seek medical care, it is important to share knowledge, uphold professional ethics and confidentiality, respecting culture and belief of others, displaying honesty, developing mutuality by participation in decision making. It is through this kind of approach that the foundation of trust can be laid for the benefit of humanity.

A more recent study on determinants of trust in health care in resource poor settings is done by Gopichandran et al. (2013) in Tamil Nadu, India. The study suggests that key dimensions of trust in health care as evident from the study includes competence, assurance of treatment irrespective of ability to pay, patients' willingness to accept drawbacks in health care, loyalty to the physician and respect for the physician, comfort with the physician and health facility, personal involvement of the doctor with the patient, behavior and approach of doctor, economic factors and health awareness. The study findings in exploring the dimensions of trust in

resource poor settings appear relevant from the context of UHC in Bangladesh.

Further to this patients' satisfaction on treatment may depend on quality nursing services which may also contribute to the patients' trust building. Izumi et al.(2010) identified four domains of nursing care such as competence domain, caring domain, professionalism domain and demeanor domain. Competence domain emerges out of cognition and technical abilities of the nurses to provide quality care to patients. Caring domain includes compassion and genuine concern for the welfare of the patient. Professional domain emerges out of commitment and responsibility of the nurses and lastly demeanor domain is meant by the appearance and the way the nurses conduct themselves to the patients to their duties. Therefore, in trust research quality of nursing services may also play as a contributor to trust building. Patients' expectation and assessment on quality in nursing care depend on patient's characteristics such as age, gender, education, type and stage of illness (Mitchell, Ferketich, & Jennings, 1998).

The relevance of trust research for health services has also received much importance particularly in the advanced countries particularly under managed care of health providers. The studies are therefore acontextual and relevant to western countries. However, doctor-patient relationship is based on interactional as well as institutional trust where communication, rapport, compassion, privacy are seen as constituents. Patient-doctor relationships in institutional setting can be determined by organizational culture, resources, dimensions of trustworthiness and institutional factors. Therefore, in order to understand patients trust in doctors, both interactional and institutional trust seem relevant which may explain the essence of trust in a given setting.

## Methodological trends in studying trust

As mentioned earlier, the measurement of trust has been complicated by the varied use and treatment of the term in different fields such as sociology, psychology, medical science etc. As Lewicki et al. (2012) noted that “trust has been conceptualized, defined, modeled and operationalized in a wide variety of ways and over a longer period of time”. Stack (1978) and Wrightsman (1991) presented comprehensive trust measures in the field of psychology. According to Stack (1978) and Wrightsman (1991), there has been a proliferation of views, perspectives and representation on trust conception and its measurement. McEvily and Tortoriello (2008) contends that most studies of trusting behavior focused on reliance ‘representing trusting behavior in which an individual depends on another’s skills, knowledge, judgments or actions, including delegating and giving autonomy’ and disclosure, ‘sharing work-related personal information of a sensitive nature’. Lewicki et al. (2012) argued that current practices of trust measurement concentrate on measuring a. beliefs regarding another’s intentions and willingness, b. trusting behaviors, c. conceptualizing and measuring trust and distrusts as distinct constructs and d. trust development, decline and repair over time. They further argue that perceptions of trust may also develop intuitively and facial characteristics play important role in building perception on trustworthiness.

Trust studies have long been carried out though laboratory games to explore the dynamics of trust. Prisoner’s dilemma is a laboratory game where each of the player makes a decision either to ‘trust’ or ‘defect’ leading to different combinations of pay offs for each player (Lewicki et al. 2012). More recently the development of Trust Games (Berg et al. 1995; Kreps, 1990) offers a sophisticated tool for measuring trusting and trustworthy behavior. Both trust game and prisoner’s dilemma are tools for laboratory experiments and are not suitable for field research. For quantitative research, survey measures for measuring trust in a given population have been commonly used by trust researchers. According to McEvily and Tortoriello (2008), survey measures are used to measure

skills, competence, knowledge, and reliance etc. as an indicator of trusting behavior. Other methods include agent-based simulation as noted by Nooteboom (2012) is a useful tool for exploring intricacies in complex interactions between agents. Some more advanced techniques as noted by Bachmann (2012) in trust research are the use of repertory grid. Repertory grid is basically an interview technique developed by Kelly (1955) where the interviewer expects more information from the interviewee with minimal input. Other forms of qualitative design is the use of narratives, hermeneutic methods are useful tools in the field of trust research.

Contemporary research on trust follows trends of both quantitative and qualitative methods. In some cases both methods have been used in a particular study. Some of the studies presented below indicate research strategies and methods followed.

**Table 3.7: Trends in Trust Research**

Author	Title of the research	Methods used
Sztompka, Piotr (1999)	Trust and rapid social change: A case study of Poland	Case method-historical sociology
1990 and 1995-1997 waves	World Values Survey	Survey
Sapsford and Abbott (2006)	Living Conditions, Lifestyle and Health survey of post-Soviet countries	Survey
Holm and Danielson (2005)	Comparative study of trust in Tanzania and Sweden	Survey and trust-game
Yamagishi and Yamagishi (1994)	Generalized trust between the USA versus Japan	Trust Game
Huff and Kelly(2003)	Trust individualistic (USA) versus collectivist cultures (China, Malaysia, Hongkong, Japan, Korea, Malaysia and Taiwan)	Survey design
Buchan et al (2002)	One- shot experimental trust game with student participants from China, Japan, Korea and the USA	Trust game
Jamil & Dhakal (2010)	Citizens' Trust in Public and Political Institutions in Nepal	Quantitative
Esau, Michelle (2005)	Legislative Oversight and Trust Relations-A case study of Legislative Oversight in South Africa: SCOPA and the Arms Procurement Deal	Qualitative
Gran, Thorvald (2002)	Land Politics and Trust Relations in Government: Findings from Western South Africa	Case Study
Gibson,Diana (2005)	Information Technology in the Health Sector: Improving Service Delivery and Public Trust	Case Study

Froestad,Jan (2005)	The Incapacitating Impact of Distrust: Observations from the Health Sector	Mixed approach
Jamil and Askvik(2013)	Citizens' Trust in Public Officials: Bangladesh and Nepal Compared	Survey

(Compiled by the researcher)

### Challenges of trust research

Because of the illusive nature of trust and also its application in several fields of study such as psychology, organization or health, trust research has been viewed as challenging from the point of view of its variety on the one hand and on the other frustrating because of its limits to measurement and application in all fields. Challenges of studying trust may arise from its definition i.e. how it is defined and how it is operationalized. Apart from that measurement could be highly subjective based on the individual responses. According to Li (2012), trust research faces many serious challenges. First there is a lack of general theory as the platform or base for trust research, secondly a widely accepted definition of trust is lacking; third, there is no widely accepted measure of trust. As trust is context-specific, it can hardly be generalized for all societies. Thus, we can study trust in a particular society or region. While the study of trust in a region may become the focus of the study, it takes into account the particular culture and history. Without taking into account the cultural and historical context, quantitative research of trust may be inadequate to fully explore the essence of trust. As Lyon et al. (2012) argues that trust is a concept that cannot be easily observed or even defined. Qualitative research has contributed much to the study and understanding of trust research. It is argued that inductive approach allows more flexibility while collecting data for enabling new concepts to emerge. Qualitative research as Tillmar (2012) observes that it has the potential to explore new insights and access to sensitive data in understanding trust in different cultures. Also trust constructs in different cultures pose further challenge which limits the measurement and universality of certain specific measures.

While qualitative research could ensure more accuracy and deep insights, quantitative research offers wider coverage and allow shorter time frame for conducting the study. However, quantitative research may lead to little convergence in trust constructs and measurement. This limits replication of trust research techniques in different cultures and society. In quantitative designs, questionnaires for surveys are most commonly used to measure trust. Gillespie (2012) points out that a lack of common questions can limit the extent of replication in different contexts and cultures. She proposes a common set of psychometric measurements of trustworthiness and trusting behavior that can be widely used for comparative purposes. Lyon et al. (2012) holds the view that such comparative studies may involve asking similar questions about trusting attitudes or moralistic trust, which again might require cultural interpretation by different cultures. Quantitative studies on trust such as a survey may have a time-bound, structured design. The responses from such design may have to be responded within the cells mentioned with little room for deviation. This is one of the serious weaknesses of structured design in quantitative research.

Lyon et al. (2012) advances five key challenges that concerns trust research such as the dynamic process of trust, researching tacit elements of trust, conceptualizing and describing trust in different cultures, the role of researchers in shaping trust situation they are researching and research ethics of trust. These challenges not only pose multiple complexities of trust research but also shape future research possibilities. It is also claimed that trust research by survey methods pictures trust situations only for a particular time and these can be treated as partial or snapshots of a given time, therefore, it is argued that longitudinal surveys could be more accurate in capturing data that may address this concern of temporal element. Non-verbal responses and facial expressions are hard to capture in survey data and can only be captured through a qualitative enquiry. Likewise the cultural dimension of trust particularly the meaning of certain words, the scales used to measure need to be identical across regions and countries.

Trust research poses further challenge from the context of reflexivity as noted by Lyon et al. (2012) between the researcher and what is researched. As Tillmar, M (2012) points out 'how the researcher is perceived to shape the information provided'. Other scholars such as Saunders (2012) have raised concerns that research on trust could lead to 'stress or behavior change' of the respondents. Ethical issues are also contributing to these methodological challenges which may involve sensitivity, confidentiality of an organization or a group of individuals and may lead to a conflicting situation between the researcher and the researching entity.

According to Hardin (2006) most trust research involving survey includes the study of interpersonal trust and studying the levels of so-called trust in government. Hardin observes that in survey research the notion of trust remains completely untheorized where it is the respondents, not the social scientists, who implicitly define it. He further observes that most of the survey research on trust implicitly assumes that the notion of trust has a commonly understood meaning and it does not test different conceptions or theories of trust. Conceptual issues also raise concerns as to the appropriate use of the term trust. Hardin (2006) points out that individual trust and trust in government are not same. According to Li (2011), there are two opposing views prevailing with regard to trust research. He points out that, on the one side the advancement of trust research since the 1990s(Mayer, Davis and Schoorman,1995) have been very impressive, the other viewpoint is that trust research lacks a general theory upon which trust research can base itself. Secondly definition of trust lacks widely accepted meaning and thirdly, about measuring trust, there is a lack of uniform scale.

Li (2011) pointed out that the future of trust research lie in the bridging of gaps between rigor and relevance which should be more holistic in its contents and coverage to make it more interdisciplinary, multi-level and multi-angle and contextualized. About the context, Li (2011) contends that it should go beyond micro level context of a single dyad to the macro-level



context of a nation (institutions,) as well as informal institutions of culture and ethics. Secondly, it should be more dynamic about the process of its temporal coverage. It should be focused more on the multi-phase trajectories and concrete mechanism of trust building, maintenance, erosion and repair. Thirdly, it should be more sensitive to the duality of nature of all complex issues to take advantage of the dual functional links of paired opposites such as quantitative-qualitative, rigor-relevance, exploitation-exploration etc. Lastly, future trust research should be more open to qualitative methods to consider the holistic content, dynamic process and duality integration.

Therefore, the core concepts of trust as evidenced from the foregoing discussion can be summed in the following way. Trust has been studied from the lens of socio-cultural perspective as soft intangibles and defined it in the fashion of symbols, meaning, values, norms, codes etc. Some scholars interpreted it from ethical and moralistic point of view. Two theories guide the debate of such differentiation in the meaning of trust one the socio-psychological theory of action and the other normative orientation of action. New streams of research based on concepts such as civil society, moral community, civic culture, cultural capital (attitudes, preferences, knowledge, goods and credentials) civilizational competence etc. have brought forward newer dimensions and relevance of trust. The growing complexities of modern life, risk society and the uncertainty embedded in the age of distrust have made the study and significance of trust more relevant today.

### **Relevance of trust research**

#### **Trust research from governance perspective**

Relevance of trust research from governance point of view can bring in new signals for the organizations or institutions to adjust and respond to the expectations of the clientele. Trust in organizations or institutions may bring legitimacy, acceptability, continuity thereby leading to more satisfactory

level of governance. In the context of an organization, authority can be ineffective if it is not trusted. For trustworthiness of the organization, proven records of its capacity and services must be evidenced and where expectations of the clientele are met in routine and objective manner. If the services of an organization as promised are not kept or delayed indefinitely, people will not trust the organization. In case of an individual, failure to remain objective and non-partisan in a particular case may result in lack of trust by one party. For objective treatment, trust is an essential component which is not only expected and should also be demonstrated. Kim (2005) referring to Herring (1936); Thomson (1993) states, that public trust had been an issue in public administration since the founding of the American System. He argues that the public has increasingly demanded higher quality services from the government such as better health care benefits, higher quality of educational services, but they do not want to share in the expenses necessary to fulfill those expectations. The resulting mismatch between the public's expectation and actual performance leads to the belief of the citizen that public employees are incompetent, wasteful, dishonest and untrustworthy. Kim (2005) further argues that very little research has attempted to look into role of government and its employees in shaping public attitudes toward building a more trustworthy government. Building public trust can lead to cooperative behavior and compliance with government decisions. While trust in government is important from citizen's perspective, there is also a requirement of checks and balances favoring accountability of public officials. For private firms, banks and other customer oriented services, trust may be a very costly resource. If the money-teller machines are not trusted or if the electronic systems for credit card operations are not trusted, there can be no business transactions. Therefore, trust is equally important for private as well as for public services. From the perspective of good governance and public policy, Jamil et al.(2014) notes that "policies that meet citizens expectations and needs generates more trust. Citizens are constantly evaluating the performance of the government on the basis of their own experiences and on the basis of experiences of others".

Trust may also influence social and associational lives which in turn may impact governance. Putnam's (1995) study on the economic backwardness of Southern Italy led him to conclude that features of social life-networks, norms and trust enable participants to act together more effectively to pursue shared objectives. Putnam's (2000) saw the decline of the civic life of the American society in their associations and social networking. He mentioned particularly the association lives, voter turnout, and newspaper readerships have declined with the decline of civic engagement through network. Putnam referring to Alexis de Tocqueville while studying Democracy in America in 1830, found that the civic association most impressive. He argued that life is easier in a community blessed with a substantial stock of social capital. Networks of civic engagement foster sturdy norms of generalized reciprocity and encourage emergence of social trust. He argues that as a result of gradual lack of participation people have begun to distrust the government in America. In 1966 thirty percent of Americans were distrustful. Less than thirty years later, the number of those who are distrustful towards the government rose to seventy-five per cent. Putnam's study reveals declining trust in government in the U.S.A. Like the U.S.A many societies witness the decline of its early associational life of people in the society. Putnam identified the complex nature of modern life; the introduction of new technology etc. as some of the reasons for such decline. Therefore, research on trust has broadened our understanding and perspectives of democratic governance.

Askvik (2005) observes that in the last decade there has been significant increase in the interest of scholars in the study and research on trust as a concept to understand and promote collective action in the modern society. Trust has been seen as a facilitator of democracy, social welfare, personal wellbeing and economic prosperity (e.g. Braithwaite and Levi, 1998; Fukuyama, 1995; Gambetta, 1998; Rosseau et.al, 1998; Warren, 1999). According to Seligman (1997). Askvik (2005) further notes that the study of trust is particularly relevant in a modern, democratic society to maintain complex sets of different institutions as needed. In order to cope with the complexity, ambiguity and risk in modern

societies, members have to rely on trust. The complex system entails more institutional, a broader network of authorities and thus greater need for trust.

Further to this, in order to understand the functioning of public institutions in new or fragile democracies pursuing modernization or reforms, the role of trust on governance becomes more compelling. As Sztompka (1999) provided broad rationale for the role of trust in a democracy. He mentions that a modern society needs to understand and work with institutions and agents to deal with uncertainty and manage development, secondly, with differentiation of roles and greater division of work, actors need to trust each other and generate cooperation, thirdly, the greater the complexity of a society and less predictable the conduct of role incumbents, the greater will be the need for trust. Giddens and Beck, cited in Askvik (2005) hold the view that modern technology create risks and threats and vulnerability resulting from being in a risk society which requires an enlarged pool of trust among its members. In dealing with number of options in our daily lives people resort to trust for example trust an air line, a provider of services. In a modern state, large segments of the society have become opaque and need to trust them such as stock market, government bureaucracies etc.

Trust is not only important for organizations or governments but it is equally important for political parties. For internal working as well as for vote seeking, political parties need to enjoy and upkeep peoples trust. In Bangladesh confrontational politics between major political parties clearly suggests absence of mutual trust. “Confrontational politics and violence have become a serious threat to democracy and development in Bangladesh” (Rahman, 2007). This has resulted in complete boycott and lack of participation in the Parliament by the opposition members leading to a recurring crisis of political friction during the transition of power. Knox (2009) maintains that though Bangladesh has achieved a steady and consistent growth rate in last successive years, a stable government would however be an important factor in establishing trust amongst the citizens of

Bangladesh. Not only a stable government will be able to upkeep trust to particular level as trust is not stable and static. But it must be able to deliver goods and services and contain the growing expectations of people to upkeep the trust level.

### **Trust from the perspective of service delivery**

With the growth of population and rise in migrant communities in many societies, the need for trust in social exchange became pervasive. Such as need for trust in dealing with strangers, trust institutions or business firms for their products and services. For example, the public should trust banks to secure their investments; the computer based banking system should be trustworthy so that the on-line credit transfer or withdrawal of the deposits is safe and reliable. Trust, is therefore, relevant not only from governance point of view but from the perspective of modern banking as well as other services also. Service delivery can be better judged when compared with similar services. The services of a particular courier service may be better, secured and home delivered compared to other similar services. Even though the services might be costly, people would be interested in a prompt, secure, trustworthy courier services. Users of the services may have to rely on the services offered by the courier company based on the satisfactory past experience may further reinforce the trustworthiness of such company even though users of such services remain unaware of the internal workings such as packaging, transshipping and transporting the goods by the courier services. As Sztompka (1999:13-14) argues that “managers of institutions and organizations, operators of technological systems, producers of goods, providers of services most often remain unknown. There is hardly any possibility of influencing, controlling or monitoring their activities. They are totally hidden and independent while the users are crucially dependent on what they are doing”. He continues that there is no means of bridging the anonymity gap but resorting to trust. For example, a patient needs to trust the pathological test reports conducted by most of the reputed diagnostic centers and conducted by unknown technicians. The gaps in monitoring or supervision of work in

carrying out the test in laboratory by the patient are either unwarranted or mostly restricted by the laboratory. Therefore, trust becomes the only solution to bridge the gaps of anonymity which concerns patient's satisfaction for reliable services on the one hand and delivery of efficient and professional services on the other.

### **Implication of trust in dealing with uncertainty and service delivery**

Trust is embraced by all in human relationships and in social transactions. Such as driver of a bus may be seen to be trusted when the passengers rely on the bus company on the basis of its track record of low accident rate, timely departure and reaching destination safely and that the driver is reliable and safe. When the doctor is said to be trusted, it is the belief of the patient that the doctors are competent to treat the patient and there will be no harm from maltreatment. When the teacher is trusted, it is the belief of the student that the teacher is sincere in his approach to teaching and will enable the student to score good grades. Whatever may be the case, the implication of trust for each of these cases may be unique and experienced by individuals differently. For the bus rider, it can result in a safe ride, for the patient, it may be a proper diagnosis of patients and appropriate treatment, and for a student, the implication of trusting a teacher may involve a belief that this will result in achieving good grades and leading to a more satisfying learning experience.

Trust is generally seen from a positive lens and believed to be beneficial for any exchange. Generally speaking, trust only leads to positive outcomes. Studies on trust have stressed on the mutual benefits of the parties involved arising out of cooperation, reciprocity etc. Gargiulo et al. (2006) focused on the dark side of trust resulting from what they called 'excessive' trust and argued that excessive trust may lead to detrimental effects closely linked with its purported benefits. They argued that trust may diminish information gathering and may result in reduced monitoring and vigilance, secondly, trust may lead to greater satisfaction with and commitment to a relationship, thirdly, trust may lead to expanded communication and

information exchanges but it can also lead to over-embedded relationships that may create unnecessary obligations between parties. It is argued that consequences of excessive trust may result in detrimental effects to an organization when the level of trust goes beyond a critical threshold in its monitoring, commitment and embedding.

Generally speaking trust encourages cooperation and promotes cooperative action. In an organization the team members of a team needs to trust their leaders if the team wants to become successful. If the team members of a team trust each other, then they tend to cooperate and reciprocate friendship. But cooperative action or cooperation can also be achieved by coercion or threat even though the parties may not trust each other. Scholars make strong claims that trust would bring good to the society and institutions and to the benefit of those who trusted. While trust may bring many benefits and generate cooperative action, nonetheless, trusting the malevolent or incompetent could be foolish and grossly harmful.

Hardin(2006) argues that such discussions presuppose that implications of trust is good since it may lead to good consequences and conversely, higher levels of trust in government would be good as it may generate cooperative action in society. According to Greek “Anonymous lamblich” (1995:294), “The first result of lawfulness is trust, which greatly benefits all people and is among the greatest goods”. Hardin (2006) observes, that “law enables people to trust each other enough to risk exchanges with each other to their great benefit. Trust arises in many contexts which benefits people from a relationship. Hardin (2006) notes that interests of individuals may be differing but institutions block conflicts of interests of individuals which might wreck trust”. Therefore, the role of institutions is to guard conflict of interest and allow voluntary and free exchanges. Hardin (2006) further notes, “Government needs the trust of citizens if it is to work well”. Rose (1994:18) writes, “Trust is a necessary condition for both civil society and democracy”. Seligman (1997:6) also claimed that “generalized trust is necessary for the workings of the civil society”. Gamson (1968:43) points

out, “the loss of the trust of citizens is the loss of system power, the loss of a generalized capacity for authorities to commit resources to attain collective goals”. Excessive trust on one individual or institution may lead to blind faith; it can also turn commitment into complacency and create unnecessary obligations which may act as a constraint for the trustor. Gargiulo et al. (2006) identified three distinct behavioral consequences of trust. First trust is associated with lower levels of monitoring, vigilance and safeguards towards the behavior of the trusted party. Secondly, trust is associated with higher levels of commitment to the relationship with the trusted party and thirdly, trust is associated with an expansion of the scale and scope of the exchange between the parties.

While a trusting situation may relatively lower the levels of monitoring and safeguards (Malhotra and Murnighan (2002), presence of trust may also reduce the inclination to guard against opportunistic behavior (Bromiley and Cummings, 1995). According to McEvily et al. (2003), trust is associated with lower levels of vigilance. In another study conducted on 71 teams, Langfred (2004) found that trust was a strong and significant negative predictor of monitoring. Gargiulo et al. (2006) argues that benefits of trust could lead to lower information processing cost (Dyer and Chu, 2003); (McEvily et al.2003), increased satisfaction (Muchinsky, 1977 ; ) (Driscoll, 1978) (Zand.1972), (Pillai et al.1999), (Davis et al. 2000), (Zaheer et al.1998), research shows high trust leads to level of lower uncertainty (Uzzi, 1996; 1997; Uzzi and Gillespie, 2002; Uzzi and Lancaster, 2003), Noteboom et al 1997), (Zaheer et al.1998). Despite the several benefits and positive aspects of trust, it is hardly thought of that trust could have negative outcomes as Gargiulo et al. (2006) observes. The negative sides of trust as indicated by Gargiulo et al.(2006) is corroborated by the scholars such as Zaheer et al.(1998), Dirks and Ferrin (2001), Granovetter (1985), Noteboom et al.(1997) as they highlight the negative outcomes that excess trust may generate.

While discussing blind faith, Gargiulo et al (2006) argue that ‘reduction in monitoring caused by excessive trust increases both the opportunities for



malfeasance and the amount of damage from such malfeasance caused to the trustor'. Reduced vigilance and safeguards render the trustor less able to detect or preempt malfeasance prior to its occurrence. This notion of trust is also referred as 'pathological trust' by Deutsch (1958) characterized by excessive gullibility and credulousness which may invite malfeasance. Along with this reduction in monitoring and vigilance due to blind faith or excessive trust may also affect the quality of the information exchanged between the parties, leading to detrimental effects. Langfred (2004) cited in Gargiulo (2006) in a study argued that low level of monitoring resulting from high trust can have negative effects on the performance of teams whose members have considerable autonomy. The study conducted by Szulanski et al. (2004) also found the detrimental effects of excessive trust when they studied the effects of vigilance and monitoring on the accuracy of knowledge transfer within organizations.

Another feature of blind trust may lead to complacency. As argued by Gargiulo et al. (2006) there may be deterioration in performance if the parties involved in a high trust situation which may preclude objectivity in perceiving deterioration in performance. They refer to 'relational inertia' which make the affected party less likely to detect early signs of declining performance. High trust may breed strong bonds which may again foster cooperation between the parties, but this may also cause difficulty to allow exit to a party. Lastly, Gargiulo et al.(2006) argue that excessive trust may generate unnecessary obligations on the parties which may go beyond what is required to secure the exchange that prompted the relationship in the first place (Wicks et al.,1998). Uzzi (1996) cited Gargiulo et al.(2006), referred to 'over embedding ' of economic transactions resulting from relationships from high trust which cause multiplex ties. They argue that excessive trust burdens actors with mutual obligations whose marginal effect in reducing uncertainty is smaller than associated costs.

## **Conclusion**

This chapter highlights the major contributions and trends of trust research and its challenges. Trust research has drawn both intellectual and academic attention by scholars and researchers not only in the field of organization and management but also health care which resulted in a number of journals with plethora of research articles. From the discussion above, it appears that trust research is multidisciplinary and requires a dynamic approach to bridge the duality of quantitative and qualitative approaches to the study to bring the gaps between academic 'rigor and relevance' Li (2011) much closer in future research.

Trust research has received attention in both macro and micro level. At macro level, studies on trust may involve institutions such as Parliament, Higher Judiciary; Government. Such studies on trust may focus citizen's perception on the working of the Parliament with respect to passage of certain law or oversight and monitoring on public expenditure by its Committees, the role of the higher judiciary in protecting the rule of law or the role of the government in protecting public goods and securing public life for example. At micro level, the study on trust may involve and remain confined to the interactions between individuals of an organization (internally) or between a citizen and a member of an organization (externally). Internally individuals of an organization may trust colleagues and cooperate with each other. It is demonstrated by reciprocity, fellow feeling, reliance, shared understanding and predictability in their interactions. Externally, a citizen expects from a member of an organization cooperation, necessary information and services, good demeanor and responsive action. The aggregate experience of individuals in a society with their encounter with members of organization may build generalized trust demonstrated by increased reliance and favorable reputation.

Trust research has put major emphasis on the sociology of culture and in the soft intangibles such as value, norms, attitudes, and preferences etc. which shape the normative and cognitive orientation to understand the

meaning of trust. It is also revealed that trust is an inter-disciplinary, multifaceted concept. As in every human encounter, its relevance to clinical services in health as well as in interpersonal relationships with the doctor is now well established. Therefore, apart from clinical competency of a doctor, patients' trust may also depend on the interpersonal skills, competency, care, compassion, honesty etc. of a doctor and may be manifested by patients' high reliance and continuity with a single doctor, adherence to prescribed treatment and satisfaction in overall health outcomes. Lack of patients trust in a particular doctor may be evidenced from low patients turn out, moving out to another doctor, seeking second or third opinion from other doctor(s) on his own, discontinuity of the treatment a patient may tend to rely low on his current doctor. Measuring patient trust is therefore may be based on patient's expectation and behavior on the one hand, doctors attitude, behavior and quality of services on the other.

In measuring trust, contextualization i.e. relevance to one's culture or context also plays important role. Trust is therefore may be context specific. Societies differ in the level of generalized trust. A high trust society is likely to have high trusting culture in typical patient-doctor relationships. Likewise, patient-doctor relationships may suffer low level of trust in a society where the generalized level of trust is also low. In a low trusting environment scope for opportunism will be high with weak institutional safeguards. This may be demonstrated by doctor's low level of professionalism and conduct, absenteeism, low integrity etc. Such criteria for measurement of trust may also remain context specific. In a developing country, absenteeism of doctors in the rural work places may be a deep seated problem, while this may be an irrelevant indicator for measuring patients trust in an advanced country. Measurement of trust and criteria for such measurement, therefore, appears to be another problem as there is no unified or single yardstick to measure trust. Given the varied interpretations of trust as a concept, trust has been operationalized by different variables with differing scales of measurement. In quantitative and qualitative designs, the view is often held that in trust research it is the researcher's perception how particular concepts of trust are defined and interpreted. As noted by Jamil

et al. (2014) trust research has received little attention in the context of South Asia. Despite much of the frustration and challenges in conducting research, the study of trust could be regarded as both fascinating and challenging with 'contextualization' and 'relevance' as one of its major strength. The following chapter IV is dedicated to the research methodology for conducting this study.

## Chapter- IV: Research Design and Methodology

*“Truth lies at the confluence of independent streams of evidence”- Karl Deustch cited in Susan Mbatudde (2013)*

### Introduction

This chapter narrates the research methodology used in studying citizens' trust in public institution i.e. UHC in rural Bangladesh. Studying citizens' trust is a complex phenomena and no single method can fully explore the nuances of trust which may be manifested either by behavior of individuals or remains deeply embedded in their minds when they may seek health services. Studying citizens' trust captures a particular phase of time of the population under study. Given the complex nature of trust study, trust researchers often combine both qualitative and quantitative methods. For deeper study longitudinal studies over a period of time on the same population is often recommended. Given the varied nature of trust in the field of social science, psychology, medical science and organizational study, the type of methods followed varies according to the context. The aim of this chapter is to adopt an appropriate research design and methodology to trace citizens' level of trust in UHC. In this study, the unit of analysis is the 'UHC' which is a public facility for delivering primary health care services to the rural people. The term citizens' have been used to mean 'patients' who may seek primary health care services at UHC. Therefore, the targeted audience of the study is the patients' coming to UHC for primary health care. This chapter lays down the research design, methods of enquiry, current methodological trends in studying trust, methodological limitations of the study, identification of the study area and size of the sample population and how the issue of validity has been tackled.

## **Research design**

According to Kumar (2011:94), “a research design is a plan, structure and strategy of investigation so conceived as to obtain answers to research questions or problem”. A research plan design is a blueprint or detailed plan the researcher undertakes to complete the study. It includes operationalizing variables so that it can be measured, selecting a sample of the study, collecting data to be used for testing hypothesis and analyzing the results (Thyler 1993:94). A design is therefore, a procedural plan for the study so that the study fulfills the objective of validity, objectivity accurately and economically (Kumar 2011:93). It serves two purposes. According to Kumar (2011) it helps the researcher to conceptualize operational plan-procedures and task to be fulfilled, secondly, ensure that procedures ensure validity and objectivity and accuracy of the answers of the research questions.

The research design adopted is a mixed approach. According to Creswell (2009), research approach can take the form of quantitative, qualitative or mixed. In quantitative studies the application of the natural sciences - a positivist/empiricist position is undertaken to explain social phenomena (Bryman 1984). Study designs in quantitative studies include ‘cross-sectional studies, before- and- after studies and longitudinal studies. As cross sectional studies are one-shot or status studies and it is best suited for finding out the prevalence of a phenomenon, situation, problem, attitude or issue by taking cross section of the population. They are useful in obtaining an overall picture as it stands at the time of the study’ (Kumar 2011:107). The study design followed in this study is non-experimental. In non-experimental studies, the researcher observes a phenomenon and attempts to establish what caused it. Therefore, the researcher looks at the effect or outcome and then tries to explore what factors caused them.

In qualitative designs Kumar (2011:104) notes “the focus is to understand, explain, explore, discover and clarify situations, feelings, perceptions, attitudes, values, beliefs and experiences of a group of people. The study

designs followed in case of qualitative studies is deductive, rather than inductive in nature and emergent in nature.” Having both qualitative and quantitative designs together as mixed methods in the study will serve the purpose of objectivity, accuracy and variation of phenomena. Kumar (2011) also notes following ‘qualitative-quantitative-qualitative’ designs which may be comprehensive and worth considered in studying social research. Using Kumar’s (2011:105) ‘qualitative-quantitative-qualitative’ designs, the study is sequenced first with observation followed by survey and later with further observation, gathering information through interview of key informants and selective patients not included in the survey to clarify and to triangulate the observed phenomena.

Six upazilas in five districts of Bangladesh has been selected for the purpose of the study. This researcher’s early experience in working as Upazila Nirbahi Officer at Gangachara, Rangpur district and Debiganj Upazila under Panchagarh district gave unique opportunity to observe functioning of the UHC and delivery of primary health care. This enabled the researcher as part of the participant observation, to develop a deep insight on the doctor-patient relationship and patient behavior in primary health care. The researcher served as Upazila Nirbahi Officer (Executive Officer) for more than 3 years and close working experience with UHC health officials in connection with primary health care in upazila. As part of the quantitative design of the study, data collection was carried out from January 2013 to March 2013. The purpose of the study is to trace citizens’ perceptions of trust in primary health care with reference to doctors at UHC across the regions in six upazilas of Bangladesh. The survey contained questions to map attitudes of patients towards the doctors at UHC. The questionnaire was developed to gather respondent’s socio-economic, demographic profile, the reasons and frequency of their visits to UHC, their conception of trust, trust perception and trust worthiness of the doctors and nurses in UHC in the delivering primary health care.

## **The research plan**

The study is about citizens' trust on public institution at upazila level more specifically patients' trust on doctors at Upazila Health Complex (UHC) which is a government facility in rural Bangladesh responsible for delivering primary health care. The scope of the study is limited to Upazila Health Complex (UHC) and delivery of primary health care. Therefore, the unit of analysis is the UHC, where patients' are considered as the target and UHC is considered as the object of trust. For measuring patients' trust in doctors at UHC, patient's experience in treatment, attitudes of doctors and nurses in dealing with patients in delivering health services in UHC were mapped. While seeking medical services, patients may experience varied treatment from the doctors and nurses depending on their socio-economic status, age, gender and nature of illness. In this study, patients are considered as the 'trustor' and doctors at UHC are considered as the 'trustee'. The type of data as needed to conduct the study in measuring patients' trust is based on patient's own assessment and their experiences in consultation with the medical professionals and in receiving treatment from UHC. For validating the findings of the survey, multiple source of evidence in the form of observation and gathering information from selective informants has been resorted. Therefore, the study plan adopted a systematic approach having 'qualitative- quantitative-qualitative' design which began with presuppositions, studying relevant theories, designing hypothesis and developing analytical framework. On the basis of the research questions and analytical framework structured questionnaire for data collection has been developed along with a sample population. The structured questionnaire has been field tested and modified with the observation of the field testing prior to the survey (Appendix-1).

On the basis of the structured questionnaires patients both at Out Patient Department (OPD) and In-Patient Department (IPD) has been surveyed. Outdoor services are delivered at OPD at a fixed time schedule and confined to doctor's consultation, physical examination and delivery of medicines based on prescription. For services at IPD, a patient is required



to be admitted in the hospital and follow a systematic treatment regime of routine checkup and observation. The patient who is admitted may be required to stay in the hospital for recommended period of time to undergo necessary treatment. Apart from the respondents of the survey, some patients having experience in receiving treatment and care at UHC are selected as cases for validating the response of the survey respondents. Along with survey, some key officials relevant to primary health care at UHC such as UHFPO and medical officers at OPD and IPD, Director, Primary Health, Deputy Director, Quality Assurance Unit, Directorate of Health has been interviewed. Besides, interview of some key informants not related with UHC but having knowledge about the services of UHC such as local residents, school teacher, Chairman, Union Council have been chosen for the purpose of structured interview and to validate the findings gathered through survey. As part of the secondary sources, reviewing the data and statistics of the Directorate of Health has also been accessed electronically. Therefore, survey findings are corroborated with the information from cases and key informants for the purpose of validation.

UHC as an institution is committed towards delivering primary health care to the rural citizens. Patient's individual expectation and experience may shape their level of trust towards doctors in UHC. A higher level of patients' trust on UHC may signify better care and satisfactory service delivery. On the contrary, lack of patients' trust may be marked by low satisfaction, low turnout, and reduced dependency and under utilization of resources in UHC. These assumptions may appear to be too simplistic, but in reality, even though patients trust perception in UHC for primary health care may be low or moderate, the patients may still be reliant on UHC for its services since they may not have options to afford cost to seek alternative medical care. One of the basic assumptions of the study is that from supply side perspective, patients' trust in doctors is beneficial for effective and satisfactory primary health care. From the demand side perspective, patients' trust may contribute to a more satisfactory patient-doctor relationship in UHC and result in beneficial health outcome. Without trust, a

patient may not fully depend on a particular doctor and cooperate to get treatment.

### **Study Location**

The study was conducted in six upazilas under five districts in Bangladesh<sup>9</sup>. The target population of the study had been the ordinary citizens seeking primary health care at UHC. A select group of UHC had been identified to conduct the study. Several considerations were attached prior to the selection of UHCs keeping in view of their geographical location from the capital city, homogeneity or heterogeneity of the patient's profile. With the exception of some upazilas of Bangladesh, most of the upazilas are rural in nature with a growing trend of upazila townships in the close vicinity of the upazila head quarters where the UHC is also located. In terms of homogeneity, most of the upazilas also display common language, culture with some distinct dialect for some upazilas. By and large, there is an observed homogeneity in terms of language, culture, occupation, economic status of patients with the exception of few hilly and riverine upazilas where the population may feature either tribal or displaced population due to river erosion. In choosing the sample, Aminuzzaman (2011:110) indicates "that a sample depends primarily on the nature of the problem, the cost and time factors involved, and the desired level of precision or reliability of the results. There is no single principle which would lead the investigator to choose a particular sample scheme to the exclusion of others. A researcher's choice is modified by the availability of resources and materials and by certain statistical and administrative considerations".

The study locations are widely sparse across three regions namely the northern, the central midland and the south-eastern part of the country. The

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<sup>9</sup> The six upazilas under five districts include Chakaria upazila under Cox's Bazar district, Ali Kadam upazila under hilly district of Bandarban both located in the south-eastern part of the country. Shariakandi and Gabtali upazila under Bogra district which is located in the midland of the country. Debiganj upazila under Panchagarh district and Pirganj upazila under Thakurgaon located in the north western part of the country.

purpose of scattering the study location is to look at the generalized trust level of patients at the peripheral regions away from the centre i.e. Dhaka, the capital city. The three regions may also vary in terms of culture, local dialect and economic status. Each region includes two upazilas. In the northern region two districts namely Thakurgaon and Panchagarh have been selected and represented by Pirgonj and Debiganj upazila respectively, two upzilas in the midland districts of Bogra (Gabtoli and Shariakandi) and two upzilas in the south-eastern districts of Cox's Bazar (Chokoria) and Bandarban (Ali Kadam) hilly district. The northern region is known to be historically backward, less prosperous with agriculture as the main source of economy. The targeted upazilas in midland region i.e. Shariakandi and Gabtoli upazila under Bogra district represents a wretched poverty stricken population made vulnerable by river erosion and lastly the south-eastern region represents hilly and relatively prosperous from tourism with some variations in ethnicity. The purpose was twofold: to focus on periphery rather than upazilas located in close proximity from the capital city, Dhaka which are mostly better resourced and closely monitored. Secondly, to have cultural differences in as much as possible so that there may be some observed differences in patient's trust perceptions across upazilas.

### **Sampling Method and Selection of Cases**

To address a research question or hypothesis, which people and research sites can best provide information and the number of respondents to be included in the population is to be determined (Creswell 2007). Creswell (2007) while referring to qualitative research mentions that the researcher purposefully selects individuals and sites that can provide the necessary information or have experience with the central phenomenon or the key concept that is being explored. In this study, patients who have direct experience and knowledge in receiving the services at UHC are selected for the study. In other words, patients seeking services at out-patient department or in-patient department has been targeted.

A sample population is a collection of people, objects that share common characteristics of interest. In identifying the sample size of the study, Aminuzzaman(2011:102) notes, that “sample size of the study depends on many factors such as homogeneity or heterogeneity of the population, number of classes, inertia of large numbers, law of statistical regularity, size of questionnaire and nature of sampling. If the population is more or less homogenous and geographically scattered, even then a small sample size may serve the purpose of the study”. Simple random and purposive sampling is followed in this study. The patients who have past experience in getting treatment in UHC were only surveyed. In the survey every alternate patient in the OPD and IPD were randomly interviewed. Thus the total sample population selected stands to 180 in 6 UHCs from different socio-economic and cultural backgrounds to make it more representative. Close parity in gender of respondents was maintained purposively.

**Table 4.8: Distribution of Respondents**

District	Upazila	Total	Male	Female	Outdoor Patients	Indoor Patients
Cox's Bazar	Chokoria	40	23	17	32	8
Bandarban (Hilly District)	Ali Kadam	20	13	7	4	16
Bogra	Gabtolli	30	16	14	15	15
	Shariakandi	30	17	13	12	18
Panchagar	Debiganj	30	12	18	15	15
Thakurgaon	Pirganj	30	15	15	16	14
<b>Total</b>	<b>6</b>	<b>180</b>	<b>96</b>	<b>84</b>	<b>94</b>	<b>86</b>

Source: Survey data

### Pre-testing and Field Visits

According to Kumar (2011), pre-testing enables the researcher to examine whether there is clarity, understanding and wording of the questions as intended by the researcher. Pre-testing was conducted in two upazilas i.e. Gabtolli and Shariakandi Upazila in Bogra district. Pre-testing was followed by field visits for data collection which was carried out from January 2012 to February 2012. The field visits began starting from south-eastern regions with Chokoria and Ali Kadam Upazila of Cox's Bazar and Badarban

districts, followed by Gabtoli and Sharia kandi upazila of midland district of Bogra and concluded with Debiganj and Pirganj upazila of Panchagarh and Thakurgaon districts respectively. Questionnaires had been administered personally as well as by a small group of enumerators who conducted the survey independently.

### **Choice of methods in data collection**

For the purpose of this study, both primary and secondary data are collected. Kumar (2011:140) mentions that “choice of a method depends upon the purpose of the study, the resources available and skills of the researcher”. Kumar (2011:140) warns that “none of the primary data or secondary data is full proof to accurate and reliable information. In selecting a method of data collection, the socio-economic-demographic characteristics of the study play an important role”. For example, educational background of the respondents may often guide choice of methods in data collection. As part of the quantitative design, random sampling is done for selecting the targeted respondents for conducting the survey questionnaire. As qualitative design, purposive sampling is used in selecting the key informants and other respondents. Other secondary sources include documents, government circulars, and newspaper reporting and participant observations. The breakdown of respondents into categories such as gender, outdoor or indoor in different upazilas has been presented in Box - 4.8.

### **Collecting data using primary sources**

According to Kumar (2011:140) “several methods can be used to collect primary data. Quality of data depends when potential respondents become aware of the purpose and relevance of the study and have clarity of understanding when questionnaire is used for data collection”. The questionnaire for carrying out survey has been designed keeping all these socio-economic and demographic factors of the respondents in view. The questionnaire was structured in the following manner: a). personal

information such as age, gender, marital status, occupation, educational attainment, family size, monthly expenditure, distance from home to UHC, knowledge of service deliverables at UHC, frequency of visit to UHC, b). whether patients' trust UHC for the services, 'meaning of trust' as construed by patients, patients' assessment on quality, costliness of services, assessment on the quality and conduct of the service providers such as doctors/nurses in the delivery of primary health care. The participants are asked to tick in the appropriate boxes corresponding to the questions, c). statements for assessing doctor's commitment, credibility, competence, institutional performance, integrity and professionalism, institutional capacity, trustworthiness and satisfactory service delivery in UHC have been included in the structured questionnaire. Questionnaires have been designed in a manner so that respondents can measure the variables in a summated scale and rank appropriately. The questionnaire includes mostly structured with some unstructured/open ended questions. In case of structured summated scale of response, as used in this study, the patients were explained when a particular question is responded following a summated scale. The questions were read out to the respondents whose literacy level was considered 'low' or 'nil' so that they could understand the questions and rank a particular question appropriately. Prior to the beginning of the survey and given the total number of questions and the amount of time needed for completion of the survey, respondents were told earlier to continue and not to abandon in half way. By using local dialects in some cases, removal of initial communication barrier and also in explaining a particular question to the respondents was achieved with much ease. For measuring patients' trust, Likert scale has been used. The scale having values ranging from '1-5' to denote '1' as 'low' and '5' as high, where '3'/'4' denotes a middle position of 'moderate' or 'medium' level'. It would also signify a state 'good enough' or neither 'too bad' nor 'too good' situation.

While conducting the survey, special attention was given to the old and female respondents particularly in explaining the purpose of the survey. The female respondents were often found to be shy and accompanied by

young children. This forced them to go home quickly. The old respondents were often found to be in poor health and weak physical state. They were released as soon as the interview was finished. Disinterested and unwilling respondents were discarded from the interview when they were approached and expressed their inability. Many female respondents could not be interviewed on grounds of their domestic works and for attending young children left at home while coming to UHC.

In selecting respondents in OPD i.e. outdoor services, random sampling was done keeping in view the relative parity in gender for response. Only adult population has been targeted who is a returnee to UHC for seeking primary health care. The OPD services are generally open to public from 8 am to 2.30 pm. The outdoor respondents were selected on simple random basis and on their willingness to take part in the survey. In each UHC, 30 to 40 respondents were targeted based on the availability of patients. In surveying patients at IPD, respondents from both male and female wards were selected based on their physical and mental ability to take part in the survey questionnaire.

### Key informants and use of cases

Key respondents of this study have been selected on the basis of the persons not directly associated with the UHC but were knowledgeable on the workings of UHC and were in a position to make independent opinions. A list of key respondents is shown below:

**Table 4.9: Antecedents of Key Informants**

SI	Name / Antecedents of the key respondents	Age of the respondents	Relevance to the study
1	Chairman, Sadar Union Council, Pirganj Upazila, Thakurgaon District	50	Local public representative
2	Member, Sadar Union Council, Pirganj Upazila, Thakurgaon	54	Local public representative
3	Local elite, Sadar Upazila Pitganj, Thakurgaon	63	Community member and knowledgeable about local affairs
4.	High School Teacher, Sadar Upazila, Pirganj, Thakurgaon	54	Informed group
5.	Head Teacher, Pirganj Pilot High School,	43	Informed group

	Pirganj, Thakurgaon		
6.	Teacher, Debiganj Upazila, Panchagarh	56	Informed group
7.	Local Journalist, Debiganj Upazila, Panchagarh	43	Informed group
8.	Government employee, Debiganj Upazila, Panchagarh	26	Informed group
9	Government employee, Debiganj Upazila, Panchagarh	29	Informed group
10.	Upazila Vice Chairman, Government employee, Debiganj Upazila, Panchagarh	52	Local public representative
11.	Teacher, Primary School, Debiganj Upazila, Panchagarh	54	Informed group
12.	Upazila Health Administrator, Shariakandi, Bogra	-	Service Provider
13	Upazila Health Administrator, Gabtoli, Bogra	-	Service Provider
14.	Teacher, Primary School, Gabtoli Upazila, Bogra	42	Informed group
15	Teacher, Gabtoli Purbapara Government Primary School, Upazila, Bogra	43	Informed group
16	Teacher, Gabtoli Purbapara Government Primary School, Gabtoli Upazila, Bogra	40	Informed group
17	Teacher, Shariakandi Government Model Primary School, Shariakandi, Bogra	43	Informed group
18	Business, Shariakandi Bazar, Shariakandi, Bogra	55	Informed group
19	Business, Shariakandi Bazar, Shariakandi, Bogra	34	Informed group
20	Madrasha Teacher, Shariakandi, Bogra	42	Informed group
21	Upazila Health Administrator, Chokoria, Cox's Bazar	-	Service provider

(Source: Survey Data)

The key informants have been interviewed with a structured questionnaire to assess patients trust in UHC in delivering services by providing their insights and explanations.

In addition to collecting primary data from out-patient and in-patient department, a select group of patients who had prior experience in seeking health services from UHC were interviewed separately to have their views on services of UHC. A total of 12 such patients were interviewed separately at the upazila head quarter. They were identified randomly from among the persons on the basis of their early experience in receiving treatment from UHC. A questionnaire guide was used for interview (Appendix- 2). All 12 individual patients are considered as 'cases' because of their unique experiences. Such cases are also considered as a basis for multiple source of evidence to corroborate with the survey findings. The patients



were asked to reflect and narrate their experience in receiving treatment from UHC. The purpose was to cross-check and to validate the claims and arguments of both indoor and outdoor patients of UHC.

The key informants are interviewed on the basis of some structured interview guide (Appendix- 3) to have their views on the UHC in terms of service delivery. They are selected on the basis of their knowledge and experiences in seeking primary health care from UHC. They are locally chosen from different occupational groups. The inputs from key informants are intended to seek a third view on UHC for service delivery based on objective criteria. The distinction between the select group of patients as 'cases' and 'key informants' is that in 'cases', the respondent is an active participant in seeking health services, while in case of the 'key informants' they are considered as non-participatory observer. They are informed and knowledgeable about the services at UHC since they are local residents and live at close vicinity in the upazila head quarter<sup>10</sup>. Apart from the key informants, UHFPO's of UHCs and senior level officials of Directorate of Health Services were interviewed along with the interview guide (Appendix 4 and 5).

### **Data processing**

The primary task in processing data is to gather filled in questionnaires and organize them in some order. The gathered questionnaires are numbered and coded under the different variables used in the questionnaire so that a particular variable can be statistically defined and analyzed. During editing incompleteness or inconsistencies of a response are corrected. In editing some of the inconsistencies in some of the filled in questionnaires, recalling the answers given by a particular respondent is resorted. Besides, relevant officials of UHC such as UHFPO and Statistician of UHC have been

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<sup>10</sup> Upazila Head quarter is the hub of the upazila where the administrative offices, other installations, shops and bazaar is usually located to become the main thoroughfare. Apart from official businesses, local residents throng in the afternoon for either shopping or for a friendly chat with fellow villagers.

contacted over phone after the survey for further clarification to verify some information. Raw data is then entered in computer based statistical program i.e. spss. Entering raw data began with questionnaire serial numbered 001 and continued till 180 as the total number of the respondents is 180. In each of the entry, the measurement of a variable is indicated either nominal, ordinal, ratio or interval scale based on the measurement of a variable or whether a question is open or close ended. Once data is entered, it was rechecked and verified with the filled in questionnaire to make sure that there are no discrepancies in the data processing. In the variable view, type, width, label, values, missing values, measures such as nominal or ordinal etc. are given. The values given are again rechecked with the survey instrument to ensure accuracy and consistency.

Presentation of data gathered through interviews of cases of patients and key informants is done in the form of short narratives which is placed in the presentation of data and analysis part. Facial or verbal expressions, remarks etc. of patients are observed during case studies of selected patients relating to service delivery in UHC and presented in verbatim. Selective patients such as residents of upazila are considered for cases given their experience and knowledge about the services of UHC. Their input is based on their earlier experience and current knowledge. Apart from the patients responses, input from doctors and nurses are also gathered through interview, discussion and by close observation.

### **Data analysis**

The gathered data is firstly coded and then tabulated. For the purpose of analyzing data, univariate analysis is done first. Univariate analysis refers to the analysis of one variable at a time (Bryman 2001:222). The first analysis was done by a simple frequency table through which the number of people and the percentage is being calculated. To measure the level of satisfactory services at UHC or how frequent and reliable are the services of UHC, a frequency analysis is done. Secondly, for measuring

relationships such level of education and measuring patients trust, or to measure whether two variables are related, bivariate analysis such as cross tabulations are also done to analyze the relationships of two variables.

For further analysis, each of these findings of data was presented against a host of hypotheses derived from the main hypothesis narrated in Chapter-I. Hypothesis is broad statements such as *“More credible is the commitment of the doctors in UHC, higher will be the level of patients trust on UHC”*. The hypotheses are tested in a Likert scale where respondents may choose to say that they ‘completely agree’, ‘partially agree’, ‘completely disagree’ and ‘partially disagree’ with the statement or simply say ‘do not know’.

### **Validating the data**

Kumar (2011:178) argues that the concept of validity is more to do with the measurement procedures and the ability of an instrument to measure what it is designed to measure. According to Creswell (2007) validity serves two purposes: it checks the quality of the data and the results. In quantitative research, validity means that the researcher can draw meaningful inferences from the results to a population.

Validity, for the purpose of this study therefore, refers to the instruments developed to carry out the study effectively on measuring patients trust in UHC. Validity also entails whether the study followed appropriate methodology and tools used in similar studies on measuring patient’s trust and whether the findings of the study have adequately answered the research questions. Measuring patients’ trust had been challenging from methodological point of view. Relying solely on survey questionnaire for capturing trusting attitude and trusting behavior was not adequate. Therefore, participant observation, interview of key informants and also interviewing some patients was considered essential for verifying information. Apart from this researcher’s deep insight on the workings of

UHC and on the basis of other secondary sources, the challenge of validity has been addressed. The measurement of patients' generalized trust on the quality, integrity of doctors, and satisfaction level of patients was carried out on the basis of summated scale. Summated scale provides approximation in estimating the effects. Lastly data triangulation was done to verify and corroborate data for validating findings of the study.

### **Methodological limitations of the study**

This chapter deals with the research design and methodology adopted for conducting the study. While research designs are broad strategies about conducting a study, a research method is a simply a technique for collecting data. The research design adopted to this study is cross-sectional design. A cross sectional design entails collection of data through survey in a single point in time measuring perceptions of respondents or indicate patterns of association. Therefore, one of the major methodological weaknesses is the temporal nature of findings on citizens' trust being captured by survey and possible risk of bias in collecting data. The measuring instrument using a summated scale provides non-quantitative, subjective judgments of individual respondents. The use of Likert scale also restricts the respondents to stick to some pattern. This may limit free flow of information during survey. However, these limitations were taken into consideration and supplemented by other sources of information derived from key informants, observation and secondary sources.

The study focuses only on primary health care at UHC and not the health system as a whole. This study only attempts to take into consideration the generalized trust perspective and not on particularized trust based at individual level. The study posits trust in a positive dimension and ignored the negative aspect of excessive trust on institutions which may often lead to complacency.

## **Conclusion**

This chapter lays down the study design, research plan and methodology followed to conduct the study. Trust research has been viewed as complex given the variety of definitions and its relevance to treatment and patients care. No single measuring scale on patients' trust is available which may fully measure patients trust towards their physicians. This study adopts a mixed approach i.e. both quantitative and qualitative methods in measuring patients' trust. The next chapter discusses the theories and concepts of trust based on which the analytical framework has been developed. Theories and concepts used are distinct from whatever has been discussed in the literature review part.

## Chapter-V: Theories and Concepts of Trust

*“Trust is one of the most fascinating and fundamental social phenomena yet at the same time one of the most elusive and challenging concepts one could study”- Fergus Lyon et al. (2012).*

### Introduction

This chapter discusses theories and concepts on trust, trust antecedents and dimensions of trustworthiness. While there may be subtlety and overlap in the meaning of trust as a concept, trust antecedent and dimensions of trustworthiness, but it is important to understand the trust constituents, the context of trust and trusting behavior and the scope and magnitude of trust relationship. Trust can be studied from several theoretical approaches. Li (2012) observes that there is dearth of a general theory on trust based on which trust research can proceed. Scholars and researchers have attempted to explain and explore the nature and complexities of trust through psychological, social, cultural lenses. In organizational leadership studies, two theoretical perspectives to study trust have been identified: i) a relationship-based perspective, ii) a character-based perspective (Dirks 2006). In the relationship-based perspective, trust is seen to be a product of interaction, behavior and reciprocity of actors such as trustor and trustee. For character-based relationship, the idiosyncrasies of the trustee such as honesty, integrity, compassion etc. build trust in the trustor. Both of these two perspectives are relevant and necessary for building trust. Relationship based perspective emphasize on interactional and character-based perspective emphasize on characteristics such as integrity, honesty of individual actors and also includes institutional dimensions such as norms and practices.

Other approaches to the study of trust include economic approach also known as rational choice theory, the institutional approach and sociological approach. Trust is seen by Hardin (2006) as ‘encapsulated interest’ and this position put trust on a ‘rational choice’ or calculative judgment. Many

scholars argue that trust emerges in a situation where there is an element of risk. Some scholars see 'trust from the context of culture while sociological studies of trust have tended to focus on the level of systems and institutions' (Möllering 2006).

### **Conceptions on trust**

Trust literature is burgeoning and the topic has received considerable interest to economists, psychologist, and sociologist as well as management theorists (Lane et al. 2008). This has led to varied meaning and definitions of trust with little agreement for converging to an acceptable definition. Kramer (2009) holds the view that although social scientists have given considerable attention to the problem of defining trust; a universally accepted definition is still missing. Consequently trust has been defined in a variety of way. Some scholars have defined it from the perspective of ethics and moral grounds, while others defined it from the perspective of strategic and calculative dimensions within organizational settings.

Castelfranchi & Falcone (2010) refers to Castaldo's (2002) content analysis of 72 definitions of trust from the period of 1960 to 1999 which resulted in the identifications of trust in several domains such as management (46%), marketing (24%), psychology (18%), and sociology (12%). From Castaldo's analysis management captures the major domain which is covered in trust literature over the years. Castaldo (2002) identifies five faces of trust: trust as construct (seen as an expectation, belief, willingness and attitude), trust involves trustee (individuals, groups, organizations, institutions), trust may result in actions, and behaviors, results and outputs of behavior (predictable, positive) and trust involves an element of risk (uncertainty, ambiguity).

Dietz (2011) observes that people trust on the basis of an assessment of other party's trustworthiness. Dietz (2011) further observes that trustworthiness evoke three dimensions i.e. ability, benevolence and integrity- a widely cited model advanced by Mayer, Davis and Schoorman

(1995). Dietz (2011) refers to the conception of trust used by Rousseau, Sitkin, Burt and Camerer as “willingness to render ourselves vulnerable” which interprets trust as a ‘psychological state’. Li (2007) sees trust as an attitude, but attitude by itself can not lead to trusting therefore trust is interpreted as a choice. According to Schoorman, Mayer and Davis (2007) trust must have behavioral manifestations.

Despite divergent views on an acceptable definition of trust, Hardin (2002) defines trust from the perspective of psychological state. In this conception of trust as a psychological state, Kramer (2009) defines trust from the point of perceived vulnerability and risk related to individuals about their motives and intentions for safe reliance. Lewis and Weigert (1985) however sees trust involving risks with the positive expectations that parties involved will behave rationally. This conception of trust is however very restrictive in the sense that people may trust without paying attention to the likely risks and consequences from such trusting.

Other definitions of trust are based on more general terms and expressed as an ‘attitude’ or ‘expectancy’ about other people and or social systems in which they are embedded (Garfinkel 1963; Luhmann 1988). Barber (1983) interprets trust as the outcome of socially learned and socially confirmed expectations of individuals in organizations. Other scholars of trust as According to Kramer (2009) trust arise out of a complex, multidimensional psychological state involving affective consideration and motivational components. According to Kramer (2009), two dimensions of trust have gained prominence: the first one is the notion of rational choice perspective brought from sociological (Coleman1990), economic (Williamson 1993) and political (Hardin 1992, 2002) theories. As a rational choice, trust decisions are considered as a risky choice and an individual are presumed to have taken decision on rational, efficient choices and secondly, is the element of the incentives of a person who is trusted to honor or fulfill that trust. Hardin’s (1999,2002) view of trust as ‘encapsulated interest’ is close to this view.



Johnson-George and Swap (1982) asserted that “willingness to take risks may be one of the few characteristics common to all trust situations”. Mayer et al. (2009) defines trust as the “willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party”. They argue that trust is not taking risk per se, but rather it is a willingness to take risk and become vulnerable.

Sztompka (1999) defines trust as a bet about the future contingent actions of others. In this definition there are two components, i). beliefs ii). commitment. This definition of trust also has a futuristic position as Luhmann (1979) puts it ‘to anticipate the future’. Frederiksen(2014) argues that trust is a function of relations from the perspective of its growth and sustenance. He sees trust as a relational phenomenon which involves interaction (Garfinkel, 1963).

### **Theories on Trust**

Two theories appear more relevant to the study on citizens’ trust which is discussed below:

#### **Rational Choice Theory**

Kramer (2006:4) observes that in trust literature “two contrasting images gained prominence, one is individual choice based on rational, calculative terms and the other is based on social and relational underpinnings of choice in trust dilemma situations”. Rational choice theory (RCT) provides one of the influential conceptions of trust in organizational theories which is drawn largely from sociology, economic and political theory. RCT assumes that individuals are motivated to make rational and efficient choices that maximize expected gains or minimize expected losses from their transactions(Kramer 2006).According to this theory, “both the trustor and the trustee are seen as rational actors, attempting to maximize their utilities

by rational calculations” (Sztompka 1999:60). Hardin (1999) views ‘trust’ as “encapsulated interest” which enables a person to trust another and there is incentive on the part of the other to fulfill that trust.

Close to RCT is the economic approach which considers trust as a scarce resource and there is a strong motivation and incentive to promote self interests at the expense of others (Casson, Mark et al. 2006). According to this view, trust is seen not only in improving the general quality of life, but also improving productivity and economic performance. It is argued that ‘trust is an intangible asset. It is important part of the invisible structure, or social capital, of an economy (Putnam, 1993). Casson et al. (2006) put forward three implications for the scarcity of trust in the economic approach, a) in order to maximize gains of the available resources, it is important to deploy most responsible task with the reputed people in the organization, b). it is to be ensured that trustworthy people gains a good reputation and the number of reputable persons in the organization increases, given the amount of trust in the economy, c). the supply of trust should increase where possible. Although trust is scarce and its supply limited in the short run, the supply can be increased in the long run by encouraging more people to be trustworthy. Therefore, the economic approach to the study of trust can be broadly seen as the coordinating or mediating mechanism to bring efficiency in any exchange or delivery of services.

Coleman (1991:177-80) notes that a reciprocal trusting relationship is mutually reinforcing for both the trustor and trustee, because each of the parties have now an additional incentive to be trustworthy. The incentives for each other in a transaction depend on the potential benefit from continuous interactions and past experiences. This is what is called the usual model of thick relationships in which a party knows one another well and have strong incentives for trustworthiness from their relationship itself. But there may be incentives to be trustworthy that are grounded in other than a thick relationship directly with a person whose trust may be fulfilled.

In economic theory, Lane (2000) argues that risk arises because trusting behavior exposes the agent to the presumed opportunistic behavior of her business partner. But in a trusting situation, 'there is the belief or expectation that the vulnerability resulting from acceptance of risk will not be taken advantage of by the other party in the relationship' (Lane 2000:3). RCT views human being as a rational actor and rationality is seen in utilitarian terms where actions are based on the judgment which brings maximum utility. In transaction economics (e.g. Chiles and McMackin 1996) trust is associated with calculations of cost and benefits in certain course of action by the parties. A rational actor bestows trust only if her calculation suggests that the gain from reciprocated trust is higher than the loss threatened by a betrayal of trust and when trust relations are supported by negative sanctions (Lane 2000).

RCT as a basis of trust has been criticized on several counts. It serves to explain the critical conditions and strategies under which dense social networks conducive to generate trust occurs. It fails to consider the social nature of actions which undermines any effort to predict outcomes. It is argued that neither gains nor losses can be predicted with certainty. It is held that trust develops incrementally and the relationships may change in an unpredictable fashion as trust develops (Lane 2000). In transaction costs economics (Williamson 1975, 1985, 1993), the key element of trust is based on the assumption of bounded rationality and opportunism. The agent minimizes risks of opportunistic behavior of a partner by adopting control mechanisms and making opportunism costly. Kramer, Brewer and Hanna (1996:384) and Zucker (1986) are of the opinion that an element of calculation is present in most of the trusting behavior.

To sum up the key element of RCT is that trust arises out of calculativeness from risk inherent in human interaction. It views trust on utilitarian terms. Actors tend to maximize benefits and take recourse to opportunism. It is argued that opportunism and maximizing self interest are common human behavior. Trust emerges out of vulnerability, risk from uncertainty. If there is no element of uncertainty and vulnerability there is

no necessity of trusting behavior. Therefore trust emerges in a situation of vulnerability and uncertainty where the trustor submits himself to the trustee believing that his vulnerability will not be exploited.

### **The institutional approach to trust**

Researchers such as Bachmann (2001), Zucker (1986) have brought institutional and system perspective on trust. Other proponents of the institutional theory on trust are David (1989) and North (1990), Jepperson (1991), Garfinkel (1963), Schutz (1932). According to the institutional theory, “trust in the system in which an individual is embedded can serve as a powerful means of reducing perceived vulnerability” (Dirks: 2006:16). Institutional theory provides an explanation of the evolution of the beliefs and moral values of a society through stimulating the role of the institutions (Casson et al.2006:341). The institutional theory upholds morals and law which may regulate human action and act as a basis of trust. Moral commitments of actors work as a driver for socially responsible decision which may make them trustworthy. Therefore, moral commitment, regulatory framework and enforcement shape human behavior which may lead to predictable and trustworthy behavior.

Trust is seen as a natural attitude (Schutz 1932) when institutions become sources of trust and ‘taken-for-grantedness’ as an implied condition of institutions. According to this view, actors face the duality to handle familiarity and unfamiliarity in their extreme of experiences (Schutz1970). Natural attitudes forces actors to analyze social reality and to take things for granted. Institutions are socially constructed, routine-reproduced, program or rule systems (Jepperson, 1991). Institutions as sources of trust generate, maintain and carry trust which leads to a situation of ‘taken- for-grantedness’. Zucker (1986) identifies three central modes of trust production, i) process-based trust which is tied to past or expected exchanges between specific actors which can be first hand or by reputation, these relationships cannot be extended outside of their relationship and therefore are not institutionalized, ii).characteristics-based

trust- is produced through social similarity between actors, and it is tied to persons possessing certain stable characteristics, and iii) institutional-based trust- includes sets of shared expectations described from formal social structures represented by signals of membership of professions or associations or by intermediary mechanisms such as a bureaucracy. According to Zucker (1986), “institutions can enable trust between actors. Such trust then can be institutionalized when the underlying shared expectations are relatively independent of time and space” (Mollering 2006:360).

The other conception of trust based on the neoinstitutionalist organization theory (DiMaggio and Powell, 1983; Meyer and Rowan, 1977) is the conception of institutional isomorphism. Isomorphism according to Mollering (2006:360), “is the process of adapting action to match and imitate institutional requirements”. According to Hawley (1968), isomorphism can be seen as a constraining process that forces one unit in a population to resemble other units that face the same set of environmental condition. According to DiMaggio and Powell (1968), isomorphism may result from competitiveness. Competitive isomorphism may result in deliberate copying from others who are doing well. It means that actors generally trust each other and it is more rewarding than non-trusting. Institutional isomorphism can be the result of three mechanisms as cited by DiMaggio and Powell (1983) such as coercive, mimetic and normative. In case of coercive isomorphism, external pressure brings institutional legitimacy and conformity. For mimetic isomorphism, which is also called ‘mimicry’ or ‘modelling’ (Galaskiewicz and Wasserman, 1989) refers to the imitation of actors the behavior of another implicitly or explicitly. According to Mollering (2006), the mimicry applies in high uncertainty and ambiguity. Referring the logic of mimicry to trust, Mollering (2006) states that actors inability to consider prudence to either place trust or distrust and to appreciate what others would normally do in similar situation. The third variant is normative isomorphism which refers to the socialization process which may instill particular cognitive bases and legitimizations to the actor. It refers to the role expectations, identity and

self-image of individual actors. Close to this concept of normative isomorphism is the notion of 'natural attitude' (Schutz 1932) and 'logic of appropriateness' (March and Olsen 1989). For trust, normative isomorphism would therefore mean actors who have been socialized would place trust in certain types of situations and conform to the expectation to match the objective reality.

The key features of institutional approach to the study of trust may be summed up that trust emerges out of 'natural attitudes' and 'taken-for-grantedness' of actors. Trust also emerges out of 'logic of appropriateness' (March and Olsen 1989) which prescribes individual actors for desirable actions and as a basis for 'institutional isomorphism' trust emerges out of organizational routines, norms and practices which are considered rational and legitimate.

### **Constituents of trust**

Lane et al. (2000) holds that trust theories entail a degree of interdependence between trustor and trustees. This dependence may be based on mutuality and reciprocity or may 'become relevant when the completion of one's own consequential activities depend on the prior action or co-operation of another person' (Luhmann 1979; Dasgupta 1988). According to Lewis and Weigert (1985) individuals would have no need to trust apart from social relationships. This view of interdependence is similar to 'reliance' used by Hardin (2008) when he says that all standard accounts of trust assume that it involves reliance on some where there is some element of risk that the other party may not fulfill. The interdependence between the trustor and the trustee with regard to trust is a matter of prudential judgment and not a matter of choice (Hardin 2008). Lane et al. (2000) holds the view that there is an inherent element of risk in social relationships and trust provides a way to cope with risk or uncertainty in exchange relationships. In such situation, there is a common belief that acceptance or exposure of risk will not be taken advantage of by the other party in the exchange. Hardin (2008) holds that there are two contexts for

trust: on-going or strictly two-person or dyadic relationships and on-going group or societal or thick relationships. In a dyadic trust, the relationship may be based on strategic considerations. This view is similar to the concept of to Hardin's (2002) view of 'encapsulated interest'. In a dyadic trust relationship - the key concern to a trustor is how much trust one should make and if such trusts would be breached.

Sztompka (1999:60) identifies three dimensions of trust such as relational, psychological and cultural. The relational perspective is addressed by the Rational Choice Theory (Elster1989). Trust is seen as "lubricant of cooperation" (Dasgupta 1988:49). The psychological dimension of trust results in "trusting impulse" (Giddens 1991) or propensity to trust. Therefore, "trust is seen as a personality disposition" (Sztompka 1999:66). Trust is seen as a "cultural rule located among the social facts" (Durkheim 1964) or "social reality" (Lewis and Weigert 1985). Apart from these dimensions of trust Sztompka (1999) identifies several elements which may contribute to primary trustworthiness such as reputation, performance, appearance. The secondary cues for trustworthiness as identified by Sztompka (1999:86) include accountability, pre-commitment situational facilitation of trust, trusting impulse and trusting culture. Appearance plays an important role in forming prima facie trust. Age, gender, ethnicity and other identity variables may build and shape primary trust.

**Trust Constructs:** Trust constructs are based on ideas built on what is expected out of the exchange, it is a belief that the trustor will be trustworthy or his expectations will not be breached. There is also an element of willingness from the perspective of the actors to trust and become vulnerable and lastly trusting attitude (Castaldo, 2002). Attitudes are worldviews of individuals and conditioned by the social interactions and environment. In such a case, it is important to note whether it is generally common to have a trusting attitude towards others such as a trader, a stranger in most of the occasions and by most of the people.

**Expectations:** Trust is seen to be emerged from positive expectations. Sztompka (1999) indicates a variety of expected conduct from others and also the contents of trust can also be extremely variable. Sztompka (1999) borrowing from Barber (1983), 'mentions that instrumental qualities of actions that may be expected from others such as a. regularity (consistency, orderliness, coherence, consistency, continuity, persistence), b. reasonableness, c. efficiency (competence, consistency, discipline, proper performance, effectiveness)'. Sztompka (1999) further notes that expectations from others to demonstrate moral qualities in their actions such as: a. expect to be morally responsible, b. expect to be kind, gentle, c. expect to be truthful, authentic, straightforward and d. expect others to be fair.

**Belief and Willingness:** Trust is also seen as belief and willingness. McKnight et al. (2009) defines 'trust' to mean that one believes in, and is willing to depend on another party. It involves a). trusting intention, meaning that one is willing to depend on the other person in a given situation b). trusting beliefs, meaning that one believes the other person is benevolent, competent, honest or predictable in a situation. Trusting belief can also have impact on trusting intention. According to McKnight et al. (2009), by believing the other party to be benevolent, competent, honest, and predictable, it is likely to form a trusting intention. Therefore, trusting beliefs may impact trusting intention. Trusting belief originates from positive experience and benevolence of the trustee. Trusting belief evokes willingness to trust. Therefore belief and willingness are intertwined in the trust development process.

**Attitude:** Attitude by itself is not trust. One cannot build trust without a trusting attitude toward others. A trusting attitude of people in general can result in trusting outcomes in the society. A trusting attitude of a trustor may not encompass full knowledge of the trustee, it may as well depend on blind trust or from the notion of trust being 'taken-for-granted' such as doctor can do no harm or a traffic police will always put the right traffic signal or a pilot of a plane whose flying capacity is not usually questioned



by the passengers. For an example, a pilot is trusted because he is recruited on the basis of demonstrated capabilities based on stringent methods of selection and fitness. Those authorities may also have external review panels. He is recruited by the most reputed airline. Therefore, it can build a generalized trusting attitude of people. The attitudinal approach of trust is “an expectation of partner’s reliability with regard to its obligations, predictability of behavior, and fairness in actions and negotiations while faced with the possibility of behaving opportunistically” (Zaheer et al.1998). An attitude is inherently an individual-level phenomenon. Trusting attitude may emanate from a trusting culture. According to Sztompka (1999:66), ‘trust appears as neither a calculated orientation, nor a psychological propensity, but a cultural rule’. General trusting attitude is the product of the whole society such as trusting a doctor or a teacher for example. ‘If the rules demanding trust are shared by the community, it may be argued that trusting attitude of people in general will be high’ (Sztompka 1999).

### **Classification of trust**

Dietz (2011) mentions a variety of trust based on the existing trust literature such as ‘contract trust’, ‘competence trust’ and ‘goodwill trust’ (Sako, 1992), ‘deterrence-based’, ‘calculus-based’ ‘knowledge-based’ and ‘identification-based trust’ (Lewicki & Bunker,1996). Dietz (2011) holds the view ‘that these different types of trust are held to have distinctive origins and dynamics and people deploy different types in dealings with others’. While the above varieties of trust may have been identified, we may also find some other versions of the different types of trust in the literature which may be discussed below.

**Calculative trust:** As the name suggests, calculative trust is based on calculations of expected outcome from another person or entity. Lane (2000) indicates that calculative trust is based on the premise that man is a rational actor and rationality is understood in utilitarian terms maximizing individual gains. Influential theorists on calculative trust is Axelrod (1984), Coleman (1990); Dasgupta (1988). A rational actor trusts if the calculation

of benefits far outweighs the costs and risks threatened by a betrayal of trust and when trust relations are supported by negative sanctions (Lane 2000). According to Coleman (1990) trusting behavior requires the making of a pre-commitment. Criticisms of this approach is that 'neither gains or losses can ever be calculated with the certainty inferred by rational choice; trust is built incrementally and the relationships can be broken as trust develops' (Lane 2000), Bradach and Eccles (1989) argues 'that the future is rarely pre-ordained'; magnitude and timing of the trustee's response is influenced by social norms which complicate calculation'.

**Value or norm based trust:** The proponents who see trust as value or norm based, argue that it is not rational self interest but solidarity which lie as the basis of collective order. Parsons (1971, quoted in Lane & Bachmann 2000:8) indicate "that solidarity, identified with institutionalized shared values, is seen as the main characteristics of a legitimate order of societal community, whose primary function is to define the obligations of loyalty to the societal collectivity". According to Parsons view, the solidary community members exercises and assumes control and exchange shared norms and values based on familiarity, kinship and common background and interest. In this view the trustor will expect that the trustee will meet her social obligation and exercise responsibility (Lane & Bachmann 2000). In the value or norm based trust, the moral aspect of trust is given prime importance. Fukuyama (1995) argues that "trust comes out of shared values" where economic actors share 'a community of trust'.

**Contract Trust:** According to Sako (2006:268), "contractual trust rests on a shared moral norm of honesty and promise keeping". Contracts between parties are instruments to ensure cooperation and make actions more predictable. It also allows the parties to safeguard their interest and insulate from opportunistic behavior. According to Sztompka (1999:90), "contracts are structural arrangements that people resort to in order to raise their trustworthiness, or trustworthiness of their partners. The most important of those is the legally enforceable contract". According to Hardin (1991), "when we have to trust strangers in important matters, we commonly prefer

to bind them through contracts under law". According to Sztompka (1999:90), "contract not only safeguards meeting trust in its specific domain, but also fosters more open relationships pervaded with trust in other domains, not explicitly regulated".

**Goodwill trust and competence trust:** According to Sako (2006:268-9), "goodwill trust can exist only when there is consensus on the principle of fairness". A precondition of good will trust is the absence of opportunistic behavior but lack of opportunism is not sufficient condition for goodwill trust. According to Ring and van de Ven (1992, quoted in Hardy et al. 2000:68) goodwill leads to mutual expectations of reciprocity among partners resulting in cooperation rather than conflicts and opportunistic behavior.

**Identity-based and deterrence trust:** According to Nooteboom (2006:252), identification-based trust "entails that people think and feel in the same way, sharing views of the world and expected norms. This may lead to 'affect- and- friendship' based behavior". Deterrence trust according to this view refers to opportunity and incentive control. Identification based trust develops with the development of relations and understanding (empathy) between partners. (McAllister 1995, Lewicki and Bunker 1996).

**Knowledge-based trust:** Lewicki and Bunker (1996), quoted in Mollering (2006:367) argues that "knowledge-based trust develops which is grounded in the other's predictability, knowing the other sufficiently well so that the other's behavior is anticipatable". According to Lewicki and Bunker (1996), the first stage of a new relationship is 'calculus based trust' where it rests on calculative reasoning about the others incentive to maintain the relationship and the deterrents to prevent breaking of trust. Where calculus-based trust 'proves to be valid, the actors may get to know each other well and understand each other's needs, preferences and priorities , then enters the second stage of 'knowledge-based' trust.

There are other conceptions of trust which is based on the different levels of analysis. Based on this, trust can be studied at micro level, institutional-based, system based, societal level.

## **Typology of Trust**

### **Trust at micro level**

Micro-level trust may concern the trust relationship between individuals in a society or at a basic unit of a particular organization. According to Lane (2000), 'individual trust is based on familiarity, developed in previous interaction or derived from membership in the same social group. Trust between organizations concerns trusting behavior of corporate actors who differ from the sum of individuals constituting the corporate unit. Interpersonal or inter-organizational trust is widely seen as informal interactive processes'. As an example of trust at micro level, the study of trust at Upazila Health Complex can be seen as a micro level study on trust as Lane (2000) argues referring to Barney and Hansen (1994) that organizations develop a corporate culture of trust and assume to have an independent stance which emit a trusting behavior and trusting culture.

### **Institutional-based trust**

Lane (2000:15) referring to Zucker (1986) argues "institutional-based trust is a type of trust which is not dependent on interpersonal familiarity and common history but where reliance is formal, socially produced and legitimated structures which guarantee trust". There may be confusion of institutional based trust with systems trust. Systems trust as observed by Lane (2000:16) is "built up by continual affirmative experiences with using the system". Institutional trust relates to trust or confidence in an abstract system. Institutional trust are 'combined structures of rules, roles and human actors who generate activities and people may trust or distrust such entities, depending upon how they perceive them and assess their actions. In this conception of trust, institutions are seen to repository of people,

appropriate norms and practices, positions, procedure and processes. Sztompka (1999:57) observes that “once the expectations are normatively prescribed, the persons or institutions become accountable for their actions. The breach of trust becomes synonymous with normative deviance”.

### **System trust**

The notion of system trust as observed by Lane (2000:16) was first developed by Simmel (1950) and later developed systematically by Luhmann (1979) and Giddens (1990). System trust occurs with the reliable functioning of certain systems. System trust overcomes the shortcomings of personal trust such as ‘familiarity’ by establishing reliable systems which offers unique and impersonal services for all. Lane and Bachmann (2000) hold the view that system trust is built up by continual affirmative experiences by using the system.

### **Societal trust**

According to Lane and Bachmann (2000:17), “societal trust can refer to the generalized notion of value or norm based trust, seeing a society as a solidary cultural community or it can refer to the institutional arrangements at a meso and macro level”. According to Fukuyama (1995) societies are cultural communities where regular, honest, and co-operative behavior, based on commonly shared norms, on the part of other members of the community are expected and demonstrated. The concept of ‘Social capital’ as coined by Coleman (1990) is linked to the concept of societal trust. Societal trust would be high in a society where the amount of social capital is also high. According to Fukuyama (1995), in societal trust, trusting goes beyond the boundaries of family, clan or close friends. The radius of trust increases with the growth of societal trust.

## **Trust, trustworthiness and Institution**

Banarjee et al. (2006) note that the concept of 'trust' and 'trustworthiness' are not simply or at least not usually descriptive terms. They are normative concepts and often the normativity is ethical or moral. To call a person or organization trustworthy is normally to praise or commend the person. Trust is defined as a belief, attitude, or expectation that actions and outcomes of others will be acceptable. Rousseau et al. (1998) defines trust "as a psychological state comprising the intention to accept vulnerability based upon positive expectations of the intentions or behavior of another". This definition according to Askvik (2009) has two elements a). willingness to become vulnerable b). positive expectations. Vulnerability is the exposure to risk that the other party i.e. trustee may inflict on the trustor which may damage his interest. Gambeta (1988) observes that trust only becomes relevant when there is the possibility for 'exit, betrayal, defection'. Coleman (1990) also sees 'trust situation as a risk situation'. Seligman (1997) and Luhmann (1979) defines trust as a "way of dealing with the risk represented by another person's freedom to decide how to act, and it is the other persons freedom that represents the potential uncertainty".

Askvik et al. (2005) observes that trust is seen differently by different groups such as the economists tend to view trust as calculative, psychologists often approach trust in terms of individual characteristics and dispositions and sociologists interpret trust from contextual point of view. According to Mayer et al.(2009) several terms have been synonymously used with trust. These terms may be argued as the outcomes of trust rather than a substitute term for trust. They are, as cited in Mayer et al. (2009); cooperation, confidence, predictability. According to Sitkin et al. (2009), scholars who focus on trust as a behavior conceptualize high trust behavior as 'cooperation' and low trust behavior as 'competition'. According to Mayer et al. (2009) though trust may lead to cooperative behavior, but trust is not a necessary condition for cooperation to occur, and cooperation may not put a party at risk. One can still cooperate with someone whom he or she does not trust.

Confidence is also synonymously used with trust. According to Cook and Wall (1980) cited in Mayer et al. (2009), trust is the “extent to which one is willing to ascribe good intentions to and have confidence in the words and actions of other people”. Luhmann (1998) makes a distinction between trust and confidence. Both trust and confidence may lead to disappointment.

Predictability - is synonymously used with trust. Gabbaro (1978) cited in Mayer et al. (2009), argues that “trust is the extent to which one person can expect predictability in the other’s behavior in terms of what is ‘normally’ expected of a person acting in good faith”. Both prediction and trust are means of uncertainty reduction (Lewis and Weigert, 1985). Predictability indicates likelihood of a person’s future behavior. In case of high predictability, there may be more trust and conversely with low predictability there may be low trust. According to Mayer et al. (2009) “another party’s predictability is insufficient to make a person willing to take a risk. Predictability might be best thought of as influencing cooperation. If one expects that a party will predictably behave positively, one will be disposed to cooperate with the party.”

As observed by Gargiulo et al. (2006), trust definitions possess three elements; first definitions on trust generally agree that trust is a belief that reflects an actor’s (trusters) expectations about another actors (trustee), secondly, it concerns the nature of trustee’s intentions. That is by trusting, it is expected that the trustee will cooperate or will not resort to anything that may be harmful, thirdly, it refers to the opportunity to defect. Trust is more likely to emerge when defection is possible.

Trust is not simply a behavior (e.g. cooperation) or simply a choice (e.g. taking a risk) but is at least in part, ‘an underlying psychological condition that can cause or result from such actions (Rousseau et al. 1998). Trust is not even just a set of beliefs or expectations. Rather trust involves, ‘an affective attitude (Jones, 1996), an emotion, even a passion (Flores and Solomon, 1997). Jones (1996) defines trust as “an attitude of optimism’.

Nooteboom's (2006) analysis of paradoxes of trust highlights the following features of trust: a). that trust goes beyond self-interest but has limits, b). entails a state of mind and a type of action, c). may concern competence or intentions, d). is based on information and the lack of it, e). is rational and emotional, g). is an expectation but not a probability, h). is needed but can have adverse effects, i). may be broken and deepened by conflict and j). is both a basis and an outcome of relations.

### **Ethical considerations**

Nooteboom (2006) observes that there is often a tendency to view trust as being always good, but one may trust mistakenly and become vulnerable. Other dimensions of trust are the ethical component of trust relationship such as fairness, integrity (Sanjay et al. 2006). There are other dimensions of trust such as goodwill, 'benevolence' resulting from loyalty or altruism (Das and Teng 1998; Maguire et al. 2001; Lane and Bachmann 2000). In order to elucidate the ethical component of trust, they observe that a 'trustworthy party is one that will not unfairly exploit vulnerabilities of the other parties in the relationship'. They note that fairness is the key to determining the moral obligations in a trusting relationship. In this case the trustee is not to take unfair advantage of the vulnerabilities of the trustors. According to Rawls (1971), those norms that could be publicly advocated and adopted by all the parties would be accepted as fair. Another ethical dimension of trust is the notion of integrity. According to Sanjay et al. (2006), one manifestation of integrity may be not to take advantage of the vulnerabilities of others.

### **A Review of the trust variables**

Trust as a concept has received diverse meaning and interpretation. Researchers have operationalized the concept of trust in several ways with distinct meaning. The following table developed and presented by Kim (2005) is a comprehensive list of variables as interpreted by several authors and scholars.



**Table 5.10: Trust Variables by Different Authors**

<b>Authors</b>	<b>Trust Variables</b>
Alvarez and Brehm (1998)	Responsiveness, honesty, fairness
Barns and Prior (1996)	Acceptance, confidence, respect, honesty, reciprocity of duty, reciprocity of interest
Berman (1996)	Fairness, honesty, faith in performance, concern for others
Braithwaite (1998)	Exchange trust (competence, predictability, consistency, cautious decision making) communal trust (treating others with respect, communicating with others, being accountable for their own actions, understanding and responding to the needs of others).
Butler (1999)	Availability, openness, receptivity, competence, consistency, discreetness, fairness, loyalty, promise fulfillment, integrity,
Carnevale (1995)	Fairness, reliability, ethical behavior, competency.
Creed and Miles (1996)	Embedded predisposition to trust, characteristic similarity, experiences of reciprocity.
Cummings and Bromiley (1996)	Good-faith efforts, honesty, not taking advantage of another (limited opportunism)
Daunton (1998)	Credible commitment, equal treatment, accountability, transparency.
Gamson (1968)	Credible commitment, efficiency
Gibb (1964)	Acceptance of self and others, data flow of information and perception, goal formation and achievement, regulatory mechanism for social control and organization.
Giffin (1967)	Interpersonal perceptions (expertness, reliability, intentions, dynamism, personal attractiveness); situational conditions (power relationships, possibility of gain through trust violation, presence of an external threat, social conformity pressure); personality characteristics (high flexibility).
Kass (1990)	Credible commitment, competency, integrity(ethical behavior)
Jennings (1998)	Performance (magnitude of power, competence of personnel, policies and programs), linkage between the citizenry and the government (representativeness and accountability, responsiveness and concern, comprehensibility, transparency), politics and corruption (honesty, lack of deceit and corruption, electoral and party system.
La Porte and Metlay (1996)	Credible commitment (consistency), competent implementation, fairness.
Lee (1995)	Reasonable policy, consistency, openness, fair procedures, predictability (keep one's word).
Levi (1998)	Credible commitments, firm procedure; competency; honest, ethical reciprocity.
Lewicki and Bunker (1996)	Consistency of behavior, predictability, identification with the other's desires and intentions.
Loomis (1957,1959)	Cooperation, communication.
Mayer, Davis and Schoorman (1995)	Ability, benevolence, integrity
McAllister (1995)	Affect-based trust (citizenship behavior, interaction

Authors	Trust Variables
	frequency); cognition-based trust (peer reliable role performance, cultural-ethnic similarity, professional credentials).
Meier (1993)	Responsiveness to public needs, competence in the performance of tasks.
Miller (1974)	Honesty, competence, efficiency, equity, responsiveness.
Rotter (1967)	Dependency, humor, gullibility, trustworthiness, popularity, friendship.
Shaw (1997)	Achieving results, acting with integrity, demonstrating concern.
The Panel on Civic Trust & Citizen Responsibility (1999)	Fairness, openness, credibility in policy making.
Tyler (1998)	Genuine concern for citizen needs, taking citizen needs into consideration, adherence to ethical standards, fair treatment.
Wicks, Berman, and Johns (1999)	Rational Prediction, affect or emotion, moral character or goodwill.
Wuthnow (1998)	Credible commitment (consistency), honesty, competency.
Zand (1972)	Information flow, influence, control.
Zucker (1986)	Background expectation, constitutive expectations.

Source: Kim (2005)

## Trustworthiness

Dictionary meaning of trustworthiness is “meriting confidence for proved soundness, integrity, veracity, judgment or ability’ (Merriam-Webster, 2003). In this definition there are two elements. Objectively it refers to the soundness and ability. As an example, whether a company has the resources and skills to perform a particular job. On the subjective element trustworthiness refers to integrity, veracity and judgment and relates to ethical consideration and context-bound. According to Govier (1998) ‘being trustworthy means being reliable out of a sense of concern and commitment. To be regarded as trustworthy, one must seem dependable; and to seem dependable, one must be dependable”. In exploring the core element of trustworthiness Flores et al. (1997) indicate that trustworthiness may be regarded as a virtue. Hardin (1996) also indicates most of the positive benefits and moral virtues associated with trust are actually those of trustworthiness: that many accounts of trust are really accounts of

trustworthiness; it therefore suggests that the moralizing of trust might be more reliably seen as a moralizing of trustworthiness’.

In order to be trustworthy, there must be fairness. Banarjee et al. (2006) observes, that a “trustworthy party is one that will not unfairly exploit vulnerabilities of the other parties in the relationship”. Kramer (2006) observes that people “readily draw inferences regarding trust-related attributes such as others’ cooperativeness, honesty, credibility, likability, fairness and intelligence from even very minimal social cues”. In a typical doctor-patient scenario, trustworthiness means that the patients’ believe in the competence as well as the intentions of the doctor. Brockner and Siegel (1996) observe that judgments about trustworthiness are reflected not only on attributions of benign intentions for being trustworthy, but also on competence to become trustworthy.

### **Reflected trustworthiness**

Sztompka (1999) in ascertaining primary trust argues that trust is the estimate of trustworthiness of others i.e. the target on which to confer trust. He mentions three bases on which primary trustworthiness of targets can be determined. Bases are reputation, performance and appearance. According to him reputation is the record of past deeds. Reputation builds the prima facie trust on an individual or an institution. The second category of clues which estimates trustworthiness is performance. Performance according to Sztompka (1999) is the account of actual deeds, present conduct and currently obtained results. Sztompka (1999) further argues that it is a less reliable clue than reputation as performance may be discontinued. Performance may be manipulated or interpreted in a way which may not produce trustworthiness of an organization with actual outcome of services. Appearance is the third type of cues that Sztompka (1999) uses in his bases for ascertaining trustworthiness. It means that appearance and demeanor of persons may invoke trustworthiness. Sztompka (1999) uses a broad list of external features such as body language, intonation, physiognomy, readiness to smile, dress etc. which

may either evoke trust or distrust. In addition to the above, he indicates personality, identity and status as further cues which may remain as central element to trustworthiness. Knowledge about reputation, performance and appearance is important. As Sztopka warns that, in many ways it could be a difficult proposition for an ordinary person to estimate directly the reputation and performance of an individual, expert, doctor, specialist or an organization. He further notes that it requires more competence to assess trustworthiness of abstract objects, government, regimes, institutions, firms, banks etc. It is noted that in reality people tend to assess trustworthiness by using all these cues together or in a manner based on their information.

Sztopka (1999) indicates the other cues which are treated as contextual cues for determining trustworthiness or secondary trust are accountability, pre-commitment, situational facilitation of trust, trusting impulse and trust culture. According to him, accountability is the enforcement of trustworthiness. It also means the presence of monitoring and sanctioning the conduct of the trustee in case of non-compliance or a breach of rules and norms. Accountability enhances trustworthiness and adds an incentive to the trustee to be trustworthy to avoid censure or punishment. For ensuring accountability clear identity is the precondition to avoid anonymity. Possession of resources at the disposal of the trustee raises accountability.

### **Public Institution and trust perspective**

In the common parlance of the term, 'public institution' refers to all those organizations and institutions created, managed and controlled by the government. They are distinct from private organizations in terms of its operation, jurisdiction and ownership. Another distinction which makes public institutions unique is its concern for public service and non-profit motive. In the broadest sense, public sector organizations are also often considered as public institutions such as post office or a rural health facility which has been in existence for quite a substantial time.

But scholars and institutional theorist define institutions as social structures which have attained a high degree of resilience. Scott (2001) presents an omnibus conception of institution in the following way:

- Institutions are composed of cultured-cognitive, normative and regulative elements that, together with associated activities and resources, provide stability and meaning to social life.
- Institutions are transmitted by various types of carriers, including symbolic systems, relational systems, routines and artifacts,
- Institutions operate at multiple levels of jurisdiction, from the world system to localized interpersonal relationships,
- Institutions by definition connote stability but are subject to change processes, both incremental and discontinuous.

Scott (2001) further indicates that institutions are multifaceted, durable social structures made up of symbolic elements, social activities and material resources. Institutions exhibit distinctive properties: they are relatively resistant to change (Jepperson 1991), they tend to be transmitted across generations to be maintained and reproduced (Zucker 1977). Scott (2001) argues that 'although rules, norms, and cultural beliefs are central ingredients of institutions, institutions encompass associated behavior and material resources'. Institutions also control and constrain behavior. Scott (2001) further explains the role of institution when he says, that 'institutions impose restrictions by defining legal, moral and cultural boundaries setting off legitimate from illegitimate activities'. According to Scott (2001), institutions have three pillars or ingredients namely regulative, normative and culturally cognitive. The regulative element of institution allows the institution to establish and enforce rules, procedure, ensure compliance, sanction rewards and punishments in order to influence future behavior. There are other theorists who consider institution resting primarily on normative pillar such as normative rules emphasizing on prescriptive, evaluative and obligatory dimension into social life. Normative systems are based on values, the notion of the preferred or the desirable and construction of the comparable standards. Norms prescribe how things

should be done. It also means the appropriate or legitimate means to pursue valued ends (Scott 2001). Institutions are also viewed as a product of cultural-cognitive elements. Institutionalists such as Geertz and Douglas and sociologists such as Berger, Meyer and Zucker, stress on the centrality of the cultural-cognitive elements of institutions. According to this view, 'institutions share conceptions that constitute the nature of the social reality and the frames through which meaning is made' (Scott 2001).

Scott (2001) advances the three pillars of institutions namely regulative, normative and culturally cognitive which are considered vital for the survival of an institution. He argues that three elements form a continuum moving from "conscious to the unconscious, from the legally enforced to the taken for granted (Hoffman1997). As the institution grows to maturity, the shift from regulative to normative and cultural-cognitive becomes more obvious as there would be fewer requirements to stick to regulative principles for basis of order, compliance and legitimacy.

### **Relationships between institutions and trust**

Institutional based trust, according to Lane (2000:12) is "tied to formal social structures which generalize beyond a given transaction and beyond specific sets of exchange partners' and "trust becomes part of the external world known in common i.e. it becomes institutionalized" (Zucker 1986). According to Lane (2000:12) institutional trust goes beyond group boundaries, structures may be in either person or firm specific such as professional credential or membership of an association or there may be intermediary mechanisms such as institution which protect the interests of all the parties. According to Zucker(1986), institutional trust is not dependent on interpersonal familiarity and common history but where reliance is formal, socially produced and legitimated structures which guarantee trust. It is likely to emerge in the following situations: a). exchange across group boundaries and hence significant social distance between groups, b).exchange across geographical distance; and c).

exchange involving a large number of interdependent, non-separable transactions.

The linkage between institution and trust can be interpreted from Scotts (2001) framework in a typical public institution such as Health institution at rural Bangladesh. The health institution such as UHC is assumed to have its mandate, resources including manpower and logistics to deliver responsive health care to the rural population of Bangladesh.

**Table 5.11: Pillars of Institutions**

<b>Modality</b>	<b>Regulative</b>	<b>Normative</b>	<b>Cultural-Cognitive</b>
Basis of Compliance	Expedience (doctors are qualified and competent to deliver professional services)	Social Obligation (to deliver prompt and reliable health services to the society)	Taken-for-grantedness, shared understanding (patients' take it for granted that services are reliable and trustworthy)
Basis of Order	Regulative Rules (Policy of the government and relevant rules and procedure)	Binding expectations (mutual understanding and support for the delivery of primary health care)	Constitutive Schema (acceptance and adopting to the system of primary health care)
Mechanisms	Coercive (Compliance is ensured with reward and punishment)	Normative (what is appropriate for example treating the old with extra care)	Mimetic(adopting or borrowing models and good practices from others)
Logic	Instrumentality (concern for efficient and reliable health services)	Appropriateness (delivering appropriate health services)	Orthodoxy (preferences of the patients, respecting local values, privacy for women)
Indicators	Rules, laws, sanctions (procedure, resources and relevant operative rules)	Certification, accreditation (health standards, campaign and coverage)	Common beliefs, shared logics of action (treatment is reliable and can be trusted)
Basis of legitimacy	Legally sanctioned (Government authorization)	Morally governed (Delivering responsive prompt health services)	Comprehensible. Recognizable, culturally supported (treatment for all without discrimination is generally accepted and compatible with local culture)

Source: Scotts (2001)

For trustworthiness of institutions the normative and cultural-cognitive pillars of the institution which comprise the 'soft intangibles' (Sztompka 1999) are more relevant when trustworthiness of institutions are concerned.

Regulative rules, procedure are instrumental to trust formation but nevertheless they fail to recognize and appreciate the informal relations arising out of interactions and communications within an organization through which trusting relationships may occur. In one of the studies pertaining to doctor-patient relationships as Kramer (2006:78) observes the remarks made by a patient that “eye contact is one of the most important things when talking to a doctor as this may give a feeling that the doctor has not ignored”. In another case a patient made the following remark with reference to her doctor, “very sterile, very - no smile, no sense of humor, just quick, quick, let’s get the job done”. Kramer (2006:78) further notes “the tendency for busy physicians to give incomplete or hurried explanations, and to make patients feel as if they aren’t respected, was felt to undermine trust”. Institutions can also be seen as a target as well as a source of trust. In this conception, institutions as a source of trust are expected to produce trust in its internal operation and in delivering its services. As target of trust, institutions are required to be seen as trustworthy in its processes, in its deliverables and more particularly in its external relationships with other entities and its clients.

Sztompka (1999) points out Robert Merton’s conception of ‘detached concern’ when he attempts to explain the ambivalent role of the medical doctor. The idea of ‘detached concern’ as used by Merton postulates two opposite positions. For an example, “a doctor is expected to be coldly professional and technically efficient, but at the same time to manifest warm care, sympathy and help toward the patients (Merton 1976). Sztompka (1999) in his study concerning doctors trustworthiness lists variables such as whether the doctor had been predictable, competent, efficient, disciplined, reliable, law-abiding, fair, honest, sharing religion, sharing ideology, truthful and helpful. In his study Sztompka (1999) found that 82.4% trusted doctor if they appear competent, while 59.6% expect the doctor to be sympathetic and helpful in order to be trustworthy. Sztompka (1999) argues that ‘for trusting a doctor, it is usually expected both’.



## **Conclusion**

This chapter provided the major theories on trust, trust-constructs and typology of trust. From the above discussion, the definition of trust that will be adopted for the purpose of the study is the definition advanced by Mayer et al.(2006:85) which is “the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party”. Rational approach to trust sees individuals as a rational man and trust is a derivative from the calculations from a particular exchange. The neo classical approach to trust is that individuals are prone to behave irrationally and sources of opportunism must be curtailed by way of contracts and awards so that trust is maintained. The institutional approach takes an ethical and moralistic view which governs individual action and lead to expected behavior in the society. Norms, values, standards and practices govern individual actions in the society and develop individuals to form a part of the moral community. On the basis of the foregoing discussions on conceptions of trust, its antecedents and theories, an analytical framework has been developed and presented in chapter VI for conducting this study.

## Chapter-VI: Conceptual and analytical framework of the study

*“A conceptual framework stems from the theoretical framework and becomes the basis of the research problem”- Kumar (2011).*

### Introduction

Based on the theoretical discussions presented in chapter V, this chapter presents an analytical framework which has been used in the study. This study is about patients' trust in public institution i.e. UHC, therefore the dependent variable is patients' trust in UHC. The independent or explanatory variables are identified as i. patients' identity, demographic variables to be represented by patients' age, gender, education, monthly household expenditure, occupation, frequency of visits and distance ii. dimensions of trustworthiness is represented by commitment, competence, level of satisfaction, cooperation, privacy and confidentiality, rapport and communication and compassion and iii. institutional variables represented by non-discrimination, integrity, dependency, quality of services, control mechanism and institutional values and norms. Patients' trust in UHC is dependent on these explanatory variables. Any changes in the independent variables will affect trust in UHC.

The analytical framework of the study is drawn from the concepts, trust variables identified by different authors (Table: 5.10), theories of trust discussed in Chapter V. To further recap, trust depends on “who we are”, ascribed or given statuses of individual citizens and may be “inferred from their appearance, age, gender, ethnicity and may be mediated by social construction and prejudices” (Sztompka 1999:80). Therefore, identity and demographic variables are considered important factors for trust formation. Other conceptions of trust as advanced by Mayer, Davis and Schoorman (1995) trust may emerge from ability, benevolence and integrity, Garfinkel (1963), Luhmann (1988), Barber (1983), sees trust as ‘attitude’ or ‘expectancy’. The constituents of trust as identified meant as expectations, beliefs and willingness and attitude (Dasgupta 1980). Trust has been

classified as calculative (Coleman 1990), value or norm based (Parsons 1971), Contract Trust (Sztompka 1999), Goodwill trust and competence trust (Sako 2009) Identity based and deterrence trust (Nooteboom 2009), Knowledge based trust (Lewicky and Bunker 1996). Trust variables as identified by different scholars consider trust as fairness, fair treatment, concern for others (Tyler 1998, Alvarez and Brehm 1998, Berman 1996), cooperation (Loomis 1957, 1959), competence (Braithwaite 1998, Carnevale 1995, Kass 1990), Integrity, ethical behavior (Butler 1999, Kass 1990, Mayer, Davis and Schoorman 1995), credible commitment (Daunton 1998, Gamson 1968, Kass 1990, La Porte and Metlay 1996), promise fulfillment (Butler 1999) responsiveness to public needs (Meier 1993), dependency (Rotter 1967) and control (Zand 1972).

Trust has been classified as calculative, value or norm based, contract based, goodwill and competence based, identity and deterrence based and lastly knowledge based. Therefore, trust is the outcome of individual interactions and emerges out of the background, socio-psychological state of the trustors which can develop on the basis of interactions. On the other hand, trust can also be the product of knowledge, competence and identity and can be derived from institutional sources. As an independent variable, trustors background and identity, age, sex, household expenditure, occupation, frequency of visits and distance have been identified as identity and demographic variables as it may impact patients' expectation and trustworthiness of UHC.

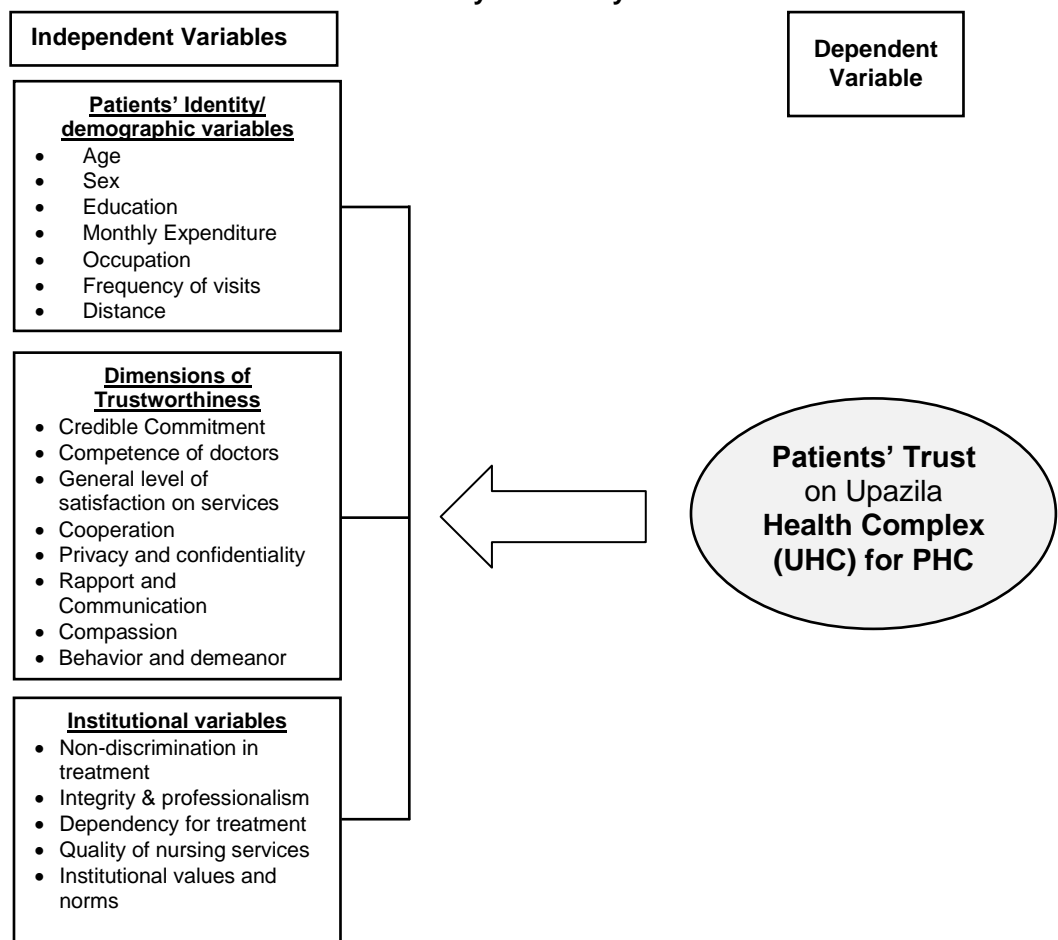
On the basis of trust variables identified by several scholars and from rational choice and institutional theory, two further clusters as independent variables such as dimensions of trustworthiness and institutional variables have been developed. As dimensions of trustworthiness trust variables such as credible commitment, competence, general level of satisfaction on services, cooperation, privacy and confidentiality, rapport and communication and compassion have been identified according to trust variables and having implications for developing patients' trust. In the category of institutional variables, trust variables identified by different

scholars having institutional bearing either as an institutional policy or as a practice, non-discrimination, integrity, dependency, quality of nursing services, control mechanism and institutional values and norms have been identified. Trust research literature on ‘doctor-patient’ relationships amply highlight competence (technical and interpersonal competency) of the physicians, communication, compassionate care, honesty, privacy and confidentiality in treatment, satisfaction (on the basis of history of fulfilled trust), upholding professional ethics, and, quality of nursing services as essential factors which may build patients’ trust. Therefore, in addition to the above variables, ‘privacy and confidentiality’ and ‘general level of satisfaction’ have been included in the category of dimensions of trustworthiness and ‘quality of nursing services’ is included in the category of institutional variables in the analytical framework mentioned below.

### Analytical Framework of the Study

Figure- 6.4 Analytical Framework

Citizens’ Trust in Public Institution-Delivery of Primary Health Care Services at UHC



## **Demographic/identity variables**

**Age:** Age of the respondents has been treated as one of the demographic variables. Age of patients is used to determine which age group of patients uses the services of UHC more than others. It is hypothesized that older group of patients will trust less compared to the young and middle age group of patients. Older patients require more complicated treatment and advanced care which may not be delivered at UHC. Therefore, trust of older patients in UHC will be low.

**Gender:** Gender has been used as another demographic variable to determine the users of the services based on the male and female categories. The null hypothesis is that female patients will trust the services of UHC more than the male patients.

**Education:** Education of patients is considered to be relevant in trust studies (Jamil et al. 2010). The null hypothesis is that educated patients will have less trust on UHC compared to the illiterate or lowly educated patients.

**Monthly household expenditure:** Monthly household expenditure of patients may be a predictor for measuring economic status of patients. More household expenditure may be associated with more income. Families with more income may seek alternative health care and tend to have low or moderate trust on UHC compared to the poor households.

**Occupation:** Occupational background of patients may also influence trust relationships. It is also used as an explanatory variable in other trust studies (Jamil et al.2010).

**Frequency of visits:** Frequency of visits to UHC may be seen as a predictor for patient's dependency on UHC. More frequency may be associated with high patients trust in UHC compared to those patients visiting less.

**Distance to UHC:** Distance to UHC from patients home may be seen as a predictor of measuring patients trust. The null hypothesis is closer proximity of UHC from patients' home; higher will be patients trust in UHC.

### **Hypotheses drawn from dimensions of Trust, Trustworthiness**

Each of the independent variables assumes to take certain hypothesis based on which patients trust is mapped. The following hypotheses have been developed for the study. Operationalization of the variables and measuring scales may be seen at Appendix-7.

**Hypothesis 1: 'Greater is the doctors' commitment to patient's treatment, higher will be the trust in UHC'.** The null hypothesis is doctors commitment can play little role in patients' trust building.

**Hypothesis 2: 'More competent a doctor is, more will he be trusted'.** The null hypothesis is that competence of doctor have minimal role in patients' trust building.

**Hypothesis 3: 'Greater is the general level of satisfaction on UHC, higher will be patients trust'.** The null hypothesis is level of satisfaction has no relationship with patients' trust.

**Hypothesis 4: 'Greater will be the level of cooperation of doctor and nurses, higher will be the patients trust in UHC'.** The null hypothesis is cooperation of doctors and nurses have minimal role in building patient's trust.

**Hypothesis 5: 'Greater the privacy during treatment, higher will be the level of patients' trust'.** The null hypothesis is that privacy during treatment in UHC has no implication in patients' trust building.

**Hypothesis 6: 'Greater is the rapport with the doctor, higher will be the patients' trust'.** The null hypothesis is that rapport and communication with doctor play a minimal role in patients trust building.

**Hypothesis 7: 'Greater is the level of doctor's compassion, higher will be the patients' trust'.** The null hypothesis is compassionate care has minimal role in patients' trust building in UHC.

**Hypothesis 8: 'Better the behavior and demeanor of doctors and quality of nursing services, higher will be the patients' trust in UHC'.** The null hypothesis is nursing services play minimal role and have no relationship with patients' trust in UHC.

**Hypothesis 9: 'More fair and non-discriminatory the services of the UHC is, higher will be the patients trust'.** The null hypothesis is fairness have minimal role in patients trust building in UHC.

**Hypothesis 10: 'Greater is the doctors' integrity at UHC, higher will be the patients' trust'.** The null hypothesis is that integrity of doctors have no relationship with patients; trust in UHC.

**Hypothesis 11: 'More dependent a patient on UHC is, higher will be the patients trust'.** The null hypothesis is dependency on UHC has no relationship with patients trust building.

The analytical framework presented above presupposes that any changes in the independent variables such as in the dimensions of trustworthiness, or identity variables or institutional variables, there will also be change in the dependent variable i.e. trust on UHC. Therefore, patients' trust in UHC is contingent upon the functions of these independent variables.

## **Conclusion**

The purpose of this chapter has been to present a conceptual and analytical framework of trust on UHC. As trust needs to be pieced together in its multiple dimensions to fit specific situation in a study (Nooteboom 2009), the independent variables either singly or collectively or in combination of some may have implications for patients' trust building in UHC. Generalized trust on UHC is assumed to be the result of collective experiences of individual patients' in their encounters with doctors and

nurses. The analytical framework presented may be helpful in explaining the generalized trust in UHC therefore, may help in tapping trust perceptions of individual patients in their encounter with doctors and nurses at UHC. The following chapter VII presents the quantitative and qualitative presentation and analysis of data on patients' trust in UHC.



## Chapter- VII: Quantitative and Qualitative analysis of empirical data

*“Empirical science pursues its quest by devising images of the empirical world under study and by testing these images through exacting scrutiny of the empirical world” (Herbert Blumer) cited in Bijlsma et al. (2012)*

### Description of the analytical chapters

This chapter presents quantitative and qualitative data with regard to patients trust in UHC. The dependent variable of this study is trust in UHC and the independent variables are patient’s demographic and identity variables, dimensions of trustworthiness and institutional factors which may affect trust on UHC. Firstly quantitative data and analysis on independent i.e. demographic and identity variables, dimensions of trustworthiness and institutional variables are presented. Then qualitative data and analysis is presented at the end.

In presenting data, firstly univariate analysis has been done with the construction of frequency distribution to show how the respondents are distributed. Secondly to measure the relationships of two variables, cross tabulations and correlations has been done to assess causal connection. Lastly, a regression model is presented to identify the relative contribution of the explanatory variables which may affect patients’ trust on UHC. Lastly, to validate the findings from the quantitative data, qualitative data is presented.

## Respondents Profile

Table 7.12: Profile of the Respondents

n=180

Characteristics	% (n)	Characteristics	% (n)	Characteristics	% (n)
<b>1. Types of respondents</b>		<b>2. Types of patients</b>		<b>3. Marital Status</b>	
Male	53 (96)	Outdoor	52 (94)	Married	86 (155)
Female	47 (84)	Indoor	48 (86)	Unmarried	13 (23)
				Widowed	1(.6)
<b>4. Age Group</b>		<b>5. Occupation</b>		<b>6. Education</b>	
20-30	30 (54)	Housewife/ Household works	34 (62)	Illiterate	43 (78)
31-40	17 (31)	Others (carpentry, ironsmith, student, business, tailoring)	22 (39)	Study up to Class-V	26 (47)
41-50	12 (22)	Agriculture/Day labor	19 (34)	Study up to Class VII	12 (22)
51 & above	31 (55)	Agriculture based	11 (19)	Study up to Class X	8 (15)
<b>7. Monthly Family Expenditure</b>		Old enough to do nothing	6 (11)	Study up to HSC	6 (10)
Tk. 3000	20 (36)			Study beyond HSC	3 (6)
Tk. 5000	21(37)				
Tk. 8000	24 (44)				
Tk. 10000	17 (30)				
Tk. 15000	10 (17)				
Tk. 20000	6 (11)				

Source: Survey Data

The above table presents profile of patients providing information on age, occupation, education and marital status. In six upazilas data collection was carried out simultaneously beginning from South eastern upazila namely Chokoria and Ali Kadam of Cox's Bazar and Bandarban districts. They were followed by Shariakandi and Gabtoli upazila, Bogra district, Debiganj upazila of Panchagarh district and Pirganj upazila of Thakurgon district. Out of a total of 180 respondents 96 were male and 84 were female patients (Table-7.1). 31% of the patients belong to age group of 51 years and above followed by 30% belonging to the age group ranging from 21 - 30 years. Only 17% of the patients belong to the age group of 31-40 years. As far as their marital status of the respondents is concerned 86% were married and only 13 % were unmarried. 34% of the respondents belong to the category of housewife or household work, 19% belong to the agricultural or day laborer, 11% were from agriculture- based background and 22% of the respondents belong to the 'other' category which includes

carpenters, ironsmith, tailor, student etc. 43% of the respondent were illiterate and only 26% respondents could study up to class V, 12% up to class-VII, 8% up to class - X, 6% of the respondents could complete higher secondary education and only 3% studied beyond higher secondary level.

The household expenditure is taken as an indicator to determine the financial condition of the respondents. The range of financial expenditure per month was categorized into six groups beginning from Tk3000, Tk5000, Tk.8000, Tk10000, Tk15000 and Tk20000. It is observed that 20% belong to the category of Tk3000 per month. 21% belong to the category of Tk5000 per month. 24% belong to the category of expenditure of Tk8000 per month, 17% Tk10000 per month, 10% Tk15000 and only 6% have their monthly expenditure in the category of Tk20000. In order to gauge the distance from respondents home while travelling to UHC, 16% of the patients travelled less than 1 km from home to UHC, 26% of the respondents had the distance less than 2km, 18% had more than 3km but less than 5km distance, 17% of the respondents had to travel more than 8km to reach UHC.

From the above profile of the respondents it is found that 43% of the respondents were illiterate, 65% of the respondents come from very low income group (monthly household expenditure from Tk3000-Tk8000). Therefore, it is observed that poor and illiterate people mostly take the primary health care services from UHC. It is also seen that the majority of the respondents (34%) were married and were either housewives or related to household works.

## Upazila wise Patients profile

**Table 7.13 Upazila wise patients profile**

Upazila (n)	Education				
	Illiterate (%)	Class V (%)	Class VIII (%)	Class X (%)	HSC (%)
Chokoria (40)	28	38	15	15	5
Ali Kadam (20)	35	30	30	5	0
Gabtolli (29)	61	14	11	4	4
Shariakandi (31)	55	16	3	13	13
Debiganj (30)	24	28	21	3	14
Pirganj (30)	57	30	10	3	0

Upazila (n)	Monthly Expenditure					
	Tk.3000	Tk.5000	Tk.8000	Tk.10000	Tk.15000	Tk.20000/ above
Chokoria (40)	0	8%	15%	36%	26%	15
Ali Kadam (20)	0	10%	55%	25%	15%	0
Gabtolli (29)	0	38%	10%	28%	17%	7%
Shariakandi (31)	0	36%	36%	11%	14%	4%
Debiganj (30)	0	17%	37%	27%	3%	7%
Pirganj (30)	33%	27%	27%	3%	0	7%

Upazila (n)	Occupation								
	Agri. Labor	Riksha puller	House wife	Unemployed	Agri. based	Pvt. /govt. service	Teaching	Old to do nothing	Others
Chokoria	15%	0	30%	5%	8%	3%	0	0	38%
Alikadam	35%	0	10%	5%	15%	0	0	0	35%
Gabtolli	14%	3%	35%	7%	10%	0	0	0	21%
Shariakandi	16%	7%	36%	0	13%	3%	0	0	10%
Debiganj	13%	3%	50%	0	7%	0	0	0	27%
Pirganj	23%	3%	40%		13%	3%	3%	10%	3

(Source: Survey Data)

## Citizens' trust perception on UHC

Citizens' perception of trust in UHC could be mixed where poor households use the services more than the better off households. Accessibility to UHC is easy for the rural people. The other reason which drives the poor people more than members of well off families to seek treatment is its almost free or low costs for services. Other studies such as the study conducted by Chowdhury et al. 2010 shows similar trends in seeking services in UHC. However, this does not preclude members of the well off households from using the services from UHC. Better off household members take services during emergency and also seek alternative care in secondary or private health facilities. Trusting services of UHC is dependent on patients' positive

experience such as receiving proper and prompt medical response. Therefore, trusting is linked to direct experiencing. The other views of trusting UHC is indirect where a user may not have any direct experience in receiving services, but he or she may be aware of the services used by others and such experience may create impression on the reputation of UHC which may also indirectly influence trust building. In each of these situations, direct experience and reputation of UHC as a service provider may play very important role in shaping citizens' trust on UHC.

Patients in general are found to have positive expectations about the treatment at UHC and they had the notion that they would be cured after the treatment. During survey as it was observed that some old patients having complex and chronic health complaints were admitted with symptoms of acute respiratory problem. They were found to have improved since they were admitted in the UHC hospital. Some service seekers particularly the poor patients appear to have minimal expectations and they were found to be happy with the services they received from UHC. Non-availability of some drugs in the UHC may often occur as UHC have a limited number of drugs and medicines. Therefore, some drugs and medicines may be required to be procured from outside. Such non-availability of drugs may not readily erode patients' trust in UHC if alternative drugs are available in the store and the prices of medicines which must be met from out of pocket expenses are not too high so that it is unbearable.

During delivery of medicines at the pharmacy counter of UHC, instructions for administration of medicines are given to patients and the medicines which need to be procured from outside. Many UHC's display the list of drugs available at the disposal of the UHC and their current stocks for knowledge of the patients. This may serve the UHC well with its intention to bring more transparency but to a illiterate and poor patient this may add very little value. For patients having complex health problem, UHC can barely provide any treatment as it only provides PHC. But patients brought with urgent health problems are generally advised and made appropriate

referrals. For those patients having complex health problems which may require prolonged treatment and specialized care, UHC cannot serve them, therefore trust in UHC may be irrelevant for them. In such cases, patients may acknowledge the limitations of UHC and may seek specialized treatment elsewhere.

It is found from the survey that most of the clients of the UHC are local rural residents. In some UHC, such as Chokoria UHC in Cox's Bazar district which attracts patients from adjoining upazilas because of its location. In general, ordinary patients are dependent on the services of UHC and tend to have no major complaints about the services they receive from UHC. Even though they might have some observations on the quality of services, they hardly get ventilated through organized voice mechanisms. From service delivery perspective, in all the UHCs surveyed under the study, citizens' charter has been found to be displayed. But the whole purpose of displaying citizens' charter and in fulfilling its objectives through conscious efforts are found to be absent in all UHCs. Demand for services at UHC is generally high at OPD and more in the early hours of the day when patients' presence is generally high. IPD remains crowded with infants and old patients due to certain seasonality's from diseases such as asthma, RTI or pneumonia and diarrhea when quality of care at UHC becomes more critical with limited number of health personnel and hospital beds. Generally the occupancy level of hospital beds in UHC's is seen to be high.

In order to gather patient's perception and understanding on the concept of 'trust' in relation to their treatment at UHC, seven different statements or formulations related to their understanding of trust were posed in the survey questionnaire. Each statement on conceptions of trust was read out and explained in 'Bangla' to the patients to allow them to tick appropriately close to the meaning of trust as "most agreed".

The respondents were asked, *"What is your understanding and conceptions of trust in relation to the doctors at Upazila Health Complex?"*

**Table 7.14: Patients' conceptions of trust towards doctors at UHC  
n=176**

<b>Operational definition of trust (in the parenthesis conceptions of trust)</b>	<b>Percent</b>
When the doctor treats with care (demonstrating compassion, benevolence, competence, professionalism etc.)	38
Availability of services when emergency arises (Demonstrating ability, capacity, resources,)	24
When cured after the treatment (Visible positive health outcomes)	12
When treatment is followed by available medicines provided by UHC ( In possession of necessary resources)	12
When all required facilities of treatment are available (Availability of required resources)	8
When cured after receiving treatment from a particular doctor (particularized trust)	2
When doctors and nurses cooperate with the patient (communication, cooperation)	1

38% of the respondents agreed that they associate 'trust' on doctors of UHC with the notion of care. Caring a patient by a doctor during treatment may mean that the doctor demonstrates compassionate, benevolent, professional behavior towards a patient. This notion of 'trust' as operationalized by 'care' is drawn from conceptions of compassion, benevolence, competence, professionalism etc. It stresses not only on the technical excellence of a physician but also on the practice that upholds compassionate care. Such conception of trust is very much compatible with the trust literature in typical patient-doctor trust relationships such as technical competency, interpersonal competency, expression of care. Caring for patients during treatment may involve a kind and compassionate approach. While most patients emphasized on 'care' as a constituent of trust, it may also be argued that while doing so, respondents might have consciously or unconsciously taken for granted the consideration of professional competence of the doctors. Many respondents believe since the doctors are appointed by the government, their qualifications and competence is usually taken for granted, rarely questioned or noticed by

the ordinary patients. Though at times doctors may be challenged or put to embarrassment, even face litigation for faulty treatment or surgery. Ordinary patients view doctor's at UHC as "government doctors" meaning appointed by the government, therefore they are taken to be safe and reliable while they discharge their professional duties. Ordinary patients may assess a doctor's competence more on their dealings with the patients such as sympathetic and kind expressions rather than by their professional degrees. This notion of professional competence of doctors is more relevant for patients at UHC who are mostly illiterate and drawn from low income groups of the society who expect to be treated with respect and kindness. Trust so conceived by ordinary citizens' display generalized trust on UHC.

The next alternative statement given as a derivative meaning of trust in UHC is "the availability of services when emergency arises". It is found that 24% of the respondents agree that they trust a system when there is availability of services during their emergencies. This notion of trust in UHC is synonymous to capacity and resources. Without capacity to deliver emergency services with appropriate resources, no emergencies can be met and health service delivery would be at stake. During medical emergencies, prompt and reliable services become more crucial for patients recovery and survival. Negligence and delay in emergency medical response can be seen as a major barrier towards building trust. This notion of trust seen from emergency response is also valid from the perspective of patients. The real test of professional competence can well be measured when there is a medical emergency. This dimension of trust is also contingent on the availability of resources including technical and support staff to meet any exigencies. Availability of qualified doctors at UHC may not guarantee effective medical care unless necessary equipment and technical support are ensured. This notion of trust also suggests that many UHCs may have a history of non-availability of adequate resources and sanctioned medical professionals including specialists and consultant physicians to meet emergencies. These conceptions of trust as perceived by the respondents are linked to ability



and resources. In coping emergencies, institutions must have right capabilities and adequate resources.

The third alternative statement which is given as a derivative meaning of patients trust is “when cured after the treatment” which is seen to be backed by positive health outcomes. 12% of the respondents agree that they tend to trust the services of UHC when they have a feeling that treatment will lead to a definite cure. Patients may be diagnosed early or late when they report to UHC for treatment. In each case, the treatment may be either short or prolonged depending on many factors such as the patient’s age, history of the disease, past treatment, current state and proper administration of drugs and follow ups. In each stage of treatment the patient may notice the pace of recovery. If the recovery rate is fast and high, then the patient would believe that the doctor has rightly diagnosed and prescribed correct medications. Though in practice, it is often seen that doctors in Bangladesh in general prescribe medicines in combination with antibiotics more frequently to offset any likely hood of secondary infections which may result in quick cure. Such use of antibiotics is often seen to be indiscriminately used and may cause more harm to a patient though recovery can be faster. This concern over prescribing antibiotics is echoed by a recent headlines in a newspaper in Bangladesh with a title *“Alarm over antibiotics- improper use of medicine causing more harm than cure; infections may be beyond cure in future”* (The Daily Star, April 27, 2014). Therefore faster recovery may of a patient may build trust in patients.

If the disease prolongs, even though the patient may be supervised by a competent doctor at UHC, patients might doubt the doctor’s ability in diagnosing correctly and give proper treatment. This may prompt the patient to seek alternative treatment from another preferably a senior and a more experienced doctor. This may lead to a shifting preference for some doctors and may have varying levels of trust relationships. Calculating number of days for complete recovery of a patient may vary with respect to cases of patients. Treatment may include both hospital care and treatment

at home when the patient may be released from UHC and advised to continue medication while at home. Treatment leading to full cure is considered to be an indicator of satisfactory level of treatment hence may contribute to building trust on doctors at UHC.

The score for other three statements in attaching meaning of patients' trust such as , '*when all required facilities of treatment is available*', '*when cured after receiving the treatment from a particular doctor*' and '*when doctors and nurses cooperate with the patient*' is 14%, 4% and 2% respectively which may be considered as less significant compared to the top three statements.

In order to map patients' generalized trust on UHC, patients' were asked "*to what extent they trust UHC as an institution for delivering reliable health services?*" The findings revealed that 80% of the respondents report moderate to above moderate level of trust in UHC, 12% of the respondents report high trust and only 8% of the respondents report low trust in UHC. These findings suggest that generalized level of patients' trust on UHC may range from moderate to a higher moderate level.

### **Demographic, identity variables and trust in UHC**

Several demographic and identity variables such as age, gender, occupation, household expenditure were used to map their effects on trust in UHC.

**Age:** 47% of the respondents belong to the age group of 15 to 40 years of age group. 43% of the respondents belong to the age group of 41 years and above. Majority of the respondents are middle aged. When age is correlated with the dependent variable trust on UHC, the correlation coefficient ( $r = -.053$ ,  $N=177$ ,  $p=.484$ ), which shows weak and inverse relationship between age and trust in UHC. That means patients' trust in UHC and age of patients has an inverse and weak relationship. It may be argued that trust in UHC decreases with the increase in age of patients. Age of patients may indicate their relative experience in seeking particular treatment and towards developing certain worldview. Generally speaking,

older persons may be more experienced in comparison to younger persons in receiving medical care at UHC. This is because older patients are likely to have more exposure to UHC. With the increase of age they may experience more health problems and are therefore more likely to make frequent visits to UHC for medical attention. Therefore, age of patients is an important variable for measuring trust in UHC. When a regression analysis is run with age and trust in UHC, the beta weight was found  $-.089$  with significance level at  $.509$  ( $>0.05$  level) showing an inverse relationship with the dependent variable. This may suggest that aging patients will have less trust on UHC as they may need more advanced care and treatment which UHC cannot deliver.

**Gender:** 52% of the respondents surveyed were male and 48% were female patients. Differences on trust can be observed based on gender differences across culture. The null hypothesis was that female patients trust the services of UHC more than the male patients. Chi-square test between gender and trust on UHC reveal no significant relationships. ( $p = .234 > 0.05$  level). The null hypothesis that female patients trust the services of UHC more than the male patients is rejected. An independent t-test is carried out to see variances in gender and trust where  $t = 1.538$  and level of significance  $p = .126$  ( $> 0.05$ ). Therefore, no variance in gender and patients' trust is seen to be statistically significant. The study conducted by Anisuzzaman (2012) showed that gender does not matter for trust formation. The study on "citizens' trust in public and political institutions in Nepal" conducted by Jamil and Dhakal(2010:53), showed that differences of trust level based on gender where it was seen that there are trust differentials across male and female population and females trust institutions such as parliament, central government and District Development Committees more than males. Males trust the political parties and the army more than the females in Nepal. In UHC, 47% of the respondents were female. As evident from the study 34% of the female patients report their occupation as 'housewife'. Female patients may feel less comfortable when consulting a male doctor and may have poor communication. Female patients at OPD require privacy during

consultation with the doctor otherwise this may constrain examination in front of other patients waiting in the queue. Many female patients when interviewed during survey expressed their dissatisfaction that they had difficulty in communicating with the doctor as the doctor did not listen to them and was hurrying to call the next patient.

In rural Bangladesh, it is expected that female patients are generally accompanied by some male persons either husband or other family members. During the survey it was observed that many female patients visited OPD at the UHC with their young children and without any accompanied male persons. This may suggest that these female patients became used to visiting UHC alone to seek treatment without any accompanied male persons. It shows that with gradual empowerment of women, trust perception on doctors may also change. It is also observed that at OPD, female patients make more frequent visits compared to male patients. A female patient may often visit UHC not only for her own care but also for the treatment of their young children where concern for treatment for their young ones may become more pressing. However, this does not infer that female patients have more trust on UHC compared to male patients.

### **Household expenditure**

65% of the respondents have monthly expenditure ranging from Tk3000-Tk.8000. 33% have their monthly expenditure ranging from Tk 10000 to Tk 20000. The correlation coefficient of patients monthly household expenditure and trust on UHC is .159\* and significant at 0.05 level. That means patients income has a significant relationship with trust on UHC. Economically poor households may have more reliance with consequent high trust on UHC for treatment. They tend to have blind trust on UHC, whereas rich households may rely more on alternative treatment outside UHC, having less reliance with consequent low trust on UHC. In order to test the relationship of patients trust in UHC and their monthly household expenditure Chi Square test shows no relationship between household

expenditure and patients' trust in UHC ( $p=.410>.05$  level). Therefore the null hypothesis that patients from higher income group will have less trust on UHC whereas low income group of patients will have more trust is thus rejected. Though it may be true that patients from poor households are likely to depend more on UHC for free treatment whereas patients from well off households may rely more on alternative health care providers operating privately.

### **Trend of illness of patients coming to UHC**

With regard to the illness, 22% of the respondent's report that they suffered from cold, cough, fever and skin disease. 16% reported that they had headache, pain in the throat, neck and body, sciatica and toothache. 10% reported that they had gastric, dysentery, diarrhea, ulcer, 9 % reported that they suffered from respiratory tract infection, asthma or urine infection, 7% reported that they suffered from cut injury, physical injury due to hurt by blunt objects in hand or parts of body, 6% had reported gynecological problem. As the survey was conducted during the later part of winter, it was found that illness due to cold resulted in respiratory problems in chronic patients. Outdoor patients are expected to be high in colder seasons relative to other months of the year. The top 10 diseases as recorded at Gabtoli UHC during 2012, includes 25% of the patients suffered from unspecified gastroenteritis and colitis of infectious origin, fever 12%, physical assault by unspecified means 8%, pneumonia 8%, chronic obstructive pulmonary disease with acute lower respiratory infection, pedestrian injured in collision with pedaled cycle, non-traffic accident 2%, urinary tract infection 2%, organophosphate and carbamate insecticides 1.13%, essential hypertension 0.74% and asthma 0.66%. The above data shows that majority of the patients reported that they suffered from gastroenteritis. The survey data however differed as major health complaint was common cold, fever, cough and skin disease. Apart from the aforementioned illness reported by patients, there may be other patients with illness of serious nature. In 2012, at Gabtoli, a review of patients casualties in UHC revealed that causes of s death was caused by heart

failure, asthma, burn and corrosion and acute myocardial infraction. This suggests that patients with heart attack and burn injury are also admitted to UHC but UHCs are not designed to manage cardio vascular disease or patients having burn injuries. Therefore, those patients are either referred to secondary or tertiary level of care depending on their health condition.

### **Frequency of visits and trust on UHC**

Visiting frequency to UHC for primary health care may signal patient's high reliance on UHC. This may also suggest inability of the patients to either take 'exit' or raise effective 'voice' for unsatisfactory services and accept the services as a 'loyal' receiver. About the frequency of the patient's visit, more frequency may suggest more dependency on the services at UHC. This may also be suggestive of non-availability of the exit option. Therefore, a regular user of the services of UHC may take the services but still may remain skeptical. The respondents were asked, *"If visited UHC for primary health care before, what is the frequency of such visits?"* 49% of the respondents reported that they always come to UHC and do not go anywhere else for similar or better treatment. 33% of the respondents have reported that they come to UHC as well as go to other places for treatment whenever needed. UHC also refer patients to secondary health care systems at the districts. Patients may also prefer to go to private clinics in nearby cities or towns. Finally, 17% the respondents have reported that they always come to UHC and hardly go elsewhere. This means, the patients do not go to other places either for better treatment or do not have the financial resources to take alternative health care elsewhere. It may also suggest that though these patients might have been referred to secondary hospitals but they still continue in UHC as they do not have resources to travel and take treatment in nearby towns.

From the above it may be seen that only 33% of the respondents may seek alternative care beyond UHC either by way of referral or in a manner of exit. Therefore, 66% of the patients take the services from UHC. Taking exit from UHC for better treatment and care is rather a prerogative of

patients from well off households where ordinary poor patient may be totally dependent and continue to choose the services from UHC. In order to find out causal connection between frequency of visits to UHC and trust in UHC, cross tabulation and Chi-square test was done and presented below.

**Table 7.15: Patients' trust on UHC and frequency of visits cross-tabulation**  
n =176

Patients frequency of visiting UHC Trust in UHC	Patients' Trust on UHC			
	Patients' trust UHC for treatment	Patients' reported no trust in UHC	Cannot tell	Total
Always visit UHC and hardly goes anywhere	26 (90%)	1 (3%)	2 (7%)	29 (100%)
Visit UHC as well as other places as needed	53 (91%)	4 (7%)	1 (2%)	58 (100%)
Always visit UHC and do not go anywhere at all	87 (98%)	1 (1%)	1 (1%)	89 (100%)
<b>Total</b>	<b>166 (94%)</b>	<b>6 (3%)</b>	<b>4 (2%)</b>	<b>(100%)</b>

From the above table, it shows that 90% of the patients who trust UHC always visit UHC and hardly goes anywhere for treatment, 91% patients goes to UHC as well as other places as needed and 98% of the patients who trust the services of UHC, always visit UHC and do not go anywhere for treatment at all. The null hypothesis was that more frequency of visit to UHC will assumed to have more trust on UHC. However, Chi square test on frequency of visits and trust in UHC reveal ( $p = .037 < 0.05$  level). Hence, the null hypothesis that more frequency of visit to UHC meaning more patients' trust is accepted. Therefore, visiting frequency may be suggestive of patient's dependency on UHC and patients' trust on UHC. However, this does not exclude the possibility of patients' trust coming to UHC less.

### **Distance to UHC and patients trust**

Distance for commuting to and from UHC to the residences of patients varies as UHC may serve population within a radius of 5 to 8 kilometers within its jurisdiction. Such distances in larger upazilas may exceed the

above range. Commuting takes place either in tri-wheeler called 'van' or bullock cart where vans are not available. Growth of different commuter services through improvised tri-wheelers, battery operated easy bikes and rickshaws and vans, have eased commuting of patients in rural roads in upazilas particularly for female and elderly people. Women patients are often accompanied by someone usually a male person from the family. From the survey it is revealed that most of the respondents live in close proximity of the UHC which gave them the opportunity to frequently visit on foot. Distance has been seen as a predictor for frequenting to UHC for services and close proximity gives patients the leverage to access information and knowledge about the services offered by UHC. The null hypothesis is longer the distance to UHC from patients home, higher will be patients trust. Therefore, it may be argued that patients coming to UHC with longer distance will have more trust.

**Table 7.16: Patients' trust on UHC and distance from home Cross Tabulation**

Patients trust in UHC	n= 177		
	Distance to UHC from home 1km-2km	Distance to UHC from home 3km-5km	Distance to UHC From home 8km and above
Low trust	4	5	1
Moderate trust	67	44	29
High trust	2	6	11
<b>Total</b>	<b>73</b>	<b>55</b>	<b>41</b>

Out of 177 patients, 73 travelled 1-2Kms to UHC, 55 patients in travelled 3-5kms and 41 patients travelled 8km and above to UHC. In the above table total out of the patients travelling to UHC from 1-2km distance, 67report moderate trust, 2 report high trust and only 4 report low trust in UHC. Patients travelling 3-5 Km, 44 patients report moderate trust, 6 report high trust and only 5 report low trust in UHC. Lastly, for those patients travelling from 8km and above, 29 report moderate trust, 11 report high trust and only 1 report low trust on UHC. Patients travelling from distant places as far as 8km and above show high trust in UHC compared to other patients travelling less (11 as against 2 and 6). This may suggest that distance



does not affect patients' trust in UHC. Chi-square test for distance to UHC ( $p = .012 < 0.05$  level) suggest that distance to hospital from patients' home has high significance in building patients' trust in UHC. This may also suggest rejection of the null hypothesis that shorter the distance from patients' home to UHC, higher will be their trust. Rather reverse may be the case that longer the distance the patient may travel from home to UHC, higher will be their trust in UHC. A patient in need of medical emergency may disregard the pains of journey and difficulty in travelling but it may show his reliance and confidence in UHC as well. Therefore, closer the proximity of UHC from patients home, more will be patients' trust and greater the distance, lower will be the patients' trust on UHC is thus rejected.

### **Patients' knowledge and formation of trust**

The number of patients visiting OPD in a particular year may provide a testimony how the services of UHC are being utilized. It may also provide trends of illness of patients in a particular upazila. If patients are informed of the services delivered at UHC, they tend to rely more on UHC for treatment. Information on availability of medicines and particular doctor for ENT or orthopedics may encourage patients to consult with the doctors in case of medical needs. For example, in two of the upazilas under survey Gabtoli and Chakoria UHC, the total number of OPD patients who visited UHC was 45,822 and 58,296 respectively in 2012. In the same year the number of patients admitted at UHC was 3265 and 7237 at Gabtali and Chakoria respectively. These figures show a large number of users of services of UHC i.e. outdoor and admitted patients in UHC hospitals which is indicative of a well informed user group. 91% of the patients under survey reported that they had prior knowledge of the services delivered at UHC. Only 6% of the patient surveyed reported that they had no prior knowledge of services delivered at UHC.

Patient's propensity to trust UHC will be more when they have full information on the services provided by UHC such as availability of doctors

and their cooperation, proper medicines, availability of beds at IPD and other required facilities such as for reproductive health, information on ANC and PNC services may encourage patients to visit UHC. Patients are aware that treatment and medicines delivered at UHC are free. The patients are required to pay a token money for outdoor tickets which allow them to see a designated doctor and who may prescribe medicines supplied by UHC. Knowledge on services delivered at UHC may be facilitated either by shared experiences of patients or by the awareness campaign conducted by UHC authority. Patients are fed with information when they are referred from Community Clinics or at the advice by the health assistants and family welfare visitors who provide door to door services. Introduction of mobile health services have also expanded the opportunity to disseminate information. Besides, patients past experiences, commentaries from fellow villagers, information provided in citizen's charter and advocacy campaigns by UHC may also expand the knowledge base of the users of the services. It is assumed that close proximity to UHC may often facilitate patients' knowledge such as arrival of certain medicines which may result from their frequency of visits and dependency on UHC. Prior knowledge of the available services may therefore be useful from treatment and service point of view.

By and large, it can be said that the users are fairly informed of the available services and as patients return home, they also narrate their story to others. With further reciprocity knowledge and information widens affecting their propensity to trust the services at UHC. Frequent visitors to UHC also get familiar to the doctors and medical staff which may also affect their trust propensity. Therefore, information on the available services at UHC is a prerequisite for trust or distrust.

Patient's awareness of the services at the UHC is also associated with their economic situations. 81% of the respondents belong to the monthly household expenditure range of Tk.3000-Tk10,000/.Therefore, a vast majority of the patients belong to the lower income group of the upazila and they rely on free medical services delivered at UHC. When patients

knowledge about the services of UHC is cross tabulated with the monthly household expenditure of the respondents, it is found that the lower income group of patients from Tk 3000 to Tk 10000 have more knowledge on the available services of UHC compared to the economically better off families. This means that the poor are more dependent and rely on the services of UHC compared to the relatively richer households. The null hypothesis is that patients' prior knowledge of the services of UHC is contingent on their relative economic status. Patients from poor households are more informed than patients from economically better off households as they may visit more and depend on UHC for free services compared to the patients from economically better off households.

**Table 7.17: Patients' knowledge of services at UHC household expenditure**

n= 176

Patients' Knowledge of the services offered at UHC	Monthly household expenditure	
	Less Than Taka 10000	More than Taka 10000
Have knowledge of the services	66%	34%
Have no knowledge of the services delivered	89%	11%
Cannot tell	57%	44%

Form the above table it is seen that 66% of the respondents who had prior knowledge about the services of UHC came from Tk10000 monthly expenditure category, in the same category of monthly expenditure 89% report that they had no prior knowledge. In comparison, 34% of respondents came from more than Tk10000 monthly expenditure category have knowledge of the services of UHC. This may mean that patients having higher level of monthly expenditure may still take the services from UHC, and may therefore remain better informed about the services. The Chi-square test result for patients' prior knowledge and monthly household expenditure reveal ( $p=.553 >0.05$  level) which may suggest no significance. Therefore, the null hypothesis that patients' from lower

income group (represented by lower level of monthly household incomes) are more informed than patients from economically better off households is thus rejected.

### **Educational level and impact on trust**

Educational level of the patients may also affect trust on UHC. Illiterate or lowly educated patients tend to be guided by blind trust rather than basing trust judgment on well informed knowledge. Whereas patients with higher education may base their trust judgment more on calculation and verification as a result they may be more skeptical in trusting others.

With regard to the education profile of the respondents, 43% of the patients were illiterate, 49% received junior /secondary education and only 8% received higher secondary education and above. It may be seen that a large number of patients of UHC comprise population with low or without any educational attainment. Therefore, most of the users of the services of UHC belong to the category of illiterate or having low educational attainment. In order to examine the relationships between educational attainment and patients' trust in UHC, cross tabulation has been conducted which is presented below.

**Table 7.18: Patients' trust and education level cross-tabulation**

n =175

Scale	Education Level of patients		
	Illiterate	Class V-VIII	Secondary and above
Have trust in the UHC for treatment	72	66	27
Do not have trust in UHC	1	2	3
Cannot tell	3	1	1

It may be seen that patients' trust in UHC is high among the illiterate and those who studied from class - V to class - VIII whereas 27% of patients with secondary education and above report high trust. The null hypothesis is that illiterate and lowly educated patients will have more trust in UHC

compared to the relatively higher educated patients. Higher educated patients may be more critical to the available services at UHC about the quality of treatment and care and likely to take alternative treatment at private clinics outside or where they can consult doctors during private practice. More educated persons are expected to be better informed or may be in a position to verify information. Such verification may either lead to trust or distrusting behavior. Therefore, in this case trusting behavior may reflect calculative judgments. Whereas trusting blindly or in good faith may be more evident in case of patients having low or no educational attainment. As majority of the service seekers of UHC are either illiterate or come from low educational background, their trust on UHC may be based on blind trust rather on calculation. As a poor patient, desire for free medical treatment may go beyond mere economic rationality and purely based on certain calculations. Rather, it may be based on other factors which may influence trusting behavior of patients. To test the null hypothesis a Chi- Square test is carried out. The Chi-square test reveal no significance ( $p=.443 >0.05$  level). Therefore, it may be inferred that educational attainment has no significance in patients' trusting behavior at UHC.

### **Occupation of patients and trust**

Occupation of respondents are clustered in several occupational groups such as housewives 35%, agriculture labor 19%, agri-based livelihood 10%, rickshaw van puller 3%, unemployed 3% and others 23%. Chi-square test result shows no relationship on patients' trust in UHC and occupations

( $p= .427 >0.05$  level). That means identity variables such as occupation of patients have no significance in determining patients' trust in UHC. In the respondents profile the dominant categories are housewife and agriculture labor or agri-based livelihood, 13% rickshaw and van puller. Therefore, it may be said that trust propensity in case of UHC is more with the patients coming from informal sector such as domestic and or labor category of people.

## **Dimensions of trustworthiness**

Trusting behavior may be a function of several attributes which may be called dimensions of trustworthiness. Patients' may base their trust perception on doctors' in UHC considering a number of factors. From patients' perspective such factors are commitment, competence, cooperation, privacy and confidentiality maintained during treatment, establishing rapport and communication and demonstrating proper behavior and demeanor. Each of these attributes may contribute towards building patients' trust in UHC.

## **Are doctors at UHC committed?**

Doctors' commitment to patients is seen to be part of their fiduciary responsibility with regard to treatment and care. Doctors' commitment to the patients is operationalised by the demonstration of sincerity to their work, their timely attendance at emergency, OPD for outdoor services and routine visits at IPD i.e. general wards of the UHC. Commitment of the doctors is visible when a patient is rightly diagnosed and necessary treatment is followed. A committed doctor may be seen to render services with utmost sincerity with no sign of negligence or opportunism. In an emergency situation critical patients require urgent medical attention. A committed doctor may attend the emergency patient beyond their normal duty hours to attend the patient until shift changes take place and the next duty doctor takes over. Commitment to work may be derived from one's sense of responsibility and dedication towards profession. Chi-square test between patients' trust and doctors commitment show strong significance ( $p=.000 < 0.05$  level). In order to measure doctors' commitment, patients were asked to rate in a Likert scale whether they agree on the following broad statement: *"Do you think that the doctors working at the UHC generally treat patients with utmost sincerity and commitment"*. 91% of the respondents reported that they think that the doctors at UHC display commitment while they treat patients. Only 7% of the respondents disagree with the statement which means that doctors are not necessarily committed

to patient's treatment and care. Only 2% of the respondents reported that they 'do not know'.

Patients' perception that most of the doctors at UHC are committed to treatment at UHC are observed phenomenon. This observation may be based on their contact time with the doctor at OPD or IPD at UHC or from perception developed over a period of time. Commitment of doctors may also vary from one doctor to another. Doctors' commitment is perceived to be high in patients when doctors behave responsibly, are sincerely responsive to patients and remain available in their duties without failure. Availability of emergency medical officers and providing effective treatment even at mid night may suggest a doctor's sense of responsibility and commitment to patient's welfare. However there may be exceptions and not all doctors at UHC may display commitment equally. Doctors' commitment may depend on their motivation and personal goal and must be seen holistically considering the environment they live and work which is observed to be de-motivating to many. From the findings of the survey it may be inferred that in general doctors' commitment in UHC as perceived by patients is high.

### **Patients' perception of doctor's competence**

In order to assess patient's perception on competence of doctors, patients were asked to *"what extent they agree that the doctors at UHC possess the requisite qualifications and experience in delivering effective treatment to the patients?"* 92% of the patients think that the doctors placed at UHC are competent and qualified enough to treat patients as general physicians. Specialists such as consultant physicians for eye, neurology, orthopedic etc. are also available at UHC. Only 5% of the patients think that the doctors at the UHC are not competent enough to treat all kind of patients. Only 3% of the patients answered that they 'do not know'. Though to an illiterate person doctor's competence is often equated with the notion of "bara daktar" (meaning big doctor) who is a government appointed doctor at UHC. Doctors posted at UHC are duly registered by BMDC on the basis

of their qualifications and given authorization to do practice. From patients perspective competence of doctor may be seen as the ability to provide necessary treatment which would bring positive health outcomes. Competence is seen as the doctor's ability to cure them by prescribing the right medicines or certain urgent procedure and bring quick relief or comfort to the patients. Competence of doctors may be based on patients' prima facie judgment and their earlier experience. Therefore, a doctor's competence is judged by patient's earlier experiences. If earlier experiences are favorable on health outcomes, patients tend to consider the doctors as competent.

Prima facie assessment of doctor may be based on his physical appearance, behavior and demeanor. Doctor's role is to diagnose illness and prescribe treatment to the patients. In some cases they may have to resort to surgical interventions. Major part of the treatment in UHC is dominated by physical examinations and rudimentary tests as may be required. Patients with more complicated symptoms or critical conditions are often referred to secondary or tertiary level for treatment. However, doctor's competency at UHC may vary from general physicians to consultant physicians who may provide specialized services. Competency of doctors in utilizing their full potential in UHC may also depend on the availability of necessary equipment and associated resources to render effective services to patients. For example for a cesarean operation, a doctor may require the services of an anesthetist, other operation team members, sterile surgical appliances and an operation theatre which may be considered safe for any surgery. Retention of qualified and trained doctors and nurses at UHC stands as a major challenge towards effective treatment. Even though the doctors may appear to be competent and experienced but their non-retention or non-availability may affect quality services in UHC. Competence of doctors may also have dysfunctional effects as some doctors may indulge themselves in opportunism. Opportunistic behavior of doctors may take several forms which often becomes self-serving. Seeking transfer for attractive work places or seen irregular at work are deviant behavior and contrary to good practice.



Disciplinary actions against the non-compliant doctors may often become ineffective. Many competent doctors posted at upazilas are attached to tertiary institutes at Dhaka by the Health Directorate though they draw their salary from upazila where they might be posted. The patients are therefore, deprived from the services and their expertise does not bring any benefit to the patients. However, from the survey it is inferred that majority of the respondents think the doctors in UHC are qualified and demonstrate necessary competence.

### **Extent of cooperation**

The level of cooperation while at treatment may also build patients trust on doctor's in UHC. Cooperative attitude demonstrated by doctors and nurses towards patients may promote respect and reciprocity. Cooperation may be demonstrated by the usual proactive actions and advice to the patients for their benefit and for prompt delivery of services. Prompt delivery of services within UHC is also dependent on internal coordination among different units. In such a situation malfunctioning of a unit may block prompt service and defeat the spirit of cooperation. Though much of the services which require cooperation may be rendered by nurses and other medical staff, but doctor's leadership role is very much needed to create a cooperative environment. In highlighting the nature of cooperation between patient and doctor, there may be instances when lack of direct attention to a particular patient may appear frustrating which may lead to distrusting behavior. Bringing this issue of cooperation in the context of UHC is relevant from treatment perspective where the patients need to cooperate with the doctor and share all the information with regard to treatment. Likewise the doctors at UHC need to focus on the patient so that they feel that they are properly attended. In order to assess the level of cooperation extended towards the patients at UHC, respondents were asked *"to what extent doctors extended their cooperation towards you during consultation and treatment?"* 78% of the respondents reported that doctors were moderately cooperative, 13 % reported that they were highly cooperative and only 7% reported that cooperation from doctors was low. It is therefore

inferred that the doctors are generally cooperative towards the patients in UHC.

### **Nature of privacy and confidentiality extended to patients at UHC**

Privacy and confidentiality of patients with regard to treatment to a doctor may be essential for building trust. A female patient is expected to be more comfortable with a female doctor rather than a male doctor with regard to easy communication for disclosure needed for treatment and also maintaining privacy. Privacy may be breached when patients are exposed during examination in a manner that others may over hear or see. It may also mean showing respect for the patients and guarantee an assurance that the patient's vulnerability as far as the disease is concerned will not be exposed to other patients and privacy of female patients are maintained during examination. In order to assess observance of privacy and confidentiality at UHC, patients have been asked whether they have been examined in front of other patients and their privacy and confidentiality were breached in a way that made them embarrassed. The usual outcome of a breach of privacy is that patients may feel embarrassed which may interrupt proper treatment leading to discomfort and may hinder trust development. Lack of privacy may also inhibit patients to express freely during consultation with the doctor.

According to the survey, 41% of the patients reported that the privacy and confidentiality level at UHC is generally low. 46% of the patients reported it to be at moderate level and only 3% of the patients think that it is high. At the outdoor services a patient is served with a token and assigned to a particular doctor. Such assignment of a patient to a doctor in a particular room is done at the time of issuing the token. A patient may be examined by a doctor in front of other patients waiting in the same cue when others may overhear the conversation. At UHC, doctors generally sit in a single room with curtains fitted at the door and windows remain pooled so that privacy is maintained. In such a situation, privacy may be well maintained if single patients are examined one by one. There may be situations when

more than one patient may be entering the doctor's room and the doctor examines and converse with the patient in front of others. Privacy during treatment may often be breached when door curtain at the entrance of the doctor's room is dragged by anyone of the waiting patients to draw attention of the doctor and to give a hint of urgency. Apart from that privacy may also mean disclosure of a patient's information to other health care providers and not securing such information.

Low level of privacy may be due to the shortages of available space and more number of patients that a doctor can effectively examine during duty time. In the IPD, in the wards where all the patients are kept are generally crowded with patients and their attendants from respective families. More crowded wards in a particular UHC may likely to have low privacy compared to those UHC where wards are relatively less crowded. In a state of low privacy patients may face discomfort particularly the female patients. Though male and female wards are separate, but there may be male visitors in female wards which limits the privacy of the ward. Privacy of patients can also be seen from the perspective of religious and cultural dimension. Certain districts may display stronger religious and cultural orientations than others. Female patients in veil may demonstrate certain behavior when interacting with male doctors. Likewise, people of some districts and upazilas may be considered more conservative and display certain behavior pattern. Religious beliefs, social values, gender, education etc. may therefore influence patients' perception and sensitivity to privacy and confidentiality during treatment.

**Table 7.19: Patients' Assessment of privacy across upazila**  
n =159

Upazila	Low privacy	Medium privacy	High privacy
Chokoria	38%	63%	0%
Ali Kadam	72%	28%	0%
Gabtolli	25%	68%	7%
Shariakandi	52%	45%	3%
Debiganj	36%	56%	8%
Pirganj	60%	37%	3%

According to the above table, 72% of the respondents of Ali Kadam upazila think that privacy is low at UHC. After Ali Kadam upazila, privacy is also said to be low at Pirganj (60%) and Sharia kandi(52%). Privacy and confidentiality is seen to be at moderate level in UHCs namely Gabtoli UHC (68%) followed by Chokoria UHC (63%) and Debiganj UHC (56%). Only 8% patients of Debiganj, 7% patients of Gabtoli and 3% patients of Shariakandi and Pirganj think that UHC maintains proper privacy during treatment at UHC. This is suggestive that patients' privacy in UHCs is generally low particularly at IPD where patients are treated in general wards. In UHCs there are no provisions for cabins for patients who may look for more privacy. It may also suggest that concern for privacy at UHC is only witnessed by a low percentage of patients, because, most of the patients at UHC are illiterate and poor and their sense of privacy may be less pressing. Lack of privacy in this sense may be due to limitations of physical infrastructure and may also be triggered by the cultural and religious orientations of individual patients. A Chi-square test in patients trust and privacy during treatment at UHC reveal ( $X^2= 36.181$ ,  $df= 16$ ,  $p= .003 < 0.05$  level) strong significance. Therefore, this supports the null hypothesis, 'greater the privacy during treatment, higher will be the level of patients' trust'. Even though privacy in treatment at UHC may be low and breached during treatment at some point, patients' may still trust UHC from the perspective of individual medical needs. This may be due to the fact that UHC is the only health facility where patients have no other choice of available services. Another reason could be that in general patients who may be coming from low economic and social backgrounds may also demonstrate low sensitivity and demand for privacy at UHC.

### **Nature of rapport and communication established during patients' treatment**

Rapport and communication may be vital for patient-doctor relationships. Without communication proper diagnosis and treatment may not possible. Illiterate patient's in particular rural women may face difficulty in

establishing proper communication at UHC. In a typical patient-doctor encounter, the doctor may be interested to take a quick history of the patient about his health problem such as pains or discomforts or history of a patient concerning medications and treatment taken so far. The doctor may begin initial diagnosis by way of some bodily checks such as taking blood pressure, pulse rate or pressing stomach by laying the patient on an examination bed. By checking the lids of the eye, the doctor may ascertain whether the patient is anemic. While checking the patient the doctor may ask if there is any pain that is being felt during a particular press in the stomach or lower abdomen of the body. The patient may respond by signs or expressions to mean aches. The doctor may seek oral response from the patient to further confirm his diagnosis. As such the doctor may encourage the patient to talk and encourage free expression. Many patients particularly the young children often get scared when they see a doctor using some appliances to examine. There may be a situation when doctors do not listen to patients or encourage free expression. Doctors may require sufficient time to examine patients in their chambers at the outdoor facility but overcrowding of patients may restrict their time to examine each patient more thoroughly. Therefore, they often render preliminary examination rather than thorough at the first place and may prescribe for further investigation. There may be variations in patients screening at OPD across UHCs in terms of communication and dedication of time per patient. Adherence to written standard operating procedure for patients screening is yet to be implemented. Its successful replication may improve the current patient screening procedure which may standardize the communication pattern with the patient more uniformly.

In this survey in order to gauge rapport and communication with the doctor, patients were asked, *“To what extent the doctor was found to be communicating in order to have proper diagnosis?”* 71% patients agree that rapport and communication with the doctor in UHC is at moderate level, 12% of the patients agree that they had excellent communication with the doctor and only 13% of the patients reported that rapport and communication level with the doctor was low. This may be due to poor

communication ability of both the patient and the doctor. It may also be due to shortage of time on the part of the doctor to examine each patient given the patient load in a particular day. Apart from patient load attitude of doctors towards patient may block or encourage effective communication. The usual model of patient consultation followed in UHC is paternalistic model where it is expected that the doctor would talk and the patient would only respond to questions. A patient may not ask any supplementary question to the doctor for example how the prescribed oral medicines will be taken etc. or it may also happen that a patient may not find any opportunity to ask any supplementary question to the doctor as he may look indifferent and non-responsive. Another explanation for doctor's perceived low rapport and communication with the patients in UHC may be attributed to the lack of proper training and orientation. Even with such limitations of time in holding proper communication, it is inferred that the doctor-patient communication in UHC is seen to be moderately at high level.

### **Do the doctors provide compassionate care to the patients at UHC?**

Compassion is considered as a vital element in physician behavior pertaining to treatment of a patient. Compassionate care may have many benefits in patients' treatment, it promotes more attention to a patient by a doctor and it may also create a healing and satisfying relationship. It may result in more trust on a doctor as the patient may feel that the doctor is competent and would not harm him. It may also promote emotional comfort to the patient. Emotional worries and discomfort may disturb the healing process in a patient. Therefore, compassionate care is vital to the patient-doctor relationships. In this study, compassionate care is operationalized by the amount of time dedicated to a patient and the way the doctor listens and examines a particular patient. Touching the patient by the hand, his or her forehead and talking to the patient directly, asking personal questions often boost up the patient's inner self and may give the patient hope, a meaning for life and ultimately builds a fulfilling patient-doctor relationship. To assess doctor's commitment in providing treatment at UHC the

respondents were asked, *“To what extent they agree that doctors at UHC treat patients with utmost care and compassion?”* 91% of the patients reported that they think that the doctors at UHC provide compassionate care to patients. Only 7% of the respondents disagree that the doctors of UHC are fully committed to their duties and non - compassionate to the patients. Only 2% of the respondents answered that they ‘do not know’. The number of medical officers for outdoor and in-hospital services at a particular UHC is reportedly short and hence existing doctors usually get more number of patients to be examined during the services at OPD. Some patients take more time for examination at outdoor services, while others with fewer complications may probably require less time. But this may give some patients the feeling that the doctor has not listened or attended him or her properly. Doctors view point on the allotted time for each patient during examination is explained by the sheer number of outdoor patients and the limited time available for examining such outdoor services. OPD services are kept open for few hours of the day beginning from morning to noon time. For urgent medical needs emergency services are available throughout the day.

During the survey, it was seen from the outdoor services at UHC that the usual time taken for examining a patient varied from 1-2 minutes. When compared with the time allotted to a patient by a doctor during private practicing, the allocation of time may usually vary from five minutes to 20 minutes or more. It may also depend on the doctor and nature of the health problem. At IPD, the schedule of the doctor in inspecting the general ward begins in the morning. In such visits doctors’ encounter with a particular patient may be very short and cursory. Hence, it can be said to be far from compassionate care. Unless accompanied by someone from home, patients at ward remain alone most of the time excepting the routine follow up of the duty nurses during the entire period of stay at the general ward and have to help themselves while using toilets. On the question of doctor’s compassion, the assessment by the respondents may be too generous or reflect guarded response. In the context of rural society and part of local culture, respondents may often resort to guarded response not

to hostile any service provider in order to avoid any risk of reprimand or loss of future service. Respondent's avoidance of straightforward response or preference for guarded response may also signify calculus-based trust.

### **State of general level of satisfaction on service delivery at UHC**

General level of satisfaction of services in UHC may be dependent on quality of treatment and services and measured by the degree of fulfillment of patients' expectations. Chi-square test conducted to show relationships between patients' trust and quality of services resulted in high significance ( $p=.000 < 0.05$  level). Patients are expected to be satisfied when health response and care in the UHC are prompt, effective, reliable and consistent. General level of satisfaction of patients in UHC is more concerned with clinical treatment and care. Apart from the clinical factors, non-clinical factors such as friendly and professional services in patient care and overall cleanliness of the hospital may contribute to patients' satisfaction. In order to map patients' level of satisfaction in the quality of health services in UHC patients were asked, "*How satisfied are you with the quality of treatment and service delivery at UHC?*" It is found that 82% of the patients reported that they are moderately satisfied with the quality of services at UHC, 13% of the respondents reported the satisfaction level high and only 5% reported their satisfaction level low. This measure of satisfaction on the quality of services at UHC by the patients is based on their subjective judgments on quality and responsive service. For example, for ANC and PNC services; patients' reliance on UHC has steadily increased over the years which resulted in safe motherhood and child care. Like ANC and PNC services, quality of treatment and patients' responsiveness in UHC is consistently kept at a satisfactory level with limited number of physicians and nurses. In the event of complex cases referrals are made where patients are directed to secondary hospitals.



## **Institutional factors**

### **Are services at UHC non-discriminatory?**

Fairness or non-discrimination in the delivery of services at UHC is operationalised by the equal accessibility and opportunity of the patients' to have treatment. Non-discriminatory services at UHC may mean fair treatment to all the citizens and without any neglect based on social or economic status of patients. Discrimination in UHC may take the form of making favor to some at the cost of other patients or depriving some patients to the benefit of others. In general, such discrimination is not visible in UHC; though in private patients often complain that the well off and rich patients draw more care and attention. Making unofficial payments may expedite more caring service, and such notion of unofficial payment in UHC may breed discrimination in delivery of service. In order to map whether the services at UHC are non-discriminatory respondents were asked whether they agree or disagree with the following statement, *"In UHC, treatment is given to patients on an equal basis, no discriminatory practices are being observed."* 84% of the respondents agree with the statement that UHC provide non-discriminatory services, 13% reported that they do not agree with the statement and hold the view that the rich and influential people of the upazila gets better care in comparison to the poor. Only 3% reported that they 'do not know'. Therefore, it may be inferred that services in UHC generally can be called non-discriminatory.

### **Dependency on UHC**

In order to assess patients' dependency on UHC for primary health care, the following statement was asked whether the respondents agree or disagree with the statement. *"The ordinary people at upazila are totally dependent on the services of UHC since there is no other health facility at UHC"*. 98% of the respondents agree with the statement that they are totally dependent on the services of the UHC, 7% disagreed that they cannot depend on UHC and 1% reported that they 'do not know'. There may be three major reasons for patients' dependency on UHC. Firstly,

treatment and medicines offered at UHC are free. This brings poor patients to get medical help at UHC. Secondly, UHC is the single public institution in a upazila having infrastructure to offer reliable treatment by registered doctors and nurses available at arm's length. Thirdly, by pursuing a proactive and a more patient-centric approach, UHC is now having wide network to reach to the patients which also encourages patients to visit UHC more for treatment. In addition to the door to door services provided by the domiciliary workers of UHC, e-health services, referrals from community clinics have expanded the coverage of patients which led to the increased dependency of patients on UHC. Though patients from economically better off background may resort to alternative private care in nearby towns, but most of the poor patients avail the services of UHC. Therefore it may be inferred that there is high dependency on the services offered by the UHC.

### **What is the state of nursing services at UHC?**

In patients' treatment generally the role of the doctor is mostly highlighted and the quality of nursing services is often overlooked. Treatment of patients involves the contribution of both doctors and nurses. Doctors diagnose and prescribe treatment, but it is the nurses who provide systematic treatment to the patients. Patient's perception of quality nursing services involves both combination of skills, professionalism, care and demeanor such as appearance, personality and compassion. IPD patients may experience greater exposure to nurses in the hospital during their treatment compared to the OPD patients. Nurses are expected to give proper attention and care to patients, offer services such as administration of a drug in a timely manner, and perform duties accurately with a friendly and professional gesture. The nurse's quality of services therefore will depend on their competence, ability to provide friendly and professional care and pay respect to individual needs of the patients. Therefore, behavior and demeanor of doctors and nurses is considered important in assessing patients' trust. In assessing quality of nursing services, only the ward patients have been interviewed since they had more contact time with

nurses in wards of UHC to assess and observe their activities and responsiveness. 66% of the ward patients consider the nursing services at a moderately satisfactory level, 9% rate it to a highly satisfactory level and 4% of the patients rate the behavior and demeanor of nurses at a lowly satisfactory level.

In UHC, the expectation for meeting quality nursing services may be challenging since there are shortages of nurses. Current doctor-nurse situation in Bangladesh is 5 doctors and 2 nurses for 10000 populations. This means that supply side of nurses is limited and unless more nurses are recruited to match the growing demand quality of nursing services will continue to face challenges in future. However, any realistic assessment of quality of nursing services at UHC must be done on the basis of available nurses in particular UHC and the volume of patients handled on average per month.

The following table shows the state of available nurses in six UHC's covered in the study.

**Table 7.20: State of nurse availability in Six UHCs**

UHC	No of hospital beds	Sanctioned positions of nurses	Filled in positions of nurses	Occupancy rate of hospital beds (%)	Patient's average length of hospital stay (in days)
Chokaria	50	15	10	129	2.57
Ali Kadam	31	9	7	48.60	1.81
Shariakandi	50	15	7	103.29	4.31
Gabtali	50	17	16	70	3.30
Debiganj	50	14	6	100	3
Pirganj	50	11	11	93.61	1.90

Source: Health Bulletin 2013, Ministry of Health and Family Welfare, Bangladesh

The above table shows the filled in positions of nurses for a particular UHC. It also shows the occupancy rate of beds and length of stay per patient in terms of days in the IPD. With the exception of Ali Kadam UHC, other UHC's had high occupancy rate in IPD. With the exception of Pirganj UHC, all other UHCs have shortages of nurses with respect to sanctioned positions. The nurses render their services on the basis of duty roasters. The duties of nurses are usually designed from 8am to 2 pm, from 2 pm to

8 pm and from 8 pm to 8 am. Besides, there may be absences on account of leave or nurses reporting sick. Many UHC remain over filled with patients in IPD which goes beyond the span of supervision of nurses having 50 patients both in male and female wards. Given the volume of patients, the available number of nurses on a daily basis and their dedicated service to the patient may determine the quality of nursing services in a particular UHC.

The duty nurse keeps record, monitors and administers doses of medicines to patients in a ward. To assess, patient's perception of the nursing services at UHC, patients were asked "*To what extent they agree that the services of nurses at UHC were satisfactory?*" 56 % (n= 86) of the patients at UHC agree that the services of the nurses were satisfactory and only 3% disagree that the services meet the required satisfaction level of patients. Given the volume of patients and number of unfilled positions of nurses, it may be very challenging to provide and maintain quality of nursing services in UHC.

### **Is integrity of doctors at UHC wanting?**

Doctor's integrity has been operationalized by their adherence to moral and ethical standards and not indulging in inappropriate behavior contrary to good medical practices. Inappropriate acts may take the form of irresponsible behavior, negligence to duty and unethical medical practice. Lack of Integrity of the doctors may manifest inappropriate behavior which stands contrary to good medical practice. Most common form of inappropriate behavior displayed by the physicians at UHC is their non-residency at UHC and unauthorized absence from duty which according to civil servants discipline and appeal rules becomes misconduct which is a punishable offense. Doctors posted at UHC are expected to be stationed and live at UHC premises in designated quarters. Most of the doctors with the exception of a few live in the UHC premises and commute from nearby towns. Commuting from nearby towns is seen as unauthorized absence

from head quarter and may often disrupt treatment much to the inconvenience to the patients.

In order to assess doctor's integrity, the respondents were asked if they agree with the statement that *"Doctors posted at UHC stay full time and reside at the UHC and discharge their professional duties"*. 89% of the respondents agree and only 7% of the respondents completely disagreed with the statement. Full information on the availability of the designated doctors is hardly circulated for information of the patient and therefore, patients have little information on the exact number of doctors available or absent in a particular day. Their response to this question is therefore may be based on the available doctors who reside at UHC and find during their visits.

### **Key findings from the survey on dimensions trustworthiness and institutional variables**

The findings from the survey on the variables of dimensions of trustworthiness and institutional variables can be summed up in the following way.

1. In the context of commitment of the doctors, 91% respondent thinks that the doctors are committed towards treatment and patients' welfare. Though there are limited number of doctors and health personnel in UHC, they render their services with utmost sincerity. Doctors' commitment therefore may be credited for increased health coverage in upazila which may be manifested with increased number of patients both in OPD and IPD, in seeking ANC and PNC services and must have contributed to the improvements in several health indicators of the country.
2. With regard to doctors' competence, 92 % of the respondent's report that they think that doctors at UHC is competent to treat patients. Doctor's competence may be assessed to diagnose disease and prescribe appropriate medical advice for patients' wellbeing and early

recovery. Doctors of UHC are appointed by the government and registered by BMDC. Therefore, doctors in UHC treat patients responsibly and with professional care.

3. On the issue of cooperation, 78% of the respondent's surveyed report that the doctors at UHC are moderately cooperative and 13% reported that doctors at UHC as highly cooperative.
4. Considering patients' privacy in UHC, 46% of the respondents agree that privacy and confidentiality was at moderate level and 41% report that it is low. There are variations of privacy perceptions across upazilas which may be attributive to the cultural, religious, economic and social factors.
5. Rapport is considered to be very important for doctor-patient relationships. 71% respondents reported that they think rapport and communication with the doctor was at moderate level, 12% reported that they agree that they had excellent communication with the doctor and 13% of the patients report that rapport and communication with doctor was at low level. Rapport and communication between doctor and nurses may improve if 'patient-centered' treatment approach is pursued and doctors and nurses are properly oriented to provide proactive services.
6. With regard to providing compassionate care it is found that, 91% of the respondents reported that doctors at UHC provide compassionate care to the patients. Only 7% of the respondents disagree that the doctors at UHC are compassionate. To the patient compassionate care is meant to be treatment which is provided with respect, sympathy and care which may take both verbal and non-verbal expressions.
7. With regard to general level of satisfaction on the quality of services in UHC, 82% of the respondents reported it to be at moderate level, 13% reported that it was high and only 5% reported low.
8. On providing non-discriminatory services, 84% of the respondents reported that in general they consider the services of UHC as non-discriminatory. 13% of the respondents differed with the statement and

think that there may be deviations in providing non-discriminatory services when favoring the rich and influential people of the upazila.

9. For dependency on UHC, 98% of the respondents reported that they were dependent on UHC for medical assistance and other health needs. Only 7% disagreed that they cannot depend on UHC instead they seek alternative medical care outside UHC. Patients with complex cases were referred to district hospitals for further treatment. As the services are free of cost, the poor are mostly dependent on UHC though the patients who are better resourced may also be initially treated at UHC and may later seek alternative treatment outside.
10. About quality of nursing services, 66% of the respondents at IPD reported that the quality of nursing services were moderately satisfactory, 9% reported it as highly satisfactory and 4% reported to be at low level. In order to improve the quality of nursing services at UHC, the current nurse-patient ratio needs to be further streamlined. In order to streamline service delivery at UHC, more nurses and cleaners are needed to provide more caring services to the patients. The role of the nurses in patient's care and service delivery is often over looked and this needs to be recognized and further strengthened.
11. With respect to doctor's integrity, 89% of the respondents agree with statement that doctors posted at UHC stay full time and reside at the complex premises and deliver their services. 7% of the respondents agree that doctor's integrity and sense of professionalism are tainted as many do not reside in the UHC premises. Physical presence of doctors and their availability in UHC is considered as duty, non-conformity to this and resorting to opportunistic behavior by way of private practicing elsewhere and neglecting respective duties may be viewed as a breach to their integrity. It may be pointed out that patients' have little access to information on the availability of the designated doctors and therefore their views on doctors' full time residency at UHC may be inaccurate and based on their partial knowledge and observation of doctors they see in a particular day. Patients' response on integrity of doctors

pertaining to full time residency at UHC is therefore contrary to the conventional wisdom and understanding.

### Are there any variations across upazilas in terms of trust in UHC?

**Table 7.21: Trust across upazilas**

Upazila	No. of patients at OPD	Scale			No. of patients at IPD	Scale			Trust score Mean
		Low	Medium	High		Low	Medium	High	
Chokoria	32	2	30	-	8	1	7	0	3.28
Ali Kadam	4	-	2	-	16	-	13	3	4.00
Gabtoli	15	2	12	-	15	1	13	-	3.39
Sharia Kandi	12	-	12	-	18	4	13	2	3.29
Debiganj	15	-	14	1	15	-	5	10	4.20
Pirganj	16	1	12	3	14	3	8	3	3.67
<b>Total</b>	<b>91</b>	<b>5</b>	<b>82</b>	<b>4</b>	<b>86</b>	<b>9</b>	<b>59</b>	<b>18</b>	

#### Upazila Health Complexes and Patients' Trust

In the above table trust assessment of patients' trust across upazilas in both OPD and IPD has been presented. In the OPD services out of a total of 91 patients, 82 report moderate, 5 low and 4 high trust. In case of IPD out of a total of 86 patients, 59 report moderate, 9 low and 18 high trusts. Chokoria scores lowest mean 3.28 followed by Shariakandi 3.29, Gabtoli 3.39, Pirganj 3.67, Ali Kadam 4.00 and Debiganj scores highest mean of 4.20 which suggests that patients trust may vary across UHC. In order to examine whether there is statistically significant differences in patients' trust across upazilas, one way ANOVA test was conducted where difference between groups show F (7.556) and significant at .000 level. This means that the null hypothesis that there are variations in trust across UHCs is accepted. In this case the F value is larger than 1 which means that the differences in mean are due to something other than the chance factor. Therefore, the differences in UHC in terms of patients' trust are not due to chance factors rather differences may be due to other factors for example presence of doctors at UHC and appropriate treatment, willingness of patients to come to UHC for treatment and follow up.

However, quality in services may differ across UHCs on a number of factors such as patient-responsiveness, motivation of doctors and other service providers to deliver prompt and effective services. UHCs may vary



in resources and quality of treatment though most of the UHCs are having similar strengths of manpower, infrastructure and other resources. Any variations across UHCs in terms of patients' trust may be due to the variations in service delivery which is contingent upon the available medical officers and nurses and their collective efforts to deliver responsive services. Non-clinical aspects such as behavior and demeanor of doctors and nurses, cleanliness of the wards, responsiveness of the doctors and nurses, supply of food and medicines may influence patients trust building across UHCs. The above data reveals that there are not wide variations in patients' trust across UHCs.

### **Regression analysis**

Based on the demographic and identity variables, dimensions of trustworthiness and institutional variables a quantitative analysis of patients' trust in UHC is made below on the basis of a regression model. In the regression model, several demographic variables such as 'age', 'gender', patterns of 'monthly household expenditure' of the respondents were included whether it contributes to trust building. Along with these, other variables in the dimensions of trustworthiness have been incorporated such as 'commitment', 'competence of doctors', and 'general level of satisfaction' at UHC. Lastly, institutional factors such as 'non-discrimination or fairness' in patient's treatment in OPD and IPD, 'dependency of the patients on UHC', 'quality of nursing services' and 'integrity of doctors' have been included in regression model.

In the regression model, model-1 used age, gender and respondents household expenditure. In model-2, variables used in the dimensions of trustworthiness such as doctor's commitment, doctor's competence, general level of satisfaction on the quality of services were used. In model-3, institutional variables such as non-discrimination in the services, dependency, quality of nursing services and lastly integrity of doctors has been used. None of these 3 models could result in higher R square. Therefore, in model-4, 3 variables from demographic and identity

variables,3 from dimensions of trustworthiness and 4 from institutional variables were used to determine their relative strength and contribution to the dependent variable i.e. patients' trust on UHC. In determining the variables, several combinations of variables in each model were run to find out the best fit in the regression model resulting in greater R square.

**Table 7.22: Variables, Definition and Hypotheses**

<b>Variables</b>	<b>Definition</b>	<b>Hypotheses</b>
Age	Binary 15-40 years= 0, 41 years and above=1	Old patients will have low trust compared to the young.
Gender	Binary Male (53%)= 0, Female (47%) =1	Female will have more trust than male.
Monthly Household expenditure	Binary Tk3000-8000(41%)=0, Tk8000-above(58%)=1	Low income households rely more on UHC than those well off in the society.
Education	Binary -illiterate to class VII(52%)=0, up to class-X and above(47%)=1, N=145	More educated have low trust in UHC compared to illiterate or lowly educated respondents.
Distance	Binary distance of 1km to 3 km=0, 3km and above =1	Close proximity to UHC from home may build patient's trust.
Doctors' Commitment	Binary, those who disagree =0, those who agree and says 'do not know'=1	Doctors commitment to patient may influence positively in building trust.
Non-discrimination in treatment	Binary, those who disagree=0, those who agree and say 'do not know'=1	Non-discrimination in the delivery of treatment may promote patients trust in UHC.
Competence of doctors	Binary, those who disagree=0, those who agree and says 'do not know'=1	Competence of doctors makes positive influence on trust. More competent a doctor is, more will he be trusted.
Integrity of doctors	Binary, those who disagree=0 and those who agree and says 'do not know'=1	Patients trust will be high at UHC when doctors demonstrate high level of integrity.
Doctors Cooperation	Binary, those who say cooperation is low to moderate level=0 and those who say above moderate level to high level=1	Doctors' cooperation may influence patients' trust building.

<b>Variables</b>	<b>Definition</b>	<b>Hypotheses</b>
Privacy and confidentiality	Binary, those who say privacy is low to moderate level=0 and those who say above moderate level to high level=1	Patients' privacy during consultation and treatment may enhance trust.
Compassion	Binary, those who say compassion is low to moderate level=0 and those who say above moderate level to high level=1	Patients' trust will be high where doctors are compassionate.
Rapport and communication	Binary, those who say rapport and communication is low to moderate level=0 and those who say above moderate level to high level=1	Patients' trust will be more with high rapport and communication with the doctor.
General level of satisfaction	Binary, those who say satisfaction of overall services at UHC is low to moderate level=0 and those who say above moderate level to high level=1	Greater is the general level of satisfaction on the services of UHC, higher will be patients' trust.
Quality of nursing services	Binary, those who say quality of nursing services is low to moderate level=0 and those who say above moderate level to high level=1	Trust on UHC will be more when quality of nursing services will be considered high.
Dependency on UHC for treatment	Binary, Binary, those who disagree=0, those who agree and say 'do not know'=1	The more patients become dependent on UHC for treatment, greater will be their trust.

**Table 7.23: Regression Model: Patients' trust in UHC  
Factors affecting patients trust in UHC in Bangladesh**

Variables	Model 4 Beta Coefficient
<b>A. Demographic</b>	
• Age	-.089
• Gender	-.058
• Household Income	-.005
<b>B. Dimensions of Trustworthiness</b>	
• Doctors credible commitment	.108
• Doctors Competence	.260**
• General level of satisfaction	.296**
<b>C. Institutional Variables</b>	
• Non-discrimination in the treatment	.047
• Dependency on UHC for treatment	.095
• Quality of nursing services	.268**
• Integrity	.241**
<b>Adjusted R Square .553 at 001 level</b>	

In the above regression model, 10 explanatory variables have been played out against the dependent variable i.e. patients' trust on UHC. Out of these variables, doctor's competence, general level of satisfaction on the services of UHC, quality of nursing services and integrity of the doctors at UHC are seen to be significant in explaining patients trust in UHC.

The adjusted R square in this model is estimated at .553 at .001 levels. Any changes in the combination in the explanatory variables shows changes in the adjusted R square less than the .553. All the explanatory variables presented in the model have been worked out one by one by controlling others with the purpose of reaching to a complete model of analysis Therefore, combinations shown ( in the Table 7.23) appears to be the best fit which displays greater adjusted R square. The most significant factors which influence patients trust in doctors and institutions relate to these above four explanatory variables such as doctors competence, general level of satisfaction, quality of nursing services and lastly integrity of doctors. Most of these variables which appear significant in the

regression model fall in the category of dimensions of trustworthiness and institutional factors. Age, gender, household expenditure, commitment of the doctors, fairness in the delivery of services though apparently considered important constituents of patients trust in UHC, are not found to be significant in the above model. Other relevant explanatory variables which may result in trustworthiness such as cooperation, privacy and confidentiality, compassion, rapport and communication, dependency on UHC for treatment have been found to have little or weak significance in explaining trust in UHC according to the above regression analysis.

The assumptions and the findings from the above model are presented below:

**Table 7.24: Hypothesis and Findings of the Regression Model**

<b>Explanatory variables</b>	<b>Hypothesis</b>	<b>Findings</b>
Age	Old patients will have low trust compared to the young.	Findings of the regression analysis supports the hypothesis with a negative beta weight(-.089)
Gender	Female patients will have more trust compared to the males.	The regression model shows the opposite, where female patients will trust low compared to the male. (-.058).
Household income	Low income households will rely more on UHC than those well off in the society.	Low income group of patients take more services compared to the relatively rich, but household income shows no significant effect in this model
Credible commitment of doctor	More committed a doctor is, more will he be trusted.	Doctors credible commitment to service shows no significant relationship in building trust in UHC
Doctors competence	More competent a doctor is, more will he be trusted.	Competence of doctor is highly significant in building patients trust.
General level of satisfaction on services	Greater is the general level of satisfaction on the services of UHC, higher will be the patients trust	Satisfaction on the services at UHC is highly significant for building patients trust
Non-discrimination of services	More non-discriminatory the services are greater will be patients trust in UHC.	The findings show no significance between non-discrimination and patients trust in UHC

Explanatory variables	Hypothesis	Findings
Dependency on UHC for treatment	More dependent the patients becomes on UHC for treatment, greater will be their trust.	Patients dependency on UHC shows no significance with building trust
Quality of nursing services	Trust on UHC will be more when more satisfactory nursing services will be considered sat when nursing services will be considered high	Quality of nursing services is seen to be highly significant in building trust in UHC
Integrity of doctors	Greater is the doctors' integrity at UHC, higher will be patients trust.	Doctors integrity according to this model is highly significant in building trust at UHC

In studying patients trust in health institutions, the general focus is mainly given to doctors / physicians with minimal attention and focus to the role of nurses. The role of nurses in patient's care and health outcomes is vital, but somehow the role of quality nursing services has been over looked. There is also a basic differentiation of patients trust in doctors or institutions across culture and advanced economies. In advance economies, patients seem to have more delicate relationships with health care providers with insurance systems where relationships are governed and grounded more on legal and normative values. Under that system patient and doctor relationships may be based on delicate norms such as privacy, confidentiality, ethical and moral values, compassionate care etc. While in the developing countries such as Bangladesh where institutional norms are weak and fragile, enforcement capabilities are weak, patient-doctor relationships seem to be grounded on more personalized relationship that may prompt faster and responsive care. Quality of treatment and care may become expensive which may favor the affluent people only while they may seek services in private hospitals. In government hospitals quality of care and treatment cannot be at par with the private services, nevertheless from equity perspective, public hospitals also require to deliver and ensure quality services to the citizens to the best of its ability. From this perspective UHCs need to provide quality care for

the citizens. However, ordinary citizens may not get the best of the services available at UHC but they may have to remain happy with whatever services they may get.

Majority of the users of the services of UHC belong to the lower income groups rather than the wealthy rich sections of the society who can afford alternative medical care. Those users of the services dependent on UHC have little power to make voice and take exit for alternative care. Many explanatory variables relevant in cultures of advanced societies with regard to patient-doctor relationships are found to have weak connections in explaining trust relationships in UHC and found insignificant. For example, privacy, rapport and communication, benevolence, cooperation, reliance seem to have strong relationships with patients trust in institutions but when a regression model is run, it is found to have weak linkage in case of UHC.

The findings of the study also draw attention to the non-clinical aspect of PHC which may have relevance from policy perspective. Building and investing on developing patient's trust may enhance satisfaction and improve quality of care. This may also help in achieving greater health outcomes for the society. The health policy of Bangladesh mentions access and quality in the discharge of primary health care. Though there is no explicit mention about the element of trust in the health policy; a new dimension on promoting patients' trust may add quality and proper utilization of resources in the delivery of primary health care.

The following sections present qualitative data i.e. information gathered from interview of key respondents, cases of patients during the field visit and other secondary sources of information gathered for the study.

## **Qualitative analysis**

### **Does trust matter for patients in UHC?**

Two questions seem relevant whether patients should trust UHC for treatment and whether they should trust the doctors? Trusting UHC may have something to do with its reputation, past experiences of patients. While trusting a doctor may be more based on one-to-one basis and may be at one point it may be called particularized trust. In both cases doctors play an important role in building trust. Individual trust of patients collectively may become generalized trust. During the survey patients' were asked whether they should rely or trust a doctor. The answer is as given by most of the patients is that the 'doctor will heal without hurting' therefore they should trust the doctors. Fear of a surgical operation or inserting a needle for injecting medicines may be quite frightening to many patients particularly to the young children. Many young children are found to cry out loudly as their parents help them to take an injection for immunization. Though the patient may believe he will be cured, nevertheless there may be fear of having surgical procedure which may justify the basis of trust.

For surgical procedure, it is quite common to consult a specialist having good reputation to carry out operation successfully. For surgical procedure, the common practice is that a patient is referred by a general physician to a particular surgeon. Generally, the general physician is expected to refer it to a competent surgeon. But in many cases, the patient may be referred in a place where there may be a nexus between the private service providers maximizing opportunism. As such to guard from opportunistic behavior, every patient may need protection from opportunistic behavior of doctors so that their vulnerability will not be exploited. Therefore, patients' need to trust their doctors for proper treatment and cure, but at the same time institutions should guard against opportunism. For elucidating the importance of trust in doctors in UHC, the following case may be helpful in understanding the complex nature of a patient's trust towards doctor. The



case is recorded when the researcher served as Upazila Nirbahi Officer of Gangachara upazila of Rangpur district in Bangladesh.

**Box 7.2: A Case of Barabil Union, Gangachara Upazila, Rangpur**

**Case no.1**

This is a case of Barabil Union, Gangachara Upazila in Rangpur district of Bangladesh. Gangachara upazila has a history of severe river erosion from once mighty river Teesta which resulted in hundreds of poor families in displacements. In 1990, the whole of Gangachara Upazila was seen to be affected by the outbreak of diarrheal disease. The epidemic was spreading so fast that emergency medical teams were formed and operated in several unions. The whole upazila was kept on alert in search of new cases of diarrheal patients so that there had been no casualty. Patients were given intravenous saline and medicines which was very instrumental in quick recovery of patient. While the search for new patient was going on and the emergency health camps were working in full swing, a Member of the Barabil union reported that Mr. Yasin Ali Pramanik who was a poor farmer of Barabil Union was lying unconscious with acute diarrheal symptom. He declined to report to any of the emergency centres operated by the UHC. Suddenly, the Upazila emergency team headed for his home and found that Mr.Yasin was lying on a damp floor with a blood clogged intravenous saline needle hanging beside him. On examination it was revealed that Yasin Ali's case was an acute case of dehydration from diarrheal disease and for his survival he needed to be hospitalized immediately. While the team was escorting him for UHC, he resisted with his weak and fragile health condition. He was crying with fear when he learnt that he was being taken to UHC. Later it was discovered that Mr.Pramanik had a fear factor working deep inside. One of his close relatives died in UHC and in his subconscious mind he had a feeling that same would have happened to him if he were admitted to UHC. Therefore, he was resisting and wanted to remain in his home. The emergency team forcibly took him to UHC and he was given immediately intravenous saline in both of his hands simultaneously as he was in a critical state with body fluid reaching at an extremely low level. After, intensive care, he recovered in two days time and went home.

Another case of a patient where trust in doctor had been critical to patient's decision making:

**Box 7.3: Story of a patient concerning trust in doctors****Case no.2**

“Mr. Shafikul Islam (pseudo name) had been found to be a patient of gall stone as tests suggested that his gall bladder developed multiple calculi. He was advised by the doctor to remove the gall bladder immediately otherwise this could lead to infection and complications. Gall stone removal requires surgical procedure which also requires the patient to be on general anesthesia. Prior to the surgical procedure several tests are required to confirm that the patient is physically fit to undergo surgical procedure for removal of gall bladder. In Bangladesh, gall bladder stones removal through laparoscopic surgery in early part of 2000 was a well known procedure though not too many surgeons had necessary training on such surgery. Laparoscopic surgery was only available in the private clinics and hospitals in the capital city. Hence, the only option was to take such services from private clinics or hospital.

Shafikul had to consider several factors for taking decisions such as i). the competence of doctor to do the task effectively without any harm, ii). the fear of the operation theatre and recovery from general anesthesia, iii). total cost of the surgery, iii.) post operative care and recovery. To avoid surgical procedure, Shafikul was also exploring the possibility of alternative treatment such as homeopathy. But after some time, he was advised by one of his relative to consult one of her known doctor to undertake laparoscopic surgery. The recommended doctor was quite well known at that time. Shafikul decided to see him. The doctor explained how the surgery would be carried out and also showed some video how the procedure will be carried out. The date for surgery was fixed. Shafikul was found to be nervous prior to the surgery and several relatives came to assure him. In the Operation Theatre, the anesthetist assured that Shafikul would not be hurt as he patted his head. This consoled Shafikul and soon he fell in to unconsciousness. When he woke up he found himself in a post operative room several hours later he was shifted to his cabin. Shafikul had the laparoscopic operation successfully done and was released the following day from hospital”.

The above cases are suggestive that trust in doctors is absolutely necessary for treatment particularly when a surgical procedure is required. The risks in surgical procedure may be high compared to the non-surgical procedure. Both the patients had fear and initial problem of trusting the doctor with regard to the treatment. In case of non-surgical procedure, there may not be any imminent risks from the treatment, but the patient need to know that the doctor is competent to diagnose and give proper treatment without risking any bodily harm. In the first case, the death of one

of the close relatives of the patient in the hospital led to the problem in not trusting the UHC. Secondly, there was a fear factor which led him to think that similar consequence might also happen to him in case of treatment at UHC. Therefore, he refrained from taking services from hospital. In the second case, the fear of the operation theatre and the requirement to keep the patient unconscious under general anesthesia was a cause of concern for Mr. Shafikul Islam amounting to certain risks. This kind of fear may be common to all human beings prior to any surgical procedure. Nevertheless, in such cases a patient may trust an operating surgeon who may be known to him or who has established reputation as a skilled surgeon. Without trusting a doctor, a patient may not avail any treatment; likewise, a doctor may also need patients' trust to provide appropriate treatment to a patient. Therefore, having mutual trust towards each other may serve both the parties i.e. patient and the doctor equally for effective treatment.

#### **What is the level of commitment of doctors at UHC?**

Commitment of a doctor can only be observed and experienced over a period of time. Commitment to one's duties only comes from sense of responsibility and motivation. Commitment to one's duties may result in sincere and responsible services towards patients which may build a reputation that a particular doctor is committed. Doctors' commitment may benefit patients in delivering responsive services. It may also fulfill a patient's personal expectation from a doctor and give him more satisfaction. It may be demonstrated through hard work and empathy for the patients. Information from two key respondents when interviewed during survey at Pirganj upazila under Thakurgaon district is produced below in verbatim to capture the essence of commitment of doctors with regard to treatment at UHC.

**Box 7.4: Case of a patient, Chairman, Pirganj Sadar union,  
Thakurgaon**

**Case no-3**

Mr. Motiar Rahman (pseudo name) is a Chairman, Sadar Union Council was admitted to the UHC hospital for treatment for several days. As a patient and also as a local elected public representative he expected more attention and care from the UHC authority. His expectation as a patient for personalized care and also as a local elected representative was not met. He did not get due attention as an elected representative from the UHFPO and the medical officers to enquire about him and also to assure him of his early recovery. He was disappointed and wondered that as local political elite he did not get any attention in UHC and treated like ordinary patients. UHFPO did not visit him while he was admitted in the hospital. He wonders how the ordinary patients are treated since as an elected public representative he was not attended by the UHFPO during his stay in hospital. He said, services have deteriorated over the years. Many patients are diverted to private clinics for better care. There are shortages of medical doctors particularly for eye and dental care. He observed that only few doctors reside at UHC while others live in towns and commute. Therefore, he said that the commitment of the doctors of UHC in delivering responsive services may often be questioned. But there may be few exceptions too.

**Box 7.5: Interview of a teacher, Pirganj Pilot High School,  
Thakurgaon**

**Interview 1**

The head teacher of Pirganj Pilot High School informs that the services at UHC have improved in recent years. The placement of local doctors to serve the residents of upazila has helped to provide services with more commitment. Mostly poor patients receive services from UHC; the affluent members of the society have access to medical services offered at private clinics in towns. Non-local doctors have a tendency to seek transfer when they are posted. The services of UHC will be more trustworthy when such services become responsive and beneficial to the patients. As far as commitment of the doctors at the UHC, not all doctors are equally motivated and committed. There are exceptions. However, according to him, monitoring and supervision can improve the commitment of the doctors.

**Box 7.6: Interview of UHFPO, Gabtoli, Bogra****Interview 2**

UHFPO Gabtoli informs that doctor's commitment to patients is a professional responsibility. At times, there may be minor lapses in prompt delivery of services. But it cannot be said that all doctors are not committed. The real test of commitment of doctor lies in the service of the patients. He says that for developing a healthy and trustworthy doctor-patient relationship, the doctor's full length of tenure at a UHC should be maintained. Sense of commitment and service to the patients can ensure a doctor's trustworthiness.

In summing up in assessing commitment of doctors, information on the basis of interview and case of a patient, it is inferred that not all doctors display commitment in the delivery of treatment and care. Many doctors do not reside in the UHC premises or upazila head quarter and commute from nearby towns. Many doctors remain unauthorized absent for which disciplinary actions are also drawn against them from the Ministry. But those who remain in the UHC premise they tend to provide responsive services and display commitment to their duties.

**To what extent doctors at UHC are perceived to be competent?**

Doctor's competence at UHC is hardly challenged by the patients in providing treatment since doctors are posted by the government. But doctor's reputation as a competent doctor may vary. At UHC there are medical officers and also specialist consultants to offer specialized care. Therefore, it can be said that all doctors are competent as a general physician but there are consultant physicians who are specialists on certain disease or procedure. From the discussion and interview of patients it is revealed that ordinary patients are not aware of the professional degrees attained by a particular doctor and competence is hardly challenged, rather their perception of competent doctor is someone who is a '*bara daktar*' (meaning qualified and experienced doctor). The following case was observed in Gangachara upazila under Rangpur district when the

researcher served as a Upazila Nirbahi Officer and presented in order to explain the intricacies while the concept of competence is used with reference to treatment.

**Box 7.7: A Case of health intervention with negative impact**

**Case no- 4**

Health intervention such as immunization or administration of drug for the prevention of certain diseases always faced some initial challenges during launching as people may be skeptic about the perceived health benefits and hazards. Likewise, for family planning programs, choosing family planning methods by the male or female persons had been always difficult. The poor people were allured with some financial and material benefits and were targeted by family planning staff to motivate them for adopting permanent methods. In the campaign for adopting family planning methods, there was widely held views across the male population in upazila that adopting permanent methods by the male persons would reduce them to a weak person unable to do any physical work. Despite such beliefs several male fertile persons were operated by Medical officer of Health and Family Planning (MoMCH. In one occasion, it was observed that one male patient who underwent surgical operation as a permanent family planning method at UHC, later found to be fertile as his wife became pregnant. On investigation, it was revealed that as instructed by the doctor he did not abstain himself from unguarded physical copulation for certain period of time since the surgical procedure was carried out. As a result, despite the permanent procedure, it resulted in such unintended result. It was found that though the procedure was technically sound, but the result was undesirable which had put a dent on the doctor's reputation and competence. There has been a breach of trust on the competence of the doctor, though the fault was with the patient.

Another case is presented below when doctors in UHC can perform extra ordinary task and save human life.

**Box 7.8: A case of survival****Case no-5**

During the survey in Debiganj UHC, Panchagarh district it was found that a male patient aged 27 approximately who swallowed poison i.e. insecticides used for agricultural purposes. Poison cases are often brought to UHC which becomes life threatening if not given urgent medical response. Many poison cases are found due to using insecticides without protection, many also swallow poison out of emotional breakdown. One such case of poisoning was found in Debiganj UHC during survey. The patient was immediately taken to UHC in critical condition. As reported by the attending persons, the patient swallowed poison i.e. insecticides used in agriculture out of dispute leading to emotional breakdown. He was found screaming with severe abdominal pain, burning sensation in chest, vomiting and later with impaired consciousness. As the patient was taken to the emergency, the emergency medical officer who was available on duty treated the patient promptly. For poison cases, a patient is treated by stomach washing so that no trace of poison remains in stomach. The procedure has to be done very promptly as any delay can damage the kidneys of the patient and the consequence could be life threatening. Few hours later after the medical procedure was done by the doctor, the patient became slightly stable. The patient survived by the prompt and appropriate medical intervention. The availability of suction machine was instrumental to the procedure without which the doctor could not have given any treatment. The patient survived since the doctor was available who was competent to deal with a patient in critical condition and also the hospital had the necessary equipment for emergency use.

From the above cases it transpires that competence of doctor can be assessed on the basis of proper diagnosis of illness prompt and appropriate response and health outcomes. A cure is only visible after the surgical procedure or administration of medicines has been completed. In some cases patient may take longer time for cure. But in such cases, doctor's competence may not be questioned unless second opinion from another doctor is taken. Doctors' competence is demonstrated through his skills, diagnostic capacity and ability to give proper treatment. Therefore, if doctor's competence is assessed on the basis of health outcomes which may mean the appropriate treatment by the doctor, then doctor's competence can also rest on patient's cooperation and adherence to the instructions given by the doctor for best results. But for achieving positive health outcomes, doctor's proper treatment and cooperation of patients is

inseparable. In UHC some nominal diagnostic test facilities are available while most of the advanced procedures for diagnosis are non-existent. Hence, patients are advised to carry out diagnostic tests from private laboratories outside.

Such incidence of managing poisoned patients is suggestive that doctors of UHC are competent in managing critically ill patients. But delay in giving urgent medical response may put a patient vulnerable which may cause death of a patient. This may put a dent on the competence of the doctor as casualty due to delay in taking the patient in the hospital will hardly be considered with possibility of backlash. Based on the observation during the survey, most of the patients are unaware of the doctor's competence level. What they may be aware of is doctor's reputation when referred by family members or villagers. It is also found that many patients, who are treated and given medicines, still complain that they are not cured since they were treated by the doctor many times. It is also to be noted that while many patients have such observations, they also tend to forget that that old age complications of patients often prolong full recovery. Certain diseases may be chronic and therefore may take long treatment and still full recovery may not be possible.

### **Perceptions on doctors' competence and service delivery**

Doctor's competence can also be measured by the volume of reported service delivery in a particular UHC. Apart from the OPD and IPD services, a key feature of service delivery at UHC is the ANC and PNC services. In order to assess, competence of doctors posted at UHC, data on health service delivery at Pirganj Upazila, Thakurgaon district (2008 to 2012) are presented below.



**Table 7.25: Health Service delivery at Pirganj UHC, Thakurgaon**

Year	ANC recipients	No. of deliveries	No. of deliveries through caesarian section	PNC services	No. of maternal deaths	No. of death of newborn
Jan-Dec 2012	6480	1569	154	3681	1	7
Jan-Dec 2011	4448	1147	64	2667	4	4
Jan-Dec 2010	817	1072	43	1039	1	5
Jan-Dec 2009	594	1064	8	1064	0	0
Jan-Dec 2008	94	982	0	158	0	0

Source: Data on UHC Pirganj, Thakurgaon, Bangladesh.

From the above data it shows that ANC services and caesarian operation has increased significantly over the years. This suggests that more people are now dependent on the services of UHC. This may also further suggest that the services of UHC are considered safe and trustworthy. Caesarian operation is considered as a major operation that takes place at UHC which requires appropriate surgical skill and competence of the doctor. Though there were some cases of maternal and newborn deaths in the above years, the ANC and PNC services have increased significantly which explains mass awareness of people and perceived competence of doctors in providing particular health response and their trustworthiness. Other UHCs under the study also demonstrates similar trends towards providing ANC and PNC services which may suggest similar competence of doctors.

### **Doctors' competence and opportunism**

Doctor's competence may develop potential for opportunism and encourage commercialization. Commercialization may be exhibited by the

doctors apart from his or her official duties by way of providing treatment to a patient with the motive of private practice. It may be argued that more competent a doctor is, more will be his scope and inclination for opportunism while delivering health services. Opportunistic behavior demonstrated by increased commercialization may result in less attention paid to patients at UHC instead encourage recruitment of patients for private practice. Opportunism may also encourage competent doctors to seek transfer in places where private practices will be more rewarding. Unless such opportunism is addressed by adequate measures such as having administrative, ethical and moral standards, this may affect quality of service at UHC. The notion of doctor's competence may also be subdued with the prominence of politicization in medical profession and decline in health service delivery at UHC. Politicization may also put incentives to professionals to engage in politics or may encourage in dysfunctional behavior undermining their professional knowledge and skills.

While talking to many patients and from the observations during the interview, it is revealed that serious patients such as cardiac or kidney patients cannot be handled by UHC since there is no proper facility for treating those patients. Those patients are referred to secondary or tertiary level of health care. While talking to some key informants in the study area, it is learnt that well qualified doctors do not continue in a particular UHC for long. Qualified doctors can hardly be retained in UHC as they manage transfer quickly to their best advantage depriving patients of their services. Many key informants informed that the UHC services are good only for some common diseases, initial health check up and for referral. As a first point of contact it delivers quite effective services for some diseases such as fever, cold, UTI, Asthma, minor surgical operations such as cesarean, tubectomy etc. It may be inferred from the above discussion that though competence of doctors in UHC is desirable and expected, nevertheless, competent doctors are hard to retain. Unless, adequate incentive structure along with monitoring and control system is in place, competence may only make room for opportunism at UHC. A case of a patient when interviewed

during survey at Gabtoli Upazila under Bogra district is produced below in verbatim to capture the essence of treatment in UHC.

### Box 7.9

#### Case no.6

#### **Abdul Jabbar(pseudo name), Village: Khidirpur, Gabtoli, Bogra**

Abdul Jabbar is a married person aged 40 years. He visits UHC whenever he needs some treatment. He also visits Bogra for better treatment. Last time he visited the Gabtoli UHC was about two months back. He lives close to UHC as such it is easy for him to visit UHC quite frequently. Every time he visited UHC, he was properly treated and given medicines. He did not have to buy any medicine from outside. He says most of the time he found the medicines supplied at UHC were adequate and he did not have to buy from outside. Doctors are found to be available during outdoor hours. But in some instances he had to wait for the doctor. He could communicate with the doctor properly and the doctor was found to be quite communicable. Last time he visited UHC was due to cold and fever. The doctor physically examined and gave medicines. There are shortages of doctors and most of the time he was treated by the health assistant whom he could not trust just like trusting a doctor. The medical assistant is experienced in dealing with common cold, fever, headache but he cannot be relied. Many patients cannot properly communicate or explain their problem to the doctor. They need help. Many doctors commute from Bogra town and they do practice in private clinics. Private practicing may be good for patients to see doctor beyond office hours but may impact on quality of service at UHC.

From the above case it transpires that there are shortages of doctors at some UHCs which may often force the UHC to use non-doctors such as health assistants at OPD. Service delivery at UHC often suffers due to a large number of unfilled positions of doctors. The existing doctors often remain busy with the extra load of patients therefore they may have to rely on paramedics and health assistants during consultation at OPD.

Form the above discussions it may be inferred that the doctors posted in UHC are in general competent, but due to non-availability of the required equipment and support staff, manpower shortages from unfilled positions, proper treatment may often be delayed. It is also inferred that opportunistic

behavior of doctors may indulge them more actively in private practicing outside UHC by recruiting patients while depriving many others at UHC.

### **Is patients' privacy at UHC considered as a barrier for treatment?**

Concern for privacy would be more with the population where people are seen to be more dogmatic and strictly observes religious values and rituals. A case of a patient when interviewed during survey at Shariakandi upazila under Bogra district is produced below in verbatim to capture the essence of privacy and confidentiality maintained in UHC.

#### **Box 7.10**

##### **Case no-7**

**Amina Khatun (pseudo name), Kuptola, Shariakandi, Bogra (Aged-50 years):**  
Amina is married and has one child. She always goes to UHC whenever there is a medical need. Last time she visited was about one month ago. As prescribed by the doctor, Amina finds most of the medicines from the UHC. On one or two occasions she had to buy medicines from local medical stores. Her monthly expenses on medicines amount to Tk 400-Tk500. She finds it easy to see a doctor at UHC and she is quite satisfied with the services from doctors. She says that she could explain her health problem to the male doctor with no hesitation but the level of privacy during treatment particularly for the female patients need to be improved. Patients are often examined in front of other waiting patients. This creates embarrassment for many. She says that she trusts the doctor who treated her and she is happy with the level of services offered by the UHC. She believes that the doctor treated her with kindness and generally treats the patients with care. She believes that the behavior and demeanor of the doctors, staff and nurses may be improved for better care and the number of available medicines at UHC needs to be increased.

According to the above case, patients' privacy during consultation and treatment at UHC needs to be improved. Patients' privacy is more relevant from the perspective of female patients. Regional variations in culture may also influence the degree of privacy and confidentiality required during treatment at UHC.

## To what extent doctors at UHC demonstrates compassion towards patients?

Compassionate care of patients is very much needed for effective service delivery. Patients are often subjected to neglect as they are often unattended. Text of a patient's interview during survey at Gabtoli Upazila under Bogra district is produced below to capture the essence of compassion of doctors in UHC.

### Box 7.11

#### Case no- 8

#### **Syed Ali(pseudo name), Unchorki,Gabtoli (Aged- 42):**

Syed visits UHC whenever there is a need for medical services. Last time he visited was about one year back. According to Syed, doctors at UHC are generally trusted because they are qualified doctors appointed by the government. Compassionate care of patient is often not possible when there are more patients. But when the number of patient is less, doctors give more time and they do not hurry. As the number of patients in outdoor services is generally high, one doctor is pressed for time to see patients quickly. There are also pressures from waiting patients as they do not want to wait for long. He says that he did not find any difficulty to see a doctor and he could explain his problem to the doctor quite freely. He says that he is happy with the services rendered by the doctor who was also kind to him. Despite insufficient number of doctors, the attending doctor was compassionate to him and extended expected care during treatment.

Another case of patient at Gabtoli Upazila under Bogra district is presented below:

### Box 7.12

#### Case no-9

#### **Rahima Begum(pseudo name), Parani para, Gabtoli, Bogra (Aged- 45 years):**

Rahima comes to UHC when she needs medical treatment. She also visits and consults doctors outside UHC. Last time she visited UHC was about six months back. The quality of treatment at UHC is quite good but there is a shortage in the supply of needed medicines. She says that she did not have difficulty either in seeing or communicating with the doctors. She says that doctors are trustworthy but at times they are busy with patients and cannot give more time to a single patient. Not all patients are treated with care and compassion but for poor patients at UHC services are free what else could more be expected. Generally old and female patients receive more compassionate care from the doctor. But not all doctors are same. The services of UHC will be more trustworthy if doctors become more attentive to patients and if medicines availability is enhanced.

From the above sources of information, it may be inferred that not all patients receive compassionate care at UHC. In general old patients, young children are more prone to receive compassionate care in comparison to young and male patients. The nature of patient-doctor relationships prevalent in the UHC does not demonstrate practice of compassionate care in patient's treatment. It is more so as because the services of UHC are free and the doctors often lack incentives to provide compassionate services to the patients.

### **State of general level of satisfaction and quality of services at UHC**

People may have variations in their level of happiness and perceptions about the quality of services in a particular UHC. Information from some key respondents about the quality of services is produced below:

#### **Box 7.13**

##### **Interview 3**

##### **Interview of a Teacher at Gabtoli Purbapara Government Primary School (Age- 43 years):**

The teacher says that he often visits UHC for treatment of the school children. He says that objectively speaking the services at UHC is far from being of quality services and at a satisfactory level. No local doctor posted at Gabtoli UHC resides at UHC. The quality of services at UHC needs to be improved. The well to do people of this upazila goes to the district for medical treatment. In UHC it is the poor who visits the most.

#### **Box 7.14**

##### **Interview 4**

##### **Anisul Haque Key informant, Debiganj, Panchagarh:**

When he visited last, he found the services of UHC quite satisfactory. He says that not all patients receive proper treatment at UHC. Since treatment at UHC is almost free, the poor and low income group of people takes its services more. For health emergency, he says he also visits doctors during their private practice as prompt services are given. The doctors available at UHC are few in number when compared to the large number of patients as such patients cannot be given quality services. During the OPD, a doctor has to see many patients, therefore he has to hurry. Over all the level of satisfaction is moderately high.

### Box 7.15

#### Interview 5

##### **Upazila Vice Chairman (Age-52), Debiganj, Panchagarh**

He visited UHC recently for his own treatment. He thinks that considering the resource limitations at UHC, its services are quite satisfactory. He believes that doctors are competent and trusted by the people but since there are shortages of doctors, hardly they can deliver more quality services. He says that the UHC is only having two doctors as against the total sanctioned positions of 16 doctors. Despite their postings at UHC, doctors do not reside in their work places.

### Box 7.16

#### Interview 6

##### **UHFPO Sharia kandi, Bogra:**

UHC provides primary health care, emergency and obstetric care to patients. Besides UHC provides prenatal and anti natal care and provide initial diagnostic and consultancy services for referral to district level secondary or tertiary level. UHC is considered as trusted institutions as doctors and nurses provide free medical care and medicines. He says that the main challenge is to cope with the patient load with limited number of medical officers. The residential accommodation available at UHC for medical officers is also limited and there is a need for major refurbishment. Young medical officers need to pursue advanced degrees and have to be released from UHC whenever they are nominated. Many doctors have to live outside since there are no suitable accommodations at upazila. He says that complicated patients are transferred to secondary hospitals where they may get better treatment. UHC are not designed to deal with complicated patients more over there are limited capacity for diagnostic facility needed for treatment. For developing healthy trustworthy doctor-patient relationships, he says that listening to the patients with patience may be the key to trustworthy patient-doctor relationships and in providing effective treatment.

### Box 7.17

#### Interview 7

##### **Dr. Syed Abu Jafar Musa, Director (PHC), DHS, Dhaka**

Dr.Musa informed that the key challenges of PHC is about strengthening the health system, addressing the equity issue for targeted population, developing capacity for service provision and commitment of the service providers. Development of indicators with accountability framework and addressing the non-clinical issues are key challenges to PHC. He informed that patients are more or less happy with the treatment, but they tend to be sensitive to non-clinical issues such as being treated with courtesy and politeness, being kind and supportive to other patients or members of their families. He says that providing quality services has been a health priority in providing primary health care. For further improvement, quality assurance policy is implemented in pilot upazilas which will be extended gradually to all the upazilas.

From the interviews of the key informants general level of satisfaction and the quality of treatment at UHC is moderately high. According to the survey findings, it is found that majority of the respondents think that the services of UHC were of quality, efficient, consistent and moderately reliable. From the interviews, it is revealed that there are challenges given the shortages of medical officers, inadequate residential facilities at UHC. Despite the quality of treatment and services at UHC, patients may become sensitive to non-clinical issues which may often subdue the brighter sides of treatment at UHC. Shortage of doctors, non-residency in UHCs and ignoring the importance of non-clinical factors are therefore some of the major challenges in delivering quality services at UHC.

### **To what extent the services at UHC are fair and non-discriminatory?**

In order to gather information whether UHC provide non-discriminatory services - a teacher from Gabtoli Government Primary School was interviewed during survey. The text of the interview is placed below:

#### **Box 7.18**

##### **Interview 8**

##### **A Teacher: Gabtoli Primary School, Bogra (Aged-42 years)**

Mr. Provat Das(pseudo name), teacher of a government primary school at Gabtoli, Bogra. He visited the UHC outdoor service yesterday. Overall he found the services of the OPD fine as there was moderate crowd of patients. He found that all patients are examined by the doctors. There is no evidence that there is any discrimination on the basis of socio-economic condition of patients or release of any patients without treatment in the hospital. In absence of known persons in UHC, services can be affected since there is more number of patients than available attending staff. He says that services at UHC can also be discriminatory considering the social structure of the rural society where prompt and more attentive services may be given to rural powerful people. But during his visit, he did not witness anything. In general terms, services are non-discriminatory and fair to all.



From the above discussion it can be inferred that by and large the services of UHC are non-discriminatory in principle but in practice there may be deviations favoring the rich and the powerful for more attention and care.

### **Patients' overall dependence on the services of UHC**

To what extent patients depend on the services of UHC, a patient from Shariakandi upazila was interviewed. Text of the key message is placed below:

#### **Box 7.19**

##### **Interview 9**

##### **Ali Ahmed (pseudo name), Nilbatia, Sharia kandi, Bogra (Aged-70 years):**

He says that his health is not going well as he complains about bodily pain on his back. He says that he comes to UHC quite often and checks his blood pressure and seeks medical advice. He says that his minimum monthly expense for medicines is Tk150. He says that the doctor is known to him and gets treatment whenever he goes to UHC. He says that he can explain his health problem to the doctor. He says that generally the doctors are trustworthy and also consults with doctors outside UHC. Like him most of the rural people come to UHC and depend as the first point of contact whenever there is a health emergency. In complicated cases patients are referred to Bogra Hospital. Other patients are treated at UHC. He says that the doctors at UHC try to deliver better services to the patients. He says that more qualified doctors are needed here so that patients do not have to go to Bogra. He complains that qualified doctors posted in UHC are very short tenured as they often seek transfer. The medical emergency services of UHC particularly at night often suffer due to the absence of doctors. Many doctors shuttle from Bogra as such services are often affected due to their late arrival and early departure from UHC.

From the above information, it is evident that there is high dependency of patients on UHC. It is the first point of health service delivery having necessary health infrastructure. Patients expect dependable services from doctors at UHC which they think is reliable and which would cure them quickly. It is free and therefore affordable to poor citizens. Similar services are not available at the vicinity of upazila and such services could also be costly. Besides, health expenses often could be high which puts extra financial burden on lower income groups of the society. Shortages of doctors often create pressure on the available doctors serving at UHC which often results in less contact time with the patients and in

overcrowding of patients to a particular doctor. Shortages of doctors are therefore a major cause of deteriorating services at UHC. Despite many of these limitations, UHC is considered as the first point of health service for rural population having infrastructural capacity and resources for delivering PHC.

### **To what extent the nursing services at UHC are of quality?**

About the quality of nursing services, patients' response is somewhat mixed as there were variations in nurses in their attitudes and services. Some nurses maintained good communication with the patients and demonstrate pleasing personality. As part of their duty, they administer the doses of medicines and injections to the patient in a timely manner and effectively. With the shortage of nurses and span of care for a single nurse for patients in a 50 bedded hospital in a particular UHC, the quality of services of nurses cannot be expected to be highly satisfactory in terms of quality care. Therefore, it may be inferred that patient's perception of nursing services at UHC appears to be mixed. On the one hand it can be said that it is moderately satisfactory, on the other there would be patients who might be critical and find the services of UHC less than satisfactory. From the interview and from participant observation it is revealed that some of the respondents resorted to guarded response as they apprehended that any negative response might put them to face noncooperation from nurses and risk their care and treatment while they may stay in the hospital.

While verifying the above question with the local residents in surrounding UHC, it is observed that on average the behavior and demeanor of doctors and nurses at UHC is good, though at times there may be some lapses. The nurses are well trained and they take good care of female and older patients. With the limited number of nurses, their role is mostly confined to timely dispensation of medicines and maintaining logs of individual patients and attendance during doctor's visit. Most of the inward patients are seen

to be aided by their family members when they needed help either to go to toilets or bring food or medicines from outside.

During field survey it was observed in Chokoria UHC where a head-cut injury patient was admitted complained that he was not examined by the visiting doctors and attending nurses since he was admitted in the general ward. While the above matter was shared and brought to the notice of the RMO(Resident Medical officer) it was resolved that head- cut injury patients have a tendency to complain compared to other patients as they remain over charged from altercations. Nursing services is vital to patient care in hospital. Like doctors, the nursing services must be considered essential for quality treatment.

Information gathered from an interview of Deputy Director responsible for quality assurance in the Directorate of Health is placed below to assess the current strategy and approaches to enhance quality of nursing services at UHC.

#### **Box 7.20**

##### **Interview 10**

**Dr. Moazzem Hossain Sarkar, Deputy Director, Quality Assurance Unit, DHS:**

He informed that in order to improve service delivery at UHC, the current nurse-patient ratio has to be further streamlined. He informed that key responsibility of nurses is to provide care and assistance to the patients. It is not the task of the doctor to remain totally absorbed with the patient. It is the nurses under whose disposal the patients are kept. The role of the doctor is to diagnose and prescribe medicines. The job of nurses is to administer those drugs to patients as per the advice of the doctors. In order to streamline service delivery, more nurses, cleaners are needed to provide more caring services to the patients. He further pointed out that the role of the nurses in patients care and service delivery is somehow overlooked. He informed that quality assurance program for hospital management and operating procedure is being introduced to UHCs of 44 districts since 1994.

Based on the above information it may be inferred that quality assurance program is yet to be implemented across the country and firmly rooted in

the delivery system. However, quality assurance program needs to be sustained and implemented for delivering quality services.

### **To what extent doctors at UHC conform to institutional norms and practices?**

Institutional norms and practices are demonstrated by adherence to rules and procedure and conduct of professional ethics and norms. Professional norms may be broken if the institutions are weak. Many UHCs are reported to have breached maintenance of professional norms and practices by doctors. Such norms are often broken by unauthorized absenteeism in UHC. Doctor's absenteeism in UHC was reported 41% in 2003 (Chaudhury and Hammer 2003). This may overburden the workload of existing available doctors and also invites an environment of gloom in the health administration in UHC. Patients' are usually not bothered about the absenteeism of doctors because they see some doctors are delivering treatment though at times they are over loaded. They can hardly raise voice on this. As such, their expectations are also curtailed to a level through which they cannot expect anything better. With regard to integrity and professionalism of the health personnel at UHC, a review of 100 departmental proceedings of medical officers drawn by the MoHFW across the country during the year 2013-14, shows that out of 100 cases, misconduct was 17, misconduct and unauthorized absence was 71, misconduct and corruption 3, criminal proceedings 4 and misconduct and inefficiency was 1. These figures however show the number of departmental proceedings for breach of integrity and professional norms.

**Table 7.26: Departmental proceedings against medical officers posted at different UHCs**

Offences	No. of cases	Show caused/proceeding drawn	Proceedings dropped/Released	Censured/Warned	Salary increment held up	Promotion held up/Down graded	Removed/Dismissed from service/compulsorily retired
Unauthorized absence from work	2	1	-	-	-	-	1
Misconduct	17	1	5	6	2	-	3
Misconduct and unauthorized absence from work place/UHC	71	1	15	19	16	1	19
Misconduct and inefficiency	1	-	1	-	-	-	-
Misconduct/and Corruption	3	-	1	1	-	1	-
Criminal Proceedings /temporary suspension	4	-	3	-	1	-	-
Long Absence	2	-	-	-	-	-	2
<b>Total</b>	<b>100</b>	<b>3</b>	<b>25</b>	<b>26</b>	<b>19</b>	<b>2</b>	<b>25</b>

Source: Compiled from sources Ministry of Health and Family Welfare, Government of Bangladesh

25 doctors or medical officers have been removed or dismissed from service on charges of misconduct due to unauthorized absence and other allegations. 19 such cases have been resolved with award of punishment that stops salary increment for some time. 26 such proceedings ended up with issuance of censure and warning and 25 proceedings have been dropped. This figure relates to only 100 cases that were collected for the purpose of this study. There may still be cases which have not been reported. Indicators such as misconduct, unauthorized absence from work, misconduct and inefficiency, misconduct and corruption etc. are important determinants to assess doctor's level of integrity and professionalism at UHC. From the above information it may be inferred that the integrity of many of the doctors posted at UHC may be wanting.

The other aspect of the integrity of doctors which may fall under inappropriate behavior and conduct involves the ethical and fiduciary responsibility of doctors which deserves discussion at this point. Forcing the patients to charge extra money or directing them to undertake tests to a particular designated place often puts burden on the patients in addition to harassment. They may often become victims of opportunism by the doctors.

The interviews taken during data collection and observation on the workings of the UHC and from the researchers own insight on UHC during his tenure as UNO in Gangachara Upazila, Rangpur in the late 1990s, it is revealed that though private practicing remains unabated, quality of services and overall service delivery at UHC has also increased in terms of volume and in quality. More people now are dependent on UHC for health service delivery. The resultant effect has augmented access to PHC. But in the quality segment there are challenges in terms of resources and in retaining doctors and in dealing with unfilled positions.

The 'Hospital Management and Oversight Committee' constituted by the government with the Member of the Parliament as the chair, is a positive step forward towards attaining quality in the health service delivery system. On reviewing the minutes of some of the working resolutions of these meetings in different upazilas namely Chakaria UHC, Pirganj UHC, Shariakandi UHC, it is revealed that most of the agenda focused on administrative matters rather than concern for quality, effective health services and reviewing health outcomes. In the minutes of Chakaria UHC, Cox's Bazar district dated 16 March 2014 which was presided over by the Hon'ble MP, out of the 10 agenda only two subjects related to service delivery a). filling in the vacant position of junior consultant anesthetist and b). repair of the x-ray machine were discussed. In Pirganj UHC, Thakurgaon, the only meeting that could be tracked was held on 13 June 2009. It was attended by 11 participants and presided over by the Hon'ble MP. Out of 8 agenda, only one agenda which is related to the service

delivery namely enhancement of allocation of medicines for both outdoor and indoor patients was discussed in the meeting. Other agenda were either administrative or related to nominating representatives from different social groups. Reviewing the minutes of the meeting dated 31 July 2010, 15 September 2012 of Shariakandi UHC, it is revealed that no agenda on service delivery was adopted. Filling in the vacant positions of doctors and nurses and repair of the x-ray machine were two subjects discussed in the meeting. It is observed that the meetings of the Upazila Hospital Management Committee were not held regularly. Many UHFPO told during data collection that the hon'ble MPs remained busy and could not give any time for the meeting. In absence of any set agenda of the meeting, such meetings are not seen to be effective from service delivery point of view. Though major focus for which the committee was constituted was the element of quality, but somehow quality issue escape proper attention. Another pressing problem for quality assurance was the problem of doctor's absenteeism. None of the reviewed minutes could address the problem of doctor's absenteeism. Absenteeism and unfilled positions are separate constructs. Unfilled positions may remain vacant, while absenteeism relates to doctors unauthorized absence from work and negligence to duties which may require administrative and disciplinary response.

### **Findings from the above discussion**

From the above discussion on qualitative data the major findings are placed below:

- Trust matters for patients who may seek treatment in UHC. Many patients particularly the rural poor may have fear of hospitals which may refrain them from seeking urgent medical services. Such fear in association with ignorance may often risk their lives. For treatment and particularly for carrying out a surgical procedure, the role of trust not only assures for a fulfilling treatment experience for the patients but also promotes cooperation between a doctor and a patient. This may also lead to a more satisfying and prolonged

doctor-patient relationship. For non-surgical procedure major trust arena for patients is the concern for proper diagnostic and treatment which may lead to prompt recovery. For a more fulfilling experience, both the doctor and the patient should have trust based on mutual interest.

- Lack of commitment on the part of the doctors at UHC towards patients may affect trust. Commitment is seen to be a function of professional responsibility and responsiveness as well as a concern to meet expectations of patient for their welfare, proper attention and care. There may be variations in doctors' commitment in UHC as many doctors commute from outside. Non-residency in UHC and also unauthorized absence of many doctors from duty raises questions about their commitment to their services at UHC.
- Doctors at UHC are generally regarded as competent. Competence of doctors at UHC is hardly challenged as they are considered to be qualified doctors appointed by the government. Doctors at UHC are competent to manage critically ill patients such as poison cases if they are produced promptly without delay. However doctors may face difficulty in providing prompt and effective services due to lack of proper equipment and resources. More people are now dependent on UHC for medical care as they find the services safe and trustworthy. Despite competence of doctors proper treatment may be delayed due to shortages of doctors and support staff. Doctors may also indulge themselves in private practicing which may also hinder effective services at UHC and may deprive the patients from what they deserve.
- Patients' privacy during treatment at UHC is often forgotten which may deserve renewed attention for delivering more responsive services. Privacy during treatment may be more pressing for female patients compared to the male patients which need to be improved.
- It is often not possible to offer compassionate care in UHC for all the patients. As the number of patients is generally high in both



OPD and IPD, providing compassionate care at UHC could be quite challenging. Not all patients may expect compassionate care at UHC. However, older and female patients generally receive more compassionate care by the doctors and nurses. Providing compassionate care at UHC may require greater commitment and motivation on the part of the doctors and nurses at UHC and nurtured through systematic and continuous training and development.

- On the general level of satisfaction, maintaining quality of services at UHC may be quite challenging due to limitations of resources and shortages of doctors and nurses at UHC. Considering the large number of patients and cost-wise its free nature, services at UHC could be quite satisfactory to the patients in general. Though it may also appear to some that UHCs could hardly deliver quality services. Therefore, the general level of satisfaction may be moderately satisfactory.
- The services offered by UHC by and large are non-discriminatory. It is mostly used by the ordinary citizens and they depend on UHC as the first point of reliable medical services.
- Patients' dependency on UHC is generally high. Most of the rural people come to UHC for treatment which has the infrastructure and resources to deliver services.
- Quality of nursing services is often impaired by the large number of unfilled positions. Quality of nursing is reported to be at moderately high level. Role of nurses in delivering quality services is largely overlooked. It is the nurses who provide essential care to the patients.

### **Inference drawn on the basis of triangulation**

In order to verify the findings with regard to patients trust on UHC data source of both quantitative and qualitative are taken together and further

cross checked with the conversational interviews and structured interviews, cases and secondary sources of information. In order to supplement primary data gathered through structured questionnaire secondary sources of evidence is also collected. On the basis of survey data, information gathered from interview and case studies and other secondary sources, data triangulation is conducted to verify whether the findings reflect the reality.

**a. State of generalized trust in UHC and response to health needs**

From the survey findings it is found that the generalized level of patients' trust on UHC may range from moderate trust to a higher level of moderate trust. There is high dependence on UHC for common illness as most of the service seekers are local residents comprising poor, illiterate and economically disadvantaged group of people. Though community clinics are the first point of contact below upazila level, but UHC provides necessary institutional infrastructure and professional support for treatment. From the interviews and secondary sources, it is learnt that shortages of doctors may often lead to poor services. But from user's perspective as evident from survey data trust in UHC can be said to be moderately high. The narratives presented in Case no.1 and Case no.2 highlight the socio-psychological dimensions of trust with regard to treatment. Case no. 3 highlights the quality and the non-committal services of services at UHC. From the narratives of interview number-1, it is learnt that not all doctors are equally motivated and committed to service. With regard to doctors competence 92% of the respondents think that the doctors are competent to treat the patients as general physicians. According to the narratives in case number 4 and case number 5, there is hardly any complaint with regard to competence of doctors. Moreover, doctors at UHC provide emergency services to put critical patients into stable situation and provide necessary treatment. This has led to a minimum rate of patient casualty during treatment. For example, only 13 maternal deaths have been recorded in the year 2012-2013.

Ordinary patients depend on UHC for treatment of common ailments such as cold, fever, cough, asthma, acidity, RTI and other diseases. 22% of the respondents report cold, fever and skin disease, 16% report aches in body, throat infection, sciatica, 10% reported gastric, dysentery and diarrhea, 9% reported respiratory infection, asthma or urine infection. 7% reported injury and 6% reported gynecological problem. In response to the health needs, it is seen from the study that 52% of the respondents reported that they always visited UHC and do not go anywhere for treatment at all. 32% of respondents reported that they have visited UHC as well as go to other places for treatment as needed, 16% of the patients reported that they always go to UHC and hardly go to any other places for treatment. This suggests that the health needs of majority of the patients are responded by UHC. The null hypothesis was that more frequency of visit of patients will mean more trust on UHC. However when Chi square test is carried out between trust on UHC and frequency of visits, Chi-square value shows significance ( $p=.037 < 0.05$  level). Hence the null hypothesis that more frequency of visit to UHC suggestive of patients' trust is accepted.

Patients' level of satisfaction in the quality of treatment at UHC may be considered as a predictor in estimating response to health needs. Chi-square test showing relationships between patients' trust and quality of services resulted in high significance ( $p=.000 < 0.05$  level). To the question, "*How satisfied are you with the quality of treatment and service delivery at UHC?*", 82% of the patients reported that they were moderately satisfied with the quality of services at UHC, 13% reported high and only 5% reported satisfaction level low. Information gathered from the interview 3, 4, 5 and 6 reveal that services at UHC may suffer from quality. Several reasons may be responsible for deteriorating services. One of such challenges may be due to the obvious reason coping with patient load with limited number of health professionals. It may be said that more people are now dependent on UHC for treatment. For reproductive health issues there are increased services in both ANC and PNC services which have reduced the number of maternal deaths and number of new borne deaths in upazila. However, the overall quality of health service may deteriorate in

case of negligence of health professionals and health service providers. The information published in newspaper<sup>11</sup> only may reveal a deplorable situation in many remote upazilas. If such trends are not reversed, it may turn the UHC into a failing institution in providing health services at upazila level.

#### **b. Major trust arena and sources of opportunism at UHC**

From patients' perspective major trust arena in UHC is linked with patients' proper treatment and recovery to health. UHC provide free treatment and supply of medicines. The number of medicines supplied is limited and not all prescribed medicines are available. Availability of hospital beds and proper diagnostic and care may in general constitute patients' trust concerns. Such concerns may be regarded as trust arena which may also pose sources of opportunism at UHC.

Quality of treatment and consultation time at UHC may constitute as a major trust arena at UHC. Quality of treatment is dependent on many factors such as investigation and proper diagnostic, beginning of prompt and effective treatment. For inpatients in hospital quality of service may mean compassionate care and professional nursing services. However, quality of services depends on competence of doctors and nurses. Competence of doctors also provides incentive for opportunism in the sense that qualified and experienced doctors do not serve in UHCs for long. Even though they are posted they get transferred to preferred places where they can engage in private practicing. Another source of opportunism in UHC which may be evidenced is the diverting of patients to private clinics. Shortage of supplies and equipment at UHC often provide private clinics to operate at close vicinity in nearby towns where patients are easily diverted with the hope of receiving better treatment.

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<sup>11</sup> Box-2.1 Newspaper clips on Health service at the periphery page.49

Patients' consultation time at OPD as evidenced during the survey and observation is seen to be minimal. The average consultation time with patients is very short which hardly gives the opportunity to either establish rapport and communication or providing compassionate care. Reduced consultation time may leave the patients dissatisfied with treatment at UHC and may compel the patients to visit doctor during private practicing.

Availability and efficacy of medicines are hardly challenged by patients in UHC. Non-availability of medicines often disappoints a patient and may put financial burden for purchase of medicines from out of pocket expenses. Therefore, availability of medicines may often become an object of trust arena in UHC. To bring transparency, UHCs display list of available medicines for information of patients. However, this is not practiced uniformly in all the upazilas. The expired medicines are reportedly withdrawn from the store but patients take it for granted that they are safe for consumption. It is gathered from interview that costly medicines are often sold out by patients as well as by lower level staff of UHC.

Discontinuity of specialist's doctors along with medical officers in a particular UHC is common to all the UHCs. The problem of discontinuity of doctors is more evident in remote rural work stations compared to the UHCs situated in close proximity to big cities. The opportunity of private practicing may often dominate decisions for discontinuity in certain UHC which may affect health service delivery.

Quality of food, availability of hospital beds may also create tensions when patients are admitted. Hospital beds are limited in number and patients are observed to compete for beds which may create opportunism for lower level staff of UHC in providing beds and more personalized care in exchange of unofficial payments.

Problems of integrity of doctors may create distrust among patients. Integrity may have many manifestations including corrupt unethical practice to negligence and misconduct in duty. Unethical practice due to greed may

erode institutional reputation and patients' trust. An example of unethical practice may be compelling or creating grounds for performing a cesarean operation which may not be recommended by a surgeon considering the state of the patient as necessary.

### **c. Factors contributing to trust formation at UHC**

Several factors may contribute to trust formation in UHC. Information based on the interview of UHFPO's (interview-2) during survey suggests that doctors' commitment and service to the patients may build doctor's trustworthiness. It is acknowledged during the interview that not all doctors are equally responsive and demonstrate commitment. Information gathered from another interview (interview-6) suggests that the UHCs are considered trusted institutions as doctors and nurses provide free medical care and medicines. As UHCs are designed for PHC, there is limited capacity for diagnostic and treating complicated patients. Such limited capacity of UHC needs to be kept in mind when patients trust or satisfaction level is discussed and analyzed. Handling the patients compassionately and with care may contribute to a trustworthy patient-doctor relationship.

Notionally many factors appear relevant and may contribute to trust formation at UHC for treatment. Many factors are relevant for patients' and doctors practicing in advanced countries having trust implications but not readily applicable in the context of Bangladesh. For example, it is very difficult to provide compassionate care to all the patients visiting OPD or IPD at a point in time, though compassionate care is known to be producing trust in doctor-patient relationships. Notionally education appears to be positively contributing towards patients' trust. However, Chi square test show no significance of patients trust in UHC and level of education ( $p = .443 > 0.05$  level). Occupation of patients and trust on UHC shows no significance ( $p = .427 > 0.05$  level). Doctor's commitment in building patients trust in UHC appears to have significant relationships ( $p = .000 < 0.05$  level). Majority of the respondents reported that

the doctors posted at UHC have necessary competence in treating patients, it is discovered from interviews that patients with complex health problems have no treatment at UHC and often referred to secondary or tertiary hospitals. Some interviewees also commented that “there is no treatment in UHC therefore they go to city hospitals and private clinics”. UHC appears to be less preferred to the rural elites as they may have their residences both in upazila and in nearby towns and can access and afford private medical care.

Patients’ trust in UHC may also be dependent on doctors and nurses cooperation. Chi square result show strong significance between cooperation of doctors and nurses and patients trust in UHC ( $p=.000 < 0.05$  level,  $n=174$ ). Survey result shows that the doctors and nurses at UHC are found to be highly cooperative in providing treatment. But in reality, doctors at OPD or IPD at UHC find very little time to cater service and care to individual patients. Likewise, doctors at OPD are pressed with time in attending all the awaiting patients in a given day which may result in reduced time for individual patients with consequent disappointment in services.

Compassionate care and trust in UHC shows high significance (  $p=.000 < 0.05$  level,  $n=175$ ). Majority of the respondents think that the doctors at UHC provide compassionate care. Information gathered from the narratives of cases (case- 3, 8 and 9) and interview of informants reveal that compassionate care may be wanting at UHC. Many patients informed during interview that the doctors lack interest to listen properly or ask pertinent questions for proper diagnosis of a health problem. A particular UHC may experience sudden patients over load. In such a situation a culture of providing special care to known patients or colleagues at upazila may often result in providing minimal attention and care to the ordinary citizens’ at upazila.

For privacy of patents during consultation and treatment at UHC, survey findings reveal low (41%) and moderate level (46%). Chi-square test

showing patients' trust and privacy in treatment at UHC shows strong significance ( $p = .003 < 0.05$  level,  $n = 159$ ). However, privacy during treatment at UHC needs to be improved as evident from the observation and from the interview and narrative from case -7.

Chi square test showing quality of nursing services delivered at UHC and trust is seen to be non-significant ( $p = .104 > 0.05$  level,  $n = 108$ ). Quality of nursing services at UHC appears to have mixed outcome as evident from findings of survey, interview and observation. Friendly, courteous and professional service is considered vital for treatment particularly for patients in the in-patient ward. From interview and from observation during survey, it is found that offering friendly and courteous service is hardly possible due to patient overload. Nursing services at UHC is often claimed to be far from satisfactory as concepts and approaches to compassionate care, helpful, courteous, efficient, confident and patient-centered services were often found to be ignored or non-existent in many UHCs. Attitudinal problem of nurses may often block quality nursing services at UHC. There is also a cultural and motivational problem which may often hinder quality nursing services at IPD at UHC.

From the survey findings integrity of doctors is found to be high. However, in the Chi-square test there is no significance in integrity and patients' trust in UHC ( $p = .364$ ,  $n = 134$ ). But in the regression model integrity along with other variables came out to be highly significant. Integrity of doctors is therefore expected to contribute to the patients' trust in UHC. Major challenge with regard to integrity is attributed to doctor's negligence to duty and misconduct. Unauthorized absence of doctors from duty is common in many UHCs which frustrate quality and effective health service delivery at UHC. Table 7.16 presents evidence of proceedings drawn against doctors on grounds of their questionable integrity.

In addition to the above, Chi-square test for rapport and communication ( $p = .000 < 0.05$  level,  $n = 169$ ) shows strong significance, non-discrimination and fairness ( $p = .001 < 0.05$  level,  $n = 176$ ) shows strong significance,



dependency on UHC for treatment ( $p=.818$ ,  $n=176$ ) shows no significance at all. In combination of all the factors a regression model is run along with demographic, dimensions of trustworthiness and institutional variables. In the demographic and identity variables, age, gender and household income has been included. In dimensions of trustworthiness, doctor's commitment, competence and general level of satisfaction have been included. In institutional variables, non-discrimination in treatment, dependency on UHC for treatment, quality of nursing services and integrity of doctors has been included. The regression model show doctors competence (.260\*\* significant at .004 level), patients' general level of satisfaction (.296\*\* significant at .001 level), quality of nursing services (.268\*\* at .001 level) and integrity (.241\*\* at .007 level) as the most significant factors contributing to patients' trust at UHC (Adjusted R square.553). It may be noted that Chi- Square value of variables such as quality of nursing services, integrity of doctors for trust in UHC though came out to be non-significant as single variables but in the regression model, the four variables became significant. The variables which showed strong significance with an adjusted R square of .553 may mean that these four variables explains patients trust in UHC at least by 55% and there may be other factors which are not included in this study may contribute to the rest to explain patients trust at UHC.

## **Conclusion**

This chapter presented quantitative as well as qualitative data for measuring patients' trust in UHC. Firstly quantitative and then qualitative data have been presented. Several factors in the category of demographic and identity variables, dimensions of trustworthiness and institutional variables have been tested and analyzed to answer the research questions. The research questions are: what is the state of patients' trust at UHC, what are the major trust arena and source of opportunism in service delivery and lastly what factors contribute to trust building affecting service delivery at UHC. Chi square tests have been carried out to indicate relationships between independent and dependent variables. A regression

model has been developed to identify factors which may contribute to patients trust at UHC. From the regression model four variables namely competence, patients' general level of satisfaction, quality of nursing services and integrity of doctors have been found to be significant in building patients trust in UHC. There may be other variables apart from these variables contributing to patients' trust in UHC. The other questions such as generalized state of trust, the state of health response at UHC, major trust arena and sources of opportunism in UHC have been discussed and analyzed. Independent t-test reveals no variation in trust on the basis of gender. Likewise, trust across UHCs is seen to be existent (one way ANOVA,  $F 7.556$  significant at .000 level). From the foregoing discussion and analysis, the responses to each of these questions have been addressed. The following chapter makes a summary and concluding discussion.

## Chapter-VIII: Summary, Concluding Discussion and Implications

### Introduction:

The main objective of the study was to map the level of citizen's trust in Upazila Health Complex (UHC) which is the locus of delivering primary health care in rural Bangladesh and to identify factors that may affect patients trust in the delivery of primary health care. Study on patient's trust in UHC for seeking PHC seem to have been overlooked in the health policy though focus and attention on quality and access to PHC has received much attention. Bangladesh has achieved impressive gains particularly in achieving the MDGs with regard to PHC. MDG 4, 5 and 6 concern health. Bangladesh has achieved more than achieved in reducing child mortality at to 53 as against 48 per 1000 live births by 2015. In Goal 5 in improving the maternal health maternal ratio per 100000 live births to 194(2010) against target of 143 by 2015 and there has been a 405 decline from the base year of 1990. In Goal 6 HIV/AIDS prevalence rate is 0.1 per cent currently and it has been controlled. However, prevalence of TB per 100000 populations is 411(2011) which needs to further improve to meet target of 320 by 2015.

The health indicators of Bangladesh which qualify human development such as life expectancy at birth, reduction in child and maternal mortality, coverage on immunization, eradication of malaria and other epidemic, reproductive health have also faired impressive progress compared to other developing countries in South Asian region. Despite its success in medical health service delivery, the quality of primary health care is often challenged from the context of quality and service delivery. Primary health care is singly managed by public health facility such as UHC which involves both clinical and preventive treatment.

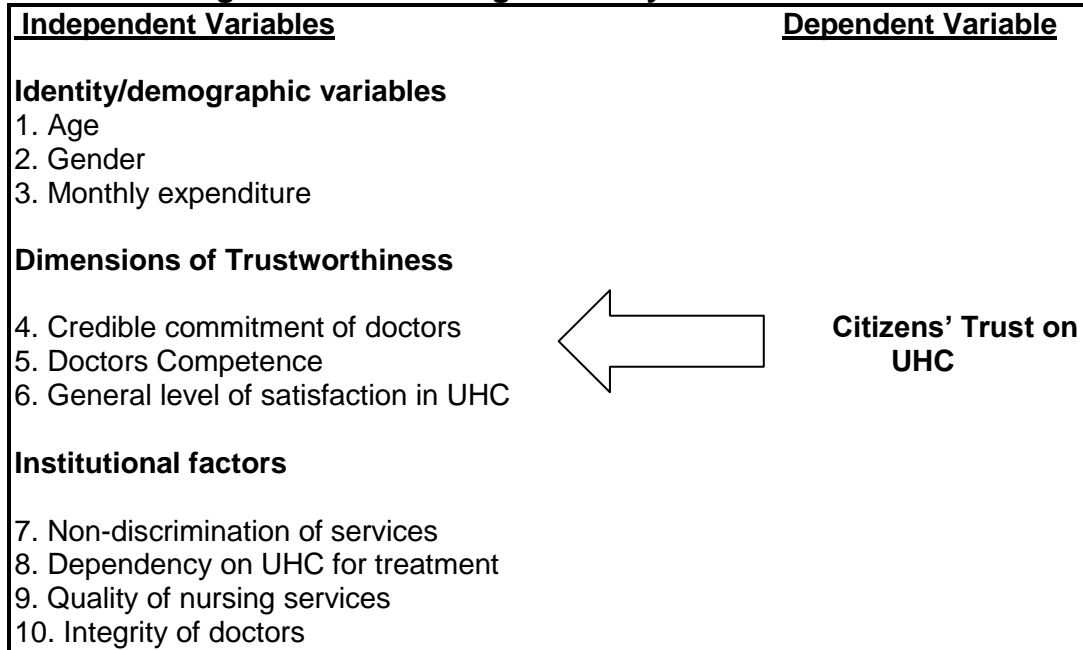
The study was about examining the generalized trust i.e. patients' trust in UHC and one of the rationale was to find relevance and objectivity of the service delivery system in the wake of development in alternative health care. The main research questions were to examine the state of

generalized trust among the users on primary health service delivery at upazila. Secondly, how the health service providers at UHC responds to the citizen's health needs? Thirdly, to find out the major trust arena and potential sources of opportunism which may affect service delivery at UHC. Lastly, to find out the factors which contribute patients trust formation in the context of UHC.

This chapter presents the major findings of the study and narrates policy implications from those findings. In conducting the study, relevant theories from trust and trends of trust research has been presented based on which major variables for conducting the study were identified. Based on those variables, the study was carried out in 6 upazilas of Bangladesh located in different regions and away from the capital city. Against each of the variables, separate hypothesis was drawn. Based on data, analysis and inference has been drawn. Lastly a regression model is presented through which the set of explanatory variables which emerged as the most significant in this study was presented. Lastly based on the findings of the study, major trust arenas of trust and sources of opportunism in UHC were identified. Based on the trust arena and sources of opportunism, policy implications and safeguards are identified. At the end of the analysis, this chapter also highlights the major limitations and also makes some futuristic guideline for research on primary health care

### **Revisiting the analytical framework of the study**

The study was carried out on the basis of the analytical framework as described in Chapter-VI Selected variables such as patients' identity, demographic variables, dimensions of trustworthiness and institutional variables are treated as independent variables on the basis of which trust in UHC (dependent variable) has been analyzed in this study.

**Figure 8.5: Revisiting the Analytical Framework**

On the basis of the analytical framework, the explanatory factors based on which patients trust on UHC may be dependent reveal the following findings:

- From the survey data it is revealed that age has an inverse and weak relationship with trust on UHC. That means trust on UHC may decrease with growing age. Therefore, older patients may exhibit less trust on UHC as older patients may have complex health problems which may go beyond the capacity of UHC. Likewise, gender and trust on UHC reveal no significant relationships i.e. no trust variations may occur due to gender differences. Income of patients' as evident from their monthly household expenditure does not seem to have any significance on their trust on UHC.
- Patients' general perception on doctors' commitment is found to be generally very high. Though there may be variations in motivations of individual doctors which may affect their commitment arising out of their non-residency at UHC and also due to unauthorized absence of many.

- It is inferred that majority of the respondents perceive the doctors at UHC as qualified and highly competent. Doctor's competence may also encourage them to indulge in opportunistic behavior which may affect quality of services at UHC.
- On the quality of services at UHC, it is found that majority of the respondents are moderately satisfied. However, quality of services may be impaired due to the large number of unfilled positions and also due to absenteeism of many doctors. This may also bring frustration to those doctors and other members of the team of health care providers at UHC mostly available for treatment and negatively impact the image of UHC to the citizens.
- Majority of the respondents perceive the services of UHC as non-discriminatory and fair. However, services of UHC may often favor the rich and powerful with better care and attention.
- Most of the ordinary citizens depend on UHC as their first point of reliable medical services compared to the rich.
- Though majority of the respondents perceive integrity of the doctors at UHC as high, but there may be deteriorating trends. Professional misconduct in the form of unauthorized absenteeism at work and engaging in opportunistic behavior manifested by recruitment of patients for private practicing may taint their level of integrity.

### **Does trust matter for patients in UHC?**

For effective treatment and satisfactory outcomes, patients' trust in doctors may be necessary as it may fulfill both the doctor and patients with their psychological needs. Patients' concern may relate to proper treatment and cure while the doctors' concern may also focus on patients' welfare so that it may add value to his professional reputation with a follow up date so as to adhere to him or her for treatment continuity. This notion of psychological state from the perspective of the doctor is rather based on motive for opportunism. Many patients tend to resort to blind trust of

doctors that they tend to take them for granted that they would do no harm. To ordinary patients they hardly have any means to verify the competence of doctors of UHC hence they resort to prima facie trust or blind trust from their professional demeanor and face value. Reputation of doctors also helps to build patients trust. Without trust, patients may not continue treatment with a particular doctor. Patients' trust their doctors and they believe that they would be cured from such treatment from UHC. However there is a growing tendency to have more reliance on medical care in private clinics and hospitals or to doctors during their private practicing for better and prompt care. Affluent people seek medical care at UHC when there is an emergency and the patient need to be stabilized first and then proceed for improved treatment in the district. This has put a dent on the quality of services at UHC, with a notion that services at UHC are of inferior quality and it is for the ordinary people. Though patients' may trust doctors for treatment but their opportunistic behavior may only highlight their increased commercialization which may erode patients trust.

**Table: 8.27 Assumptions and Findings of the regression model**

Explanatory Variables	Hypothesis	Findings
Age	Old patients will have low trust compared to the young. Some study observed that high trust is found to be associated with old people.	Findings of the regression analysis support the hypothesis with a negative beta weight (-.089). Despite its weak significance it can be argued that older people will have low trust in UHC since older people will have more complex health problems which will require prolonged and specialized treatment not available in UHC. Therefore, the hypothesis is found to be wrong as far as old age of patients is concerned.
Gender	Female patients will have more trust compared to the males	One way ANOVA test show no differences in trust based on gender. The regression model shows the opposite, where female patients will trust low compared to the male (-.058). Female patients visit UHC more than their male counterparts. As because they visit UHC for their treatment as well as for the treatment of their young children. Hence they are more initiated and experienced than the male patients and tend to be more critical as far as trust in doctors is concerned.

Explanatory Variables	Hypothesis	Findings
Household expenditure	Low income households will rely more on UHC than those well off in the society	Low income group of patients may also have low expenditure trends in their monthly household expenses. Low income patients take more services in UHC compared to the relatively rich, but household income shows significance at .000 level which may affect trust on UHC. The rich patients may not trust UHC and may take services from outside, but may also take services for UHC in case of emergency thereby leading to high trust.
Commitment of doctor	Greater the doctors' commitment is, higher will be patients' trust.	Doctor's credible commitment to service shows no significant relationship in building trust in UHC. Patients' trust may be low even though doctor's commitment is demonstrated high. The patient may relate trust with outcome of treatment.
Doctors competence	More competent a doctor is, more will he be trusted	Competence of doctor is highly significant in building patients trust. Doctor's competence may be related with treatment outcome hence competence of doctors may lead to high generalized trust in UHC.
General level of satisfaction	Greater the satisfaction on the services ,higher will be the patients trust	Level of satisfaction at UHC is highly significant for building patients trust Satisfaction may be related with institutional performance and treatment outcome hence may lead to high generalized trust in UHC
Non-discrimination of services	Fair and non-discriminatory the services are, higher will be patients' trust.	The findings show no significance between non-discrimination and patients trust in UHC.
Dependency on UHC for treatment	More dependent a patient on UHC is, higher will be his trust.	Patient's dependency on UHC shows no significance with building trust. Even though patients may be dependent on UHC, it may not lead to build high generalized trust on UHC.
Quality of nursing services	Better the quality of services is, higher will be patients' trust.	Quality of nursing services is seen to be highly significant in building trust in UHC. Therefore, generalized trust on UHC is associated with quality of nursing services
Integrity of doctors	Greater the doctors integrity, higher will be the patients' trust	Doctors' integrity is highly significant in building trust. Therefore, high generalized trust is associated with high level of integrity of doctors at UHC.



## **Response to citizens' health needs by service providers at UHC**

Response to health needs of patients is subject to varying treatment. From the study findings, response to health needs are often based on doctor-centric approach i.e. patients have to report to UHC at OPD for treatment. From the study it is observed that patients admitted in UHC receive treatment immediately. The response time for patients admitted at night could be long compared to the patients admitted during day time as the night time care providers are reduced compared to day time. The critical patients are often referred to district hospitals for treatment. Given the limited resources, UHC can not address the total response needed for a particular medical intervention. For example, a particular doctor of UHC may diagnose a patient's illness but he may base his judgment on the basis of the report done from private diagnostic laboratories. Poor patients may not have financial capacity to undertake those costly tests, therefore may remain vulnerable.

## **Major trust arena and potential sources of opportunism affecting service delivery in UHC?**

Based on the interview and observation, certain trust arenas on which patients may base their trust in UHC has been identified along with the principal sources of opportunism. Three cells are presented and includes trust arena, potential sources of opportunism, and implications and safeguards with regard to patients trust in UHC. Patients trust on UHC may concern the areas located in the trust arena. Opportunistic behavior may arise from the trust arenas which may lead to dysfunctional behavior inconsistent with the norms and values of the UHC. Therefore, UHC may be seen as the object of patients' trust and trust arenas within the UHC may be viewed as the targets of patients' trust upon which trust in UHC may depend. Ten major trust arenas in UHC have been identified. Each of these trust arenas may put certain opportunism which may affect trust relationship. In order to deal with the sources of opportunism some institutional safeguards may be necessary to offset any negative

consequence.

The implications for each of the arenas of trust and sources of opportunism can affect treatment and service delivery in UHC. Institutional safeguards and effective enforcement as mentioned in the last cell may offset opportunistic behavior of the doctors and other service providers. Institutional safeguards are enforced by organizational norms and practices, rules, regulations and compliance is ensured by administrative and disciplinary actions. Stricter the compliance of institutional norms less would be the application of regulative measures. Institutions where values and norms are strong, routines are more structured as patterned behavior; service delivery would be more institutionalized with consequence of more predictability and taken-for-grantedness.

**Table 8.28: Trust Arena and Potential Sources of Opportunism**

<b>Trust Arena</b>	<b>Potential Opportunism</b>	<b>Safeguards</b>
Patients receiving free treatment and medicines	Free treatment may lack quality service delivery	Normative and regulative measures
Quality of treatment	Divert patient for private practicing	Normative and regulative measures
Consultation time at OPD	Divert patient for private practicing	Normative and regulative measures
Availability of medicines	shortage shown for disposal outside	Adequate resource allocation and regulative measures
Continuity of specialists	Secure postings at places potential for private practicing	Effective Health Personnel Management and creation of incentive structure
Availability of hospital beds	Beds sold to patients on unofficial payment	Effective hospital management and regulative measures
Quality of food and environment of IPD	Unofficial commission charged on food contract	Effective hospital management and regulative measures
Integrity of doctors	Non-availability, Unofficial payment, issuing false medical certificate	Normative and regulative measures
Behavior and demeanor of doctors and nurses	Dispensed on calculation	Behavioral, cultural and communicative
Competence of doctors	Private practicing beyond office hours	Normative and regulative

Adapted from Lyon, 2000

Each of these trust arenas and opportunism is discussed below:

1. Patients receiving free treatment and medicines by themselves may raise doubts about the quality of treatment and the product with its relative value in the market. Compared to private treatment, treatment at UHC may receive less attention and care. In other words, patients may be forced to take recourse to private practice. Free goods are not appreciated on the basis of their quality and relative value. Patients are also not made aware neither it is possible for them to verify about the quality of products such as medicines and supplies. Since, UHC receives the medicines procured through central supply depot, actual sources of opportunism may lie with the central procurement department for not ensuring proper quality and timeliness of supplies. Costly medicines are often alleged to be sold outside UHC by the staff and such medicines may often be dispensed to selective patients arbitrarily. Such opportunism may also encourage patients to sale off medicines outside. This led many UHCs to cut the tablet straps in to small pieces so that it may not be sold in the market. Besides, the straps of medicines also bear distinct marks and colors to make it readily visible that they are from government supply and are not for sale. Many UHCs display stock of medicines at the entrance of the UHC hospital. But this is not seen to be uniformly practiced across UHCs. Expired medicines are reported to be withdrawn on a regular basis. Drugs and medicines supplied to a patient are given on prescription for a particular course. But patients may not take all the drugs as prescribed. Therefore some medicines may be wasted at individual patient level. More awareness at patient level for proper use of medicines may reduce wastage. Ensuring more quality of products supplied at UHCs may encourage more opportunism unless strict compliance and monitoring are in place. As a safeguard, regulative measures may not be enough to offset opportunistic behavior and unless moral restraints and ethical behavior is ensured.

2. Quality of treatment may be regarded as a major trust arena for which the patients may visit a UHC. Quality of treatment may depend on the number of available qualified and experienced doctors at UHC and the nature of care. Poor attention to patients and avoidance of proper care may affect quality of treatment at UHC. This may divert or force patients to seek alternative care privately outside UHC at his own expenses. Therefore, diverting patients to private clinics is often alleged against doctors at UHC. When the services are free and there are more demands for free treatment within the limited resources. Therefore, quality of treatment and care may be inferior compared to private clinics. By adequate resource allocation and by having normative and regulative interventions, quality of treatment may be ensured.
3. Consultation time at OPD may often become a source of concern to the patients and constitute a source of trust arena. In OPD patients are generally examined on the basis of conversations and brief outwardly examination based on which prescription may be given. In UHC, doctor-patient consultation generally takes a doctor-centric approach where the patient may not be encouraged to take full participation. Therefore, the doctor decides based on his brief assessment of the patient which may signal inadequate time for patient-doctor consultation. Inadequate patient-time may force patients getting diverted to private consultation outside UHC. Regulative measures such as allocating minimum time for consultation and implementing the standard operating procedure for uniform patient screening may improve on quality time for patients. Along with this, normatively shifting gradually to a more 'patient-centric' approach which may promote compassionate care. This may lead to a more satisfying and effective patient-doctor interface in UHC. Ensuring availability of sufficient number of doctors and creating incentive structures, cultivating ethical and moral values may bring positive changes in patient consultation in UHC.

4. Availability and efficacy of medicines may also be considered as a trust arena at UHC where patients may base their trust. Costly medicines may be short in supply and get exhausted soon. Poor patients may not have resources to buy costly medicines. In general, patients have minimal information on the supply of medicines at UHC. Availability of medicines and its proper use ensured through a transparent procedure may bring openness and build trust towards UHC and may bring a check on any opportunism. UHCs regularly withdraw expired medicines which may lie in its stock. However, for ensuring quality and efficacy of the medicines, it is the responsibility of the procurement authority and UHC. It should not be the case that the patients become skeptic about the quality of the product and their efficacy. Patients should be given information that the medicines supplied have all passed due quality standard and safe for human use and consumption. Regulative interventions along with quality assurance may safeguard efficacy and availability of medicines at UHC.
5. Retention of specialist/ consultant physicians in UHC is another source of concern which may affect patients trust. Retention of qualified doctors at UHC particularly in the remote upazilas is a challenge for health governance. Qualified doctors and specialists often compete for postings in suitable work stations where they may resort to private practicing. Doctors are allowed to private practicing beyond their duty hours. Specialist doctors prefer to work in the Capital city. Even though they may be posted in UHCs, their tenure is usually short. In extreme cases government doctors may take early retirements and join private hospitals. Creating incentive structure for retention of doctors at remote upazilas and also developing a workable career plan for junior, mid level and senior medical professionals may promote career as well as quality treatment at UHCs. Therefore, regulative and normative interventions may be suggestive.
6. Availability of hospital beds in UHC often become a problem when more patients are required to be hospitalized. Hospital beds may be

dispensed on the basis of 'first come and first served'. However, availability of beds by making unofficial payments may become a source of opportunistic behavior for some lower level staff at UHCs where patient load may be high. Therefore, regulative interventions along with regular oversights and monitoring may offset opportunistic behavior of lower level staff.

7. Quality of food and environment at IPD is another arena for patients trust in UHC. Quality of food served at IPD is of inferior quality and many patients prefer to bring food from their home. The food is supplied by contractors; the daily permissible amount of money allocated for each patient is minimal which barely can guarantee 'good enough' food for patients. Awards for supply of food may often be given to local contractors having political clout. In some cases contractors may obligate officials by making unofficial payment which may result in weak supervision and quality control. Generally the wards remain crowded with patients, therefore continuous cleaning of the general ward and toilets are necessary. Cleanliness of the ward and toilets are generally poor and the air remains stuffy. Cleaning is generally done only once and the current strengths of cleaners do not allow cleaning more frequently. Regulative measures may not be enough to ensure cleanliness in UHC unless more cleaners are recruited and supervised by hospital administration.
8. Integrity of doctors of UHC may impact on patients' trust. Doctors having reputation of issuing certificate to patients on the basis of false statement, practicing without medical ethics or those who may remain unauthorized absent from duty provide sufficient ground to raise questions about their integrity. Advising patients for diagnostic tests beyond requirement or in a pre-designated diagnostic centre is a common allegation leveled against some doctors which may reward them with certain commissions. Prescribing medicines to a patient which may not be considered necessary may also bring in the ethical issue and constitute a problem of integrity. Normative

and regulative interventions may be helpful to uphold integrity of doctors. From policy point of view, integrity of doctor can be sustained through motivation and reward.

9. Behavior and demeanor of doctors and nurses may evoke trust in patient. Warm and courteous behavior of doctors and nurses may often favor the familiar, influential and the rich. The ordinary patients expect that they are dealt respectfully and with compassion. Proper behavior and demeanor of doctors and nurses may also demand reciprocal behavior from patients. Proper behavior and demeanor may generate particularized trust and collectively it can lead to generalized trust in UHC. Both normative and regulative interventions may prove to be successful.
10. Competence of doctors is a major trust arena upon which patients can base their trust. Competent doctors may take more interest in private practicing rather than concentrating more on UHC. Increased competence may generate greed when doctors indulge in more time in private practicing. Normative and regulative interventions may promote competence along with a sound policy which may provide a reward system to offset any opportunistic behavior of doctors.

### **Factors which contribute patients' trust formation in the context of UHC**

From the regression model the significant explanatory variables based on which trust in UHC is dependent includes competency of the doctors (.260\*\* significant at .004 level), general level of satisfaction of services (.296\*\* significant at .001 level), quality of nursing services (.268\*\* significant at .001 level) and integrity of the doctors (.241\*\* significant at .007 level). Other variables such as gender, age of patients, doctor's commitment, dependency on UHC, non-discrimination in the treatment at UHC is not significant in the model.

## **Challenges to PHC from the context of UHC**

From the study it is evident that several challenges may constrain service delivery in primary health care at UHC. Some challenges relate to the structural problem while others may relate to the approaches to PHC. Structural problems are related with the systemic weaknesses of the health delivery system and governance. The PHC is largely driven by a top-down centrally controlled system where virtually everything is assigned from the top. The resources for PHC are largely drawn from the Directorate of Health; in addition UHC also receives 15% of the allocation from the annual development program from respective Upazila Parishad under health and social welfare heads. There is a duality of UHC in terms of its local level accountability and central control. Local level accountability and functional control lies with the Upazila Parishad, and for administrative and departmental control it is responsible to the DGHS. Such duality may often give rise to conflict unless matched by ground realities and well coordinated by the DGHS. The charter of duties of the UHFPO(LGD:2014) is a long list comprising as many as 26 activities. The UHFPO is responsible for successful implementation and delivery of ESP as well as for providing quality treatment and services at UHC and subordinate health outlets within his jurisdiction. In UHCs where the position of UHFPO is temporarily unfilled or those UHFPO's who does not reside in UHCs are likely to face more challenges in providing appropriate leadership needed for PHC. Besides, UHCs having shortages of doctors and nurses could also face more challenges than others in fulfilling the responsibilities mentioned in the charter effectively.

The approach to PHC is largely seen as doctor-centric. During the outbreak of diarrhea or spread of other communicable diseases, a more patient-centric approach is under taken when doctors adopt a more proactive posture and may serve the patients more closely. A patient-centric approach may be more focused towards the patient's specific needs. A combined approach having a mix of both the approaches may be



culturally compatible and pursued to shift gradually towards a more patient-centric approach in UHC in future.

### **Inadequate capabilities and resources**

Enhanced access and expectation in the services of UHC may demand increased capacity and consistency in the delivery of services. With increased awareness and referrals of patients from Community Clinics, there are more demands for quality services in UHCs. But the existing structure such as manpower, hospital capacity and resource allocations remains the same. Besides capacity for handling critically ill patients for stabilizing and for suitable referral need to be further developed. Capacity for handling casualties from accidents or burnt cases is minimal which needs to be developed. Since, the organization TO&E is fixed and requires a complex procedure for any amendment, the demand side of PHC will have to be met by existing manpower and resources. Shortages of doctors and other staff, limitations in resources such as equipment, medicines and ambulance severely constrain the capability of the UHC for a more responsive PHC.

### **Monitoring and compliance**

Weak and ineffective monitoring and compliance system may lead to poor quality in service delivery and hospital management at UHC. The hospital management committee headed by the local member of the parliament is a new administrative arrangement which is expected to contribute positively for closer monitoring and for ensuring responsive service delivery. Strict monitoring and compliance in UHC may become difficult due to the duality of control system exercised by Upazila Parishad at local level and the DGHS at the central level. Such duality may prove to be counterproductive unless well coordinated and integrated. In such a situation the hospital management committee may not play effectively unless the DGHS becomes fully supportive and acts responsively. The hospital management

committee is yet to be seen to have made any visible impact on service delivery at UHC.

### **Implications of the findings**

The current growth in the health indicators of Bangladesh also suggests that there has been a demand and supply side growth as well in the delivery of PHC through the UHCs and other health outlets at upazila. Continued growth in the demand side will require additional resources which need to be sustained. Over all gains in the health indicators will be lost if sustained programs for improvement of health and nutrition is not continued. A key element which remains central to any health intervention is the notion of quality and satisfactory services which may bring patients trust in UHC. However, providing both quality and satisfactory services across UHCs may be challenging and may depend on many factors. Some of the factors upon which patients' trust in UHC may depend have been identified and discussed in this study. Some of the findings of the study appear to be more relevant for UHC while many others appear relevant but less significant in light of the regression model as presented earlier. Implications of these findings may serve several purposes from quality and service delivery point of view. The current approach is based on doctor-centric or paternalistic model where the doctor is considered to have the specialist knowledge on the basis of which treatment may be given. In this approach patient's role is essentially passive and minimal. From service delivery perspective, the findings of the study call for a shift from 'doctor-centric' approach to a more 'patient-centric' approach in providing PHC which may address both quality and satisfactory service delivery. Implications of the findings may be discussed from different perspectives as mentioned below:

### **Theoretical implications**

Doctor-patient trust relationships has been studied from the perspective of health systems in advanced countries where it has been looked as the

function of three cross cutting segments- the patient, the care provider and the insurance company. In developing countries such as Bangladesh, doctor-patient relationships have been construed more at generalized level when institutional trust is concerned. But when patients' trust towards a doctor is seen from an individual level it becomes particularized trust rather than generalized trust. It may be said that particularized trust collectively can become generalized trust. The study is about patients trust in public health facility i.e. UHC. As Li(2012) observes that trust research is yet to have any general theory to be used as a base or platform on which trust research may progress. Two theories namely Rational Choice Theory (RCT) and the Institutional Theory have been used in this study. Revisiting the main elements of these theories in explaining patients' trust in UHC may be necessary here. RCT emphasizes on individual choices based on calculativeness on perceived gains and losses. It also assumes the inherent risks in transactions and confides the trustee that vulnerabilities from such transaction will not be exploited. The rational choice theory views individuals as rational actors and in utilitarian terms maximizing self benefits. It assumes that individual decisions are made on the basis of calculativeness which may lead to maximizing gains and minimizing losses. Rational Choice theory also assumes trust as a function of encapsulated interest and there is incentive to both the trustors and trustees to become trustworthy. Rational choice is often criticized to have a very narrow focus on trust decisions based on mere calculativeness. Trust decisions may also result from social relationships and contextual issues which may lead to emotional attachments.

To what extent RCT as a theory has been able to explain trust relationships with regard to doctor-patient relationships particularly in UHC? Firstly, trust emerges out of a situation having certain vulnerabilities and risks. A patient may perceive certain vulnerability and risk when he seeks treatment to a doctor. The patient believes that the doctor would not do any harm rather he would be treated properly and get cured. In this sense, trusting doctor is essentially a rational decision and it could be damaging not to trust the doctor in this sense. Even not trusting the doctor

at a particular point could also be a rational decision. Two conditions make the trust situation relevant- i.e. the patient is taken to be vulnerable and the doctor does not exploit his vulnerability. The patient submits himself to the knowledge and expertise of the doctor with the positive expectations that (s)he would be cured. Therefore, the patient trust's towards the doctor is based on calculations of perceived gains and losses.

Secondly, trusting becomes beneficial for both the doctors and the patients. There is an incentive to both the doctor (Trustee) and the patient (Trustor) to have reciprocal trusting relationships. For the patient by trusting the doctor (s)he may be cured and for the doctor, trusting patients may lead to a more fulfilling and rewarding experience.

Thirdly, patients' trust is seen in utilitarian terms when patients make rational and efficient choices for maximizing benefits and minimizing risks and losses. A patient may therefore base his decision on his preferences about choice of doctors or treatment. In UHC many patients come for free treatment and medicines rather than going to other health facility which may be purely a rational choice.

Though RCT has been useful in explaining human behavior for trust relationships, certain behavior cannot be fully explained by mere calculativeness. Patients' trust based on prima facie judgments, or having blind trust on doctors may go beyond calculations which may be considered irrational. Even though this kind of behavior may be considered irrational but still people may put trust. Trust such as blind trust or prima facie trust cannot be explained by RCT. Many patients may base prima facie trust on the basis of facial cue, demeanor and compassionate behavior of the doctor and nurses. It may also be noted that many patients' who may posit blind trust or excess of trust to a doctor, also undertakes the risks which may lead to dysfunctional consequences. As Kramer (1991) notes that the rational choice perspective is the most dominant and influential image of trust in organizational behavior but criticisms such as RCT negates emotion and social influences also deserves attention if

trusting behavior is to be fully understood. The other view that trust is acontextual also highlights the importance of culture which results in trusting attitude of people. However, since the study maps generalized trust on UHC, the RCT has been found to be helpful in analyzing and interpreting the nuances which may build trust relationships between doctor and patients.

Therefore, the limitations of the rational choice theory may only help in explaining patients' trust partially. In order to deal with such limitations of RCT, institutional theory has been used to account for the role expectations, moral values of doctors and nurses and their actions based on logic of appropriateness which may build patients' trust. Key elements of the institutional theory are:

Firstly, institutions play important role in reducing vulnerability from any transaction. Institutions through regulative, normative and cognitive mechanisms shape and constrain human behavior and action. Normatively institutions provide the basis of action which is guided by "logic of appropriateness". A doctor performs not only by regulative and cognitive measures but also by the normative values which is considered as ethical and appropriate. As trust emerges in vulnerability and risk, normative elements may guard opportunistic behavior of doctors and nurses. It can be said that dominance of the normative values over regulative measures in an institutions, fosters generalized trust in the institution. Institutional trust and trust on doctors would be more lasting where normative institutionalism will be dominant. Trust would be seen as a natural product of institution and patients would take trust for granted. A key element in the institutional theory is the concept of normative isomorphism which refers to the role expectation, identity and self-image of the actors. The notion of normative isomorphism (DeMaggio and Powell 1983) is close linked to the notion of 'natural attitude' (Schultz 1932) and 'logic of appropriateness'(March and Olsen 1989). For patients' trust in doctors at UHC, the implications for normative isomorphism would therefore mean

that patients who come to UHC for treatment would have trust both on UHC as well as on the doctors' and the processes involved for treatment.

Secondly, institutional theory presupposes trust as a natural attitude. This means that patients may consider UHC as 'taken for granted'. It is considered more natural for the patients to trust than not to trust or distrust. Patients in UHC may consider that they would be cured if treated by a doctor in UHC. Such belief creates more generalized trust in UHC. It is also natural for the patients that their vulnerability would not be exploited.

Thirdly, trust in the system may reduce vulnerability. Institutions produce patterned and routinized behavior and activities which may offset vulnerability and uncertainty. Patients in UHC may expect similar treatment and expect predictability in treatment. Therefore, to deal with vulnerability, institutions play significant role. For elucidating patients' trust in UHC, the institutional theory provided the theoretical underpinnings for the study with greater relevance for measuring generalized trust.

The limitations of RCT in explaining patients' trust on the basis of calculativeness can be substituted and mitigated by 'taken-for-grantedness' and 'logic of appropriateness'. The institutional approach assumes that people are not intrinsically selfish rather it enables individuals to resort to altruistic behavior. Patients' trust may be dependent on the altruistic behavior of the doctor which may be manifested by compassion, benevolence, non-discrimination, fairness, cooperation etc. Therefore, the limitations of RCT may be substituted by the institutional theory in explaining patients' trust. The constituents of trust in UHC such as commitment, compassion, cooperation, non-discrimination, benevolence, privacy, rapport and communication, integrity, quality of nursing services etc. have normative roots and may be determined by 'logic of appropriateness' or as 'natural attitude'. Therefore, it can be concluded that in absence of a more general theory to explain and interpret patients' trust in UHC, the theoretical perspective based on a rational choice account and institutional theory have thus made significant contribution in understanding patients trust in UHC and may have also served well in terms of theoretical

relevance and rigor. Therefore, the findings of the study support and reinforce the RCT and Institutional Theory.

### **Policy implications**

Patients' trust occupies a central place in the delivery of primary health care. It becomes even more pressing when health services suffer from anomalies in terms of access, equity and lack of quality assurance.

Patients' generalized trust in UHC will depend on persistent efforts based on the outcome of several factors and when it is grounded in collective realism. It may also be said that patients' trust in UHC cannot grow overnight. Patients trust at UHC may be built in close and long interactions which may promote generalized trust. From policy perspective several issues appear pertinent to the issue of patients' trust which may be discussed under the ambit of equity, quality assurance, investing in people and ethical perspectives.

**Equity:** The health policy in stating its specific objectives emphasized on the equity issue in terms in quality treatment and expanding easy access. Such policy statement is expected to demonstrate the intention and basic premise of a responsive health policy. Such policy statement may appear to be weakly implemented unless it is backed by resources and proper manpower. Channeling resources towards UHC and below could become a serious sustainability issue of the program. It is noted that 60-65% of the total resources required for UHC could become a challenge. Such challenge could affect both easy access and coverage in PHC with a subsequent impact on patients' generalized trust level. According to the National Health Accounts data, inequity in health sector persists with respect to resource allocation and expenditure incurred with little gain for the poor. It is seen that rich 10% of the population enjoy 15% of the national health budget. The health service delivery also suffers from proper targeting and in reaching the poor. Since the UHC attracts the poor more

than the rich, making special provisions for targeting the poor and the vulnerable may be considered necessary from equity point of view.

**Quality assurance:** The health policy of Bangladesh also recognizes quality of services in PHC as one of its key challenges. Quality assurance in the service delivery such as product and treatment in UHC is largely missing. The quality assurance program though was initiated since 1994 and continued till 2010 under the HNPS, total quality assurance with respect to emergency services, out-patient department, in-patient department, and housekeeping and hospital management is hardly seen to be achieved. The main areas of concern with regard to quality assurance in UHC fall in the category of limited availability of required medicines, attitudinal problem of the service providers, long waiting time for treatment, difficulty in access, limited seating capacity for waiting patients, opportunity for low talk time, lack of privacy and lack of proper cleanliness. Other dimensions of quality with regard to UHC as identified by the Quality Assurance Unit may also include effectiveness, efficiency, technical competency, safety, accessibility (financial and geographical), interpersonal relations, continuity and amenities. Attaining quality assurance may not be possible unless pursued systematically over a period of time and assessed periodically through regular customer feedback. Such feedback may help UHC to pursue quality assurance in service delivery which may build patients' trust in UHC.

**Investing in people:** Patients' trust in UHC cannot be attained without the full cooperation and motivation of the service providers i.e. doctors and nurses. The current unfilled positions of the doctors and nurses should be filled systematically keeping in view the future vacancies. Retention of the doctors in remote UHCs has been a challenge. Shortages of doctors and nurses have been seen as a major weakness in the delivery of PHC. Unless the current challenges with regard to human resources are met by systematic career progression, on the job training and service delivery at UHC will continue to be weak which may impact on patients' trust in UHC.



The current doctor-patient ratio and the doctor-nurse ratio need to be further narrowed down to provide responsive services.

**Ethical issues:** Demonstration of fairness and moral values during treatment in UHC may generate patients' trust. Moral values and the ethical standards come into play during treatment to guard against opportunistic and inappropriate behavior of doctors and nurses so that patients are dealt sympathetically and not subject to harassment. Patients are often burdened with unnecessary diagnostic tests and costly treatment which might not be necessary. Greed should not overshadow compassion and humanity which is the cornerstone of patient care. Cultivating ethics and morality in doctors are expected right from the beginning of their medical education. In the core curriculum for MBBS, forensic medicine is included where medical jurisprudence is taught to the students. It emphasizes on the code of law of medical ethics, professional secrecy, doctor-patient relationship, fairness and equity etc. through which ethical aspects to treatment is introduced. As a professional requirement all practicing doctors are required to register with BMDC, the regulatory authority for ensuring professionalism, quality and discipline. Applicants for registration are also required to submit code of medical ethics declaration form. As regulator, BMDC takes legal actions against fraudulence of doctors using fake professional degrees and training to deceive patients. Registered doctors are also required to use their registration numbers in their official pads and cards so that patients are not cheated. Another aspect which may deserve further attention from ethical point of view is the detachment of service at UHC from private practice. Such detachment may mean avoidance of patient recruitment for private practicing and giving more compassionate care at UHC. In practice such subtlety in detachment of two domains may prove to be extremely difficult, but it attaches an ethical dimension which must not escape discussion in policy.

The health policy recognizes and emphasized on the need for attaching ethical aspects and moral values with regard to treatment. Ethical and moral issues become particularly relevant to treatment and when patients'

vulnerabilities need to be protected and not exploited. From policy point of view ethical and moral standards to treatment across medical profession may deserve a fresh look given the professional norms of a particular profession. Penal provision and disciplinary action for non-observance of appropriate moral and ethical norms should also be regularly and strictly enforced. However, the BMDC's capacity to effectively monitor and ensure ethics and morality in medical profession is severely constrained due to its organizational limitation to take appropriate actions against fraudulent behavior of doctors. Ethical and moral issues pertaining to treatment though draws media attention quite frequently, but it receives very little attention from government and policy response.

Assessment of service delivery in UHC by way of only achievements of targets may not give a picture of patient's satisfaction and trust towards the doctor and nurses. Patients trust towards doctors may go beyond competence and professional skills of doctors and nurses. Manifestations of professional norms and ethics are not only a professional requirement but from treatment point of view it may also lead to a more satisfactory and fulfilling experience. Therefore from policy perspective, patients trust may well receive similar focus and attention such as equity, quality etc. whenever service delivery at UHC will be studied.

### **Scope for further research**

This objective of the study is to measure patients' trust on UHC and its effect on service delivery. The study was carried out focusing on UHC rather than secondary or tertiary level of health care. Therefore, the findings may only be relevant for UHC though some of the variables may also be relevant for other health service providers. This study only captures a temporal element and as suggested by trust scholars a longitudinal study or a more detailed case study could perhaps be necessary to trace the actual nature of trust. This study only focused on factors which build patients' trust in UHC, but it has not focused on identifying the factors which may lead to breach of trust or assessing the consequences of such

breaches. Another area of trust research which may be interesting is the notion of trust repair and its consequences. Though in organizational theory trust breaches or trust repair may be interesting from the point of leadership theory, but to what extent this may be relevant in connection with assessing patients' trust needs to be examined.

There is no commonality with regard to trust research in doctor-patient relationships particularly in measuring criteria and also in using the explanatory variables for the study. Attaching importance to the context within which trust research is being carried out has been highlighted by many scholars. Therefore, future trust research may be more context specific rather general and highlight both resource-rich and resource-poor settings. Generalized trust may differ across high trust and low trust societies. Therefore though trust constituents may be same across societies but trust is also context specific therefore trust behavior may also depend on local culture. Therefore, developing and validating trust measurement scales on the basis of specific context and culture may be necessary and may get focus and attentions in future trust research.

Another important dimension of trust research is the notion that trust relations do change in a changing environment. Patients' trust towards doctors have moved from traditional blind trust towards a more informed interpersonal and institutional trust system in the wake of changes in organizational structure and culture of health care delivery. These changes might be prompted by both technology and also due to changes in the demand side of the health service delivery. As a result, the future of trust research may involve the impact of technology on doctor-patient relationships.

### **Revisiting the research questions and hypotheses**

In order to recapitulate the findings of the study, the research questions and hypothesis is revisited again to check whether the study have answered the research questions.

- What is the state of generalized trust of patients on the services of UHC ?
- What are the major trust arena and potential sources of opportunism in service delivery at UHC?
- What factors may contribute to trust formation for UHC and how it may affect service delivery?

The above questions are explained below:

**i. What is the state of generalized trust among the users on primary health service delivery and response to the citizen's health needs at UHC?**

The study found that the generalized trust in UHC is high. As 91% of the patients report that they think that the doctors at UHC are committed to their services. 92% of the respondents think that the doctors at UHC are competent to provide treatment. About doctors' cooperation with the patients, 78% of the respondents agree that doctors are moderately cooperative in dealing with the patients. About compassionate services, 91% of the respondents think that the doctors at UHC provide compassionate services to the patients. 82% of the respondents responded that the quality of services at UHC is at moderate level, 84% of the respondents agree that the services of UHC are non-discriminatory. 98% of the respondents report that they are dependent on UHC for their treatment. Based on these observations, it may be said that generalized trust in UHC is high. However, based on the information from interview of key informants and patients, cleanliness of hospital wards and toilets needs to be improved. Per-patient consultancy time at OPD should also be extended to give more quality time to patients. For Wards two or three routine rounds by doctor will raise patients' confidence and enhance quality of care. About compassionate care, it is not possible to provide compassionate care to all the patients considering the number of patients and limited availability of doctors. Deteriorating trends with regard to integrity of doctors coupled with the disappointingly persistent problem of

unfilled positions of doctors and nurses and unabated unauthorized absenteeism on behalf of some doctors, often deny quality services to patients.

98% of the respondents agree that they depend on UHC for treatment and for emergency health needs. There are also no other similar health facility which has the infrastructure and resources to provide quality treatment in upazila. Therefore, majority of the population depend on upazila. Besides, there are referrals from community clinics. Recent developments in e-health services, essential service packages have made the UHC as the hub of medical services in a upazila. However, the treatment and service delivery at UHC is regarded as doctor-centric rather than patient centric. This is due to dominant culture and the existing doctor-patient ratio which cannot deliver more patient-centric approach to PHC. Besides resource constraints, often limit the capacity of UHC in delivering quality treatment. Emergency patients with complex health problems are referred to secondary health facility. Nevertheless, UHC has been able to manage critically ill patients and bring it to stable position for further treatment to appropriate hospitals. From the study, it is seen that there are no complaints about the competence and quality of services, there are some observations with regard to non-clinical aspects such as non-residency, non-availability of doctors during a particular time of the day. UHC's have also found to have managed critically ill patients and save their lives. Many UHCs receive patients with assaults, respiratory tract infections and pneumonia; it is found that they are treated properly. Shortage of doctors often over burden the work of existing doctors which often becomes very difficult to cope with. Increased monitoring and supportive role can enhance performance of UHC and improve on patients' response.

**ii. What are the major trust arena and potential sources of opportunism in service delivery at UHC?**

From the findings of the study it is revealed that there are several trust arenas with regard to patients' trust in UHC which may lead to

manifestation of opportunistic behavior by the doctors. Major trust arenas of UHC with regard to patients are discussed below:

- a. Patients receiving free treatment and medicines: The source of opportunism is that generally free treatment runs short of quality and discretion may determine the ultimate quality of services. In other words free services may not have proper accountability which may lack proper care and attention.
- b. Quality of treatment: Quality of treatment is another trust arena where a patient may show his concern for better treatment. This has become more of a problem when treatment is guided by the motivation of greed and doctors do not perform the task by themselves rather they delegate to technicians or junior staff. Presence of fake doctors, costs of treatment also make the quality issue a big concern for patients.
- c. Consultation time at OPD: If the consultation time is too short, it gives the patient a feeling that the doctor has not examined the patient properly. Lack of eye contact with patient during treatment may also give a sense of remoteness. These may also force and encourage patients to seek services at private clinics.
- d. Availability and efficacy of medicines: Non-availability of medicines at UHC may render treatment at UHC useless to the patients unless they buy these medicines from outside. This may discourage patient to seek services from UHC. Medicines supplied at UHC may be sold outside. Though no evidence from interview was found that medicines are sold out but it is learnt from interview that medicines are sold out by both the patients as well as by the hospital staff. As gathered from an interview with one UHFPO that straps of medicines are being cut to small pieces containing the tablets so that they cannot be sold. This in other words intended also to guard against internal leakage of medicines by medical staff.
- e. Continuity of specialists/consultant physicians: Patients tend to trust UHC more when well reputed consultants and doctors are available.

But many competent physicians seek premature transfer at stations for attractive postings where they can engage in private practicing side by side.

- f. Availability of hospital beds: In general occupancy level in a 50 bedded hospital at UHC is very high. Therefore, demands for hospital beds for patients when admitted to hospital become high. Bed availability in hospital may also require unofficial payment at lower levels at UHC. Unofficial fees or unauthorized payments that co-exist in government health facilities is well documented in health literature and policy briefs. However, no evidence of such complaints was found in UHCs during survey with regard to bed availability.
- g. Quality of food: Quality of food supplied in the hospital also poses a concern for patients which may also constitute a trust arena. Complaint about quality of food supplied at UHC is common which force many patients to bring food from home. However, the current allocation for food per patient is too low to allow modest quality of food at UHC for hospitalized patients.
- h. Integrity of doctors: Unofficial payment for issuing false medical certificate to patients, unnecessary tests in designated laboratories or corruption in recruitment, procurement are common grounds where doctors' integrity may be faltering. The quality of care at UHC in comparison to private hospitals may be low as because UHC provides free and the other operates for profit. Some doctors of UHC might be operating at both the places squeezing consultation time at UHC but extending more during private services. Integrity of many doctors placed at UHC may be incompatible with the institutional norms and persists in absence of a strong regulatory and effective monitoring regime.
- i. Behavior and demeanor of doctors and nurses: Behavior and demeanor of doctors and nurses dispensed on calculation and may often favor the rich and powerful.

- j. Competence of doctors: More competent doctors remain busy and resort to private practicing beyond official hours. Availability of competent doctors at UHC does not guarantee of proper treatment and care at UHC. Demand for competent doctors are more which gives them leeway to private practicing and secure placement in a preferred place having potentials for a thriving practice. For such doctors, this might make patients' examination at UHC secondary to the neglect of patients.

**iii. What factors may contribute to trust formation for UHC and how it may affect service delivery?**

Several explanatory factors have been investigated to measure trust at UHC. Patients have high generalized trust in UHC. Nevertheless, for building patients trust a regression model was developed with several explanatory factors. From the regression model the significant explanatory variables are competency of doctors in UHC (.260\*\* significant at .004 level), general level of satisfaction (.296\*\* at .001 level), quality of nursing services (.268\*\* significant at .001 level) and integrity of the doctors (.241\*\* significant at .007 level).

For competency of doctors the Hypothesis was '*more competent a doctor is, more will he be trusted*'. The null hypothesis was that *competence of doctor have minimal role in patients' trust building in UHC*. The p-value is (.004) which is < 0.05 (significance at .260\*\* at .004 level). This rejects the null hypothesis that doctors competence play a minimal role in patients trust building rather, it suggests doctors competence is considered highly significant for patients' trust in UHC.

For satisfaction, the hypothesis was '*Greater the general level of satisfaction on UHC is, higher will be patients trust*'. The null hypothesis was *level of satisfaction has no relationship with patients' trust*. The p value is .001 which is <0.05 (significance .296\*\* at .001 level).General level



of satisfaction is seen to be significant in building patients' trust in UHC. Thus the null hypothesis that general level of satisfaction has no role to build patients' trust in UHC is rejected.

For quality of nursing services the hypothesis the hypothesis was '*Better the behavior and demeanor of doctors and quality of nursing services, higher will be the patients' trust in UHC. The null hypothesis was nursing services play minimal role and have no relationship with patients' trust in UHC.* The  $p$  value is .001 which is  $<0.05$  and significant at .268\*\* at .001 level. This rejects the null hypothesis and supports the hypothesis that quality of nursing services and behavior and demeanor plays a significant role in patients' trust building in UHC.

Lastly, for integrity of the doctors the hypothesis was 'patients' trust will be high in UHC, when doctor's integrity will also be high. The null hypothesis was that integrity of doctors has no relationship with patients' trust in UHC. The  $p$  value is .007  $< 0.05$  and significant at .241\*\* at 0.007 level. This suggests that integrity of doctors is highly significant according to this model in building patients trust. Thus the null hypothesis is rejected.

Other variables such as gender, age of patients, doctor's commitment, dependency on UHC, non-discrimination in the treatment at UHC is not significant in the model.

The above four variables have been found significant with regard to patients' trust building in UHC which may also affect service delivery. Firstly, it is natural for patients' to seek treatment from a competent physician where it may be perceived that he will get better treatment and eventually cured. The notion of competence as perceived by the patients' is that doctors are government appointed and registered by BMDC and therefore they are well qualified and competent for providing necessary treatment. This notion of competence of doctors at UHC is particularly important from the view point of other traditional doctors (*Gram daktar or village doctors*) at upazila who may lack necessary academic and

professional qualifications for treatment. The demand for competent doctors at UHC is therefore may be high from patients' quality treatment perspective. But the continuity of competent doctors at UHC may often be uncertain and their tenure short. Therefore, service delivery at UHC may be impaired.

General level of satisfaction can be a broad measure about the quality of treatment and service delivery. Patients' satisfaction may include both clinical and non-clinical aspects of services delivered from UHC. Patients' may base their trust on nature of care such as prompt and responsive service which may give quick relief and comfort to the ailing patients and gradually return to a normal state of health. Patients' satisfaction may also depend on the nature of behavior and cooperation extended to the patients by the health providers. Cleanliness of the general ward, toilets and quality of food etc. may positively contribute to general level of satisfaction.

Service delivery at UHC is also dependent on the nature and quality of nursing services. Quality of nursing services may depend on the professional outlook and conduct of the nurses to offer friendly, courteous and professional services to the patients. Patients expect to be treated respectfully, sympathetically during their stay in the hospital. Unkind, unfriendly and non-cooperative attitude towards the patients may not only bring annoyance and displeasure for the patients but it may also impact patients' faster recovery and well being.

And lastly integrity of doctors may also affect service delivery. Doctors whose integrity may be questioned may not enjoy patients trust. By trusting a doctor, a patient may do away with doubts or hesitations about the kind of treatment he or she is going to receive. Such treatment may have serious consequences on health. But a doctor who may not enjoy patients trust may not attract patients for treatment or patients may prefer other doctors at UHC. This may create imbalance in having unequal patient load with some doctors having more number of patients while others may neglect duties and indulge in private practice. Lack of integrity of some

doctors at UHC may affect the reputation and image of the institution giving a sense of service marked by lack of interest and energy from the health professionals. This not only may disappoint the patients but may also frustrate the whole approach to PHC delivered at the level of UHC.

The implications for these variables in terms of service delivery in UHC may therefore be huge. Patients' trust is not static as it is subject to change. It involves patient's expectations, relationships of medical professionals and their attitudes towards the patients. The majority of the users of services of UHC are illiterate and from low income groups of rural society. Therefore, they rely on UHC for low cost and also for the health facility which is available at their arm's length. Patients coming from relatively wealthier section of the society may seek alternative health services which may be costlier when compared to UHC. Filling up the vacancies and retention of health professionals at UHC is a major challenge towards service delivery. Availability of essential medicines and drugs, poor quality of food for indoor patients, lack of proper cleanliness of wards are some of the most common concerns of services at UHC. The introduction of e-health and e-medicine may be considered as new window of opportunity for extending health services to the rural people thus may create more pressure from demand side. Health expenditure is very low even when compared to neighboring countries. Quality of health services can only be ensured with scaled up financial resources. The introduction of citizen's charter and its use, displaying stocks of medicines for public are not uniformly followed by UHCs and yet to be seen as a routine feature. The integration of health and family planning needs to be further streamlined for bringing maternal and child health care together. There is also an observed low motivation of health professionals to work in rural stations instead they prefer urban areas where they can benefit from more thriving private practice. Partisan politics within the health professionals may create disincentive among the doctors which may become a barrier to professionalism. Political divide in medical profession have developed a culture of principal-agent relationships resulting in group loyalty and lineage. This may adversely affect the motivation of the doctors to render

quality services at UHC. Other aspects of UHC which demand equal attention and care with regard to service delivery at UHC is the creation of proper environment for work and living. Therefore, if citizens' trust is to be built, regained and sustained, then the provision for investing in doctor's welfare and creating the right environment suitable for offering responsive medical care cannot be ignored.

At this stage of the dissertation, revisiting the major hypotheses of the study may be pertinent to further verify whether they have been accepted or rejected.

**Hypothesis: 1 “Greater is the doctor’s commitment to treatment, higher will be patients’ trust at UHC”.**

According to the survey majority respondents agree that doctors of UHC are committed to their duties. Information gathered through interview reveals that not all the doctors are equally committed toward their professional duties. Notionally though it appears that doctors' credible commitment as a determinant of patients' trust at UHC may be a significant variable, but in the regression model, doctors' commitment as a constituent of patients' trust is not found to be significant. Hence, the hypothesis is rejected against the mainstream position that commitment contributes to trust building.

**Hypothesis: 2 “More competent a doctor is, more will he be trusted”.**

Survey data reveals that majority of the respondents believe that the doctors at UHC are competent. Patients may often assess the competence of doctors by their prima facie judgments and from their reputation. Other views of doctors competence are very much subjective which may be based on familiarity, continuity and treatment adherence to a doctor or it may be simply based on the belief that government appointed doctors are generally taken to be competent as general physician and may not require any scrutiny. Since BMDC provides registration to doctor for

practicing, that institutional check and quality control issues has to be ensured by BMDC. Patients' trust on UHC is generally seen to be high. Competence of doctors has been found to be significant (.260\*\* at .004 level) in the regression model. Therefore, according to this model doctors' competence build patients trust in UHC. More the doctor is considered competent, more will he be trusted by patients. Hence, the hypothesis is found to be correct and accepted.

**Hypothesis 3: “Higher is the general level of satisfaction on the services at UHC, higher will be patients' trust”.**

According to the survey findings, quality of services at UHC is reported to be moderately high. Level of satisfaction at UHC is highly significant for building patients trust. Satisfaction may be related with clinical as well as non-clinical aspects with regard to treatment at UHC. Non-clinical aspects such as behavior and cooperative attitude of the health care providers, dealing patients with respect, or when the nurses in general considered friendly to the patients may contribute to satisfaction. Other features such as cleanliness of the hospital wards and toilets, availability of medicines and hospital beds at times of need etc. may enhance satisfaction and may lead to high generalized trust in UHC.

Qualitative data reveals that service quality of UHC needs to be improved. Shortage of doctors is often seen as a major challenge towards offering quality services to the patients. Non-clinical issues such as compassionate service, respect and cooperative attitude also play important role in improvement of quality services. Quality of services has been seen to be significant in the regression model (.296\*\* significant at .001 level). Hence quality of services of UHC is a vital element for building trust in patients at UHC. The hypothesis is thus accepted.

**Hypothesis: 4 “Patients’ trust will be high in UHC, when doctor’s integrity will also be high”.**

Doctor’s integrity has been seen to be a significant explanatory factor in the regression model (.241\*\* at .007 level) on which patients may base their trust on UHC. Survey data shows that 89% of the respondents agree that doctors maintain their integrity, but secondary data and information gathered from interview suggest that there are deviations across the upazilas pertaining to doctors’ integrity which may erode patient trust on UHC. However, the hypothesis is found to be correct and accepted.

**Hypothesis: 5 “Greater the level of cooperation of doctor and nurses; higher will be the patients trust in UHC”.**

From the survey data 78% of the respondents rated doctor’s cooperation as moderately high. But in practice, doctors remain busy in attending too many patients which may put challenge to quality care. However, cooperation as an explanatory variable has been run in the regression model but found to be insignificant in building trust in UHC. The hypothesis is thus rejected against the mainstream position that cooperation promotes trust building.

**Hypothesis: 6 “Greater the privacy during treatment, higher will be the level of patients’ trust”.**

Though privacy has been recognized as an important factor in building patients trust, it has not been found to be significant in contributing to patients trust in UHC. Privacy as an explanatory variable has been included along with variables, but it came out to be insignificant. Therefore, though privacy is considered to be a necessary element during treatment, its role in patients’ trust building at UHC is not established, hence the hypothesis is rejected.

**Hypothesis: 7 “Greater the rapport and communication with the doctor is, higher will be the patients’ trust”.**

Notionally rapport and communication with the doctor appear to be an important predictor in patients’ trust building. In trust literature rapport and communication has been cited as an explanatory variable producing trust. In the regression model as an explanatory variable rapport and communication came out to be insignificant in building patients’ trust in UHC. Therefore, the hypothesis is thus rejected against the mainstream position that communication promotes patients’ trust at UHC.

**Hypothesis: 8 “Greater the level of doctor’s compassion is, higher will be patients’ trust”**

Compassionate service as an explanatory variable has been run in the regression model but found to be insignificant in building trust at UHC. The hypothesis is thus rejected against the mainstream position that compassionate care promotes patients’ trust.

**Hypothesis: 9 “Better the behavior and demeanor and quality of nursing services is, higher will be patients’ trust in UHC”**

Quality of nursing services as explanatory variable has been found to be significant in the regression model in building trust in UHC (.268\*\* at .001 level). The hypothesis is thus accepted.

**Hypothesis: 10 “More fair and non-discriminatory the services of the UHC is, higher will be the patients trust”**

Non-discriminatory services at UHC are found to be insignificant in explaining patients trust in UHC. Hence, the hypothesis is rejected against the mainstream position that non-discrimination promotes trust.

**Hypothesis: 11 “More dependency on UHC for treatment is, higher will be patients’ trust”**

Patients’ dependency on UHC for treatment and care is seen to be insignificant in explaining patients trust in UHC. Hence, the hypothesis is rejected against the notional belief that dependency promotes patients’ trust.

To sum up, out of the above 11 hypotheses, competence, general level of satisfaction, nursing quality and integrity of doctors have been found to be accepted and hypotheses which are rejected based on the variables include commitment, cooperation, privacy, communication, compassionate care, non-discrimination and dependency on UHC. Individually these variables may be significant in building patients’ trust but when put together in the regression model, they found out to be less significant. The rejection of these hypotheses challenging the apparent notional views might have several explanations. There are cultural beliefs and orientations which determine individual expectations and preferences (Gambetta,1988:217;Humpherey & Schmitz,1966; Zucker,1986:54; Mayer et al.,1995; Rosseau et al.;1988; Griffith et al.,2000; Thompson,1996). Societal norms and practices shape trust perceptions. As trust relationships develop in dyadic condition and emerge as relational phenomena, trust is conditioned by the individual perception, prima facie judgment and also through a cognitive process which may take things for granted. As reality is subject to change, the trust constituents for UHC are also likely to change from the perspective of a middle-ranged theory.

In the regression model the interrelationship of the variables in the model determine the significance level with the dependent variable. This may suggest that there are other determining variables which may constitute patients’ trust at UHC.



## Course of actions on the basis of hypotheses

On the basis of the hypotheses, some alternative courses of actions can be examined from trust perspective which may be implemented at the level of UHC.

- a. **Policy on professional development:** Investing in the health care providers for professional development and for improving their competence level both as general physicians and also as specialists has been emphasized in the health policy. It is recognized in the health policy that the health care provided at different levels suffers from minimum quality. Professional development of health care providers needs to be looked holistically where professionals both in public and private sector qualify and demonstrate requisite professional standards and practices. This will call for a concerted action from medical institutions, regulators to uniformly and effectively apply and enforce specific standards. In dealing with competence of health care providers, adequate incentive structure needs to be attached appropriately. For health care providers, competent doctors will be less interested to work in remote UHCs unless incentives for continuity in UHC are created. Otherwise, increased competence may encourage more opportunistic behavior and to the detriment and harassment of patients. It is seen that more competent doctors have shorter tenure at UHCs as retention of competent doctors at UHC by creative engagement such as incorporating career progression scheme; introducing reward and recognition are seen to be either non-existent or inadequate.

Bangladesh Medical and Dental Council (BMDC) is responsible for accreditation and registration of medical professionals for medical practice. The certification and regulatory role of BMDC needs to be revamped on the basis of actual performance of practicing doctors and for conformity of professional and ethical behavior. The BMDC has

limited functional capacity to effectively monitor and undertake surveillance to bring quality in health system. The development of health professionals and their career advancement needs to be addressed systematically.

- b. General level of satisfaction:** Patients general level of satisfaction may be considered as a broad indicator of effective service delivery. At present there is hardly any mechanism at UHC to address and capture the general level of satisfaction of patients. This may require a paradigm shift from 'doctor-centered' approach to a 'patient-centered' approach. Prevailing socio-economic situations may not be compatible for a radical shift, but a mix of both the approaches may address the issue of patients' satisfaction during treatment. The Citizens' Charter which has been introduced in UHCs is hardly brings any qualitative change in service delivery. As indicated in the strategic plan for Health, Population & Nutrition Sector Development Program (2011-2016) human resources is seen as a major obstacle to providing quality service delivery. One of the main aims of the project is to serve particularly the poor with increased access and utilization of health services. Patients' awareness as to their rights and privileges during treatment, their entitlement to receive honest and proper care must be accompanied by adequate resources and delivered by a well motivated team of health care providers. With increased commercialization of medical profession which may reward the affluent people with more close treatment and care, erosion of ethical and moral values, dedication and commitment of medical professionals becomes a major challenge for ensuring quality services in UHCs. Attitudinal problem may become a major barrier for providing quality services and for delivering satisfactory services. Limitations in supply of equipment and medicines including dealing with the number of health care providers must be addressed to enhance the general level of satisfaction at UHC. The budgetary allocations and other resources needed for essential service package needs to be ensured and consistently maintained.

- c. Nursing quality:** Quality of nursing services is an overlooked area which needs to be closely looked into from patients' trust perspective. The current doctor-nurse situation in Bangladesh as indicated in the health policy is 1:0:48. The standard ratio for doctor-nurse and other health service providers is 1:3:5. Shortages of qualified and trained nurses have put many UHCs to run ward services with limited available nurses. Shifting duties, leave and illness of nurses may often disrupt smooth Ward services in UHC. Therefore, the existing vacancies must be filled in with qualified and trained nurses. The departmental coordination among the directorates in filling existing vacancies, forecasting future needs etc. and posting of nurses must be revamped in light of the practical needs. Living and working conditions of nurses, offering rewards to best performers may instill energy for better services.
- d. Integrity of doctors:** Ethical practice and morality in treatment has been well recognized in the health policy of 2011. Integrity of medical professionals is essential from the perspective of good medical practice and also from ethical and moral point of view. Breaches in doctor's integrity may arise out of greed, lack of professionalism, negligence to duty and failure in cultivating the moral values of life. Moral qualities and character is to be learnt and values embedded in ones' early childhood learning in school. Professional development and orientation may only reinforce what has been already learnt as virtues. However, the ethical and moral aspects in the conduct of medical practice is seen to be greatly undermined along with the erosion of social values and norms and often considered as secondary. With increased politicization of health administration which may often reward loyalists and incompetents, effective monitoring and regulatory control could also become ineffective. This has affected medical profession as a whole as well as UHC with large vacancies from unfilled positions and unauthorized absence from duty. Medical profession has also undergone changes particularly in their attitudes which often manifest

greed and opportunism and source of harassment of patients. The regulatory authority Bangladesh Medical Dental Council is mandated for ensuring professional norms and standards for practicing doctors in conformity with the laid out norms. Without certification, no doctor can do practicing. However, there is a tendency on behalf of the doctors to use degrees not recognized by BMDC befooling patients and resort to private practice. Likewise Bangladesh Nursing and Midwifery Council and Pharmacy Council of Bangladesh along with awarding certification of particular degrees and accreditation also regulate the professional and ethical aspects of the nurses and pharmacists. The regulatory authorities appear to be weak and lack in capacity to strictly monitor and ensure compliance needed for ensuring quality of treatment. Therefore, by and large it may be said that the respective regulatory authorities are seen to be ineffective in ensuring patients' quality of treatment and safeguarding the interests of the patients. From policy perspective, concerted efforts are needed to ensure quality and patient centered approach to treatment by enhancing the integrity system in medical profession.

### **Revisiting the definition of 'trust'**

It is also pertinent at this stage, to revisit the definition of 'trust' adopted in this study (in Chapter V) which is advanced by Mayer et al.(2006:85). Trust as defined is "the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party". While this is applied to the situation of a patient and doctor in case of UHC, it may be seen that patients do trust the doctors at UHC with the expectation that such treatment will not harm rather bring their health benefits. Therefore the patients' are willing to take risks of such vulnerabilities with the belief that doctors actions will not harm rather bring health benefits, secondly, such vulnerabilities will not be exploited. In such a condition, necessity of control or monitoring on the part of the patients may not be required. That means doctors would perform

whatever is beneficial and necessary from the point of treatment perspective and considering patients' welfare, but there may be consequences which may at times lead to negative health outcomes which may be irreversible. In general it is expected and believed that most doctors' at UHC act professionally and to the benefit of the patients. It is also important to note that doctors may also behave opportunistically which may amount to exploitation of the vulnerabilities of the patients. Evoking doctors' moral and ethical values in combination with professional norms and practices may shield patients from such vulnerabilities arising out of their treatment. Therefore, from this study, it appeared that the definition not only captures the essence of trust in doctor-patient relationships but also relevant to the understanding and analysis of the study.

## **Epilogue**

The study on citizens' trust in public institution - a study of service delivery institutions at local level in Bangladesh has brought in patients' trust perception on treatment at UHC and examines trust from institutional perspective. Treatment in Bangladesh is largely seen to be doctor-centric where patients' perspective to treatment and care are often ignored or not properly addressed. In case of UHC, the concept of free medical service and care often lends health service providers to forget that patients' need to be treated with respect, compassion and kindness. Though trust in doctor-patient relationship has been in the research agenda for advanced countries since long, studies are limited in the context of developing countries which typically addresses doctor-patient relationships. Trust research on primary health care in Bangladesh is perhaps a new area of study. Such limitations have resulted in some challenges in studying patients' trust where there is free service provision. Patients' trust in doctors' may be considered essential from the point of reliability of treatment, positive health outcomes and satisfactory services. The study of trust reveals that satisfaction on services and positive health outcomes cannot be solely achieved only by clinical interventions. Therefore, more focus and attention should also be given to non-clinical factors such as

behavior and demeanor of doctors and nurses, compassion, benevolence, fidelity etc. which may build generalized trust in UHC.

The study attempted to map generalized trust in UHC, identified the major trust arenas for UHC and sources of opportunism which may erode and damage patient's trust. Policy implications for each of these sources of opportunism and trust arenas warrant serious engagements of the actors and policy community to bring and review the agenda in policy debate.

The study on trust reveals that trust differences due to gender, income is less significant in case of UHC. There is apparent high trust in UHC as far as treatment of the poor and lower income groups of citizens is concerned. But non-continuity, unauthorized absence of doctors from work, opportunistic behavior of doctors may erode patients' trust. Quality of nursing services is an often ignored area which needs special attention if service delivery needs further improvement. For a more satisfying experience on health services at UHC, the focus is only given to doctors and the contributions of the nurses, cleaners often seen to be overlooked as their services may contribute to a more satisfactory stay and treatment in the hospital. Therefore, the role of nurse and cleaners are very much part of the service delivery system which also needs attention when similar studies may be conducted. The set of factors which emerged as significant in the regression model contributing to trust building in UHC are competence of doctors, quality of services delivered, quality of nursing services and lastly integrity of doctors. From policy perspective, these four areas need to be focused and strengthened in order to make service delivery more effective and satisfying to the public.

Based on the findings of the study, primary healthcare may be seen and evaluated on the basis of the assessment of the patients with regard to services at UHC. In other words, the supply side dynamics can be tailored on the basis of the demand side. This will also make the services more relevant and cost effective. In order to mitigate the challenges, service delivery at UHC cannot be studied with the performance of the doctors

alone. The often dismal notion of service delivery at UHC arising out of negligence to duties and shortages of doctors may frustrate the development interventions at UHC. This may also affect patients' trust at UHC which once damaged could take long time to repair. Satisfactory and reliable treatment may build patients' trust which may remain as a sensitive and delicate area and must not lose sight from the perspective of quality service delivery. Therefore, when issues such as quality, access and equity in PHC may dominate the policy discourse, it may also be pertinent to focus on the softer skills involved in the non-clinical aspects of care which may be essential for rendering quality services. Non-sensitivity to this may undermine the existing services at UHC which may erode patients' trust. Erosion of trust may also lead to non-utilization of the available services and other health interventions at upazila. Therefore, effectiveness and future prospects of PHC at upazila may rely on those conditions which may generate and sustain patients' trust.

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**Questionnaire for Survey**

1. Demographic status:
  - a. Age of the respondent -
  - b. Village-
  - c. Upazila/District-
  - d. Gender- Male/Female
  - e. Marital Status- Married/ Unmarried/Divorcee/ Widow
  - f. Occupation- (Day labor, agriculture labor, unemployed, tri-wheeler /van driver, housewife, teaching, service, others),
  - g. Educational background- Illiterate, up to class five in primary education, up to class eight, up to class ten, higher secondary and above, F
  - h. Family Size-less than four, up to four, up to six, up to ten and more than ten members,
  - i. Monthly household expenditure- Tk3000, Tk5000, Tk 8000, Tk 10000, Tk15000, Tk20000 and above.
2. Distance to Upazila Health Complex (UHC) from home- in .....Kilo meters.
3. Please state the reasons/health complains for visiting the UHC.
4. Are you aware about the services that are delivered at UHC?
  - a. Aware about the services it delivers
  - b. Have no idea about the services it delivers,
  - c. Cannot tell.
5. What is the frequency in coming to UHC in the past for treatment?
  - a. Always come to UHC and hardly go anywhere for treatment,
  - b. Come to UHC for treatment as well as go elsewhere
  - c. Always come to UHC and do not go anywhere
6. Do you trust the services offered at UHC?
  - a. I have trust,
  - b. I have no trust,
  - c. Cannot tell
7. What is your conception of 'trust' with regard to treatment in UHC?
  - a. when the doctor treats patient with care
  - b. when services are available during emergency situation
  - c. when illness is cured after treatment
  - d. when treatment is followed by free supply of medicines
  - e. when all treatment facilities are provided
  - f. when doctors and nurses are cooperative
  - g. reflecting on past experience in getting proper cure from a particular doctor
8. Please comment on the following about service delivery at UHC.
  - a. Cost of treatment- (free/ very low/high)
  - b. Quality of treatment-(more or less satisfactory/Satisfactory/ Not at all satisfactory/cannot tell)
  - c. Conduct of doctors and nurses (more or less satisfactory/Satisfactory/ Not at all satisfactory/cannot tell).

**(The following statements relate to the health service delivery provided under the UHC. Please tick in appropriate boxes.)**

9. Do you agree that the doctors at UHC treat their patients with credible commitment and compassion?
- Completely agree (4),
  - Partially agree (3),
  - Partially disagree (2),
  - Completely disagree (1),
  - Do not know (9).
10. Do you think that the doctors deputed at UHC have the requisite qualifications and experience to treat common diseases?
- Completely agree (4),
  - Partially agree (3),
  - Partially disagree (2),
  - Completely disagree (1),
  - Do not know (9).
11. What according to you is the quality of services and treatment at UHC? Please rank by using the following scale from '0' (Low level of quality and services) to '5' (high level of quality and services).

(Low) 0            1    2    3    4    5 (High)

12. Please explain the reasons if the answer to the above question is rated below '3'.
- - 
  -
13. Do you agree with the statement that many doctors reside in the towns and do private practicing; nevertheless, as far as treatment at UHC is concerned no negligence on behalf of the doctors has been visible.

Completely agree	Partially agree	Partially disagree	Completely disagree

14. Is there anyone familiar to you working at UHC? Yes /NO.
- 14.1 If the answer to the above question '14' is 'yes', whether they have been helpful
- in seeking the audience of the doctor and in collecting the medicines?
- They provided help,
  - It was not required,
  - No help was extended.
15. If the answer to the above question '14' is 'no', whether you faced in difficulty in seeing the doctor or in collecting the medicines? 'Yes' / 'No'.
16. If the answer is 'yes' then explain the difficulties you faced.

17. How long you have been admitted to the hospital?

- a. 1 day,
- b. 2 days,
- c. 3 days,
- d. 5 days
- e. more than 5 days.

18. Do you agree with the statement that, if no one from home is accompanying while at hospital, getting proper treatment becomes extremely difficult.

Completely agree	Partially agree	Partially disagree	Completely disagree

19. To what extent you believe that you will be relieved of your pain or cured from your illness by having treatment from UHC? Please rank by using the following scale from '0' (Expectation Low) to '5' (Expectation high).

(Low) 0    1    2    3    4    5 (High)

20. Do you agree with the statement that number of doctors in comparison to patients at the OPD and IPD is inadequate?

Completely agree	Partially agree	Partially disagree	Completely disagree

21. Do you agree that UHC take proper initiatives for campaign to raise awareness among people against preventive medicines and campaign?

Completely agree	Partially agree	Partially disagree	Completely disagree

22. Do you agree that UHC provides treatment to all with no discrimination?

Completely agree	Partially agree	Partially disagree	Completely disagree

23. Please rank the level of cooperation received from the doctors at UHC during your consultation and treatment. Please rank by using the following scale from '0' (Low cooperation) to '5' (High cooperation).

(Low) 0    1    2    3    4    5 (High)

24. Do you agree with the statement that the doctors posted at UHC reside at the health complex at all times and provide treatment to the patients?

Completely agree	Partially agree	Partially disagree	Completely disagree

25. Do you agree with the statement that usually medicines are available and provided to the patients. But there may be a case when patients' may have to buy few medicines from outside which are not supplied.

Completely agree	Partially agree	Partially disagree	Completely disagree

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26. "Complaints about medicines and food in the hospital at UHC are quite common".  
Do you agree with the statement?

Completely agree	Partially agree	Partially disagree	Completely disagree

27. Do you agree that there has been deterioration of services provided at UHC over the years?

Completely agree	Partially agree	Partially disagree	Completely disagree

28. Do you agree that patients are all dependent on UHC for treatment and for their medical needs since there are no other health care providers at upazila?

Completely agree	Partially agree	Partially disagree	Completely disagree

29. Do you agree that the qualities of services provided by the nurses at UHC are quite satisfactory?

Completely agree	Partially agree	Partially disagree	Completely disagree

30. Do you agree that for getting treatment at UHC, patients are not generally subject to any harassment?

Completely agree	Partially agree	Partially disagree	Completely disagree

31. Do you agree that generally beds in hospital are available to patients, but there may a time when patients may have to be admitted beyond the capacity of beds and accommodated in floor.

Completely agree	Partially agree	Partially disagree	Completely disagree

32. Please rank the level of privacy and confidentiality at UHC and state if you have been examined in front of others and whether this caused any embarrassment as a breach to privacy? Please rank by using the following scale from '0' (Low privacy) to '5' (High privacy).

(Low) 0 — 1 2 3 4 5 (High)

33. Please rank the level of communication and rapport with the doctors during the time of treatment at UHC and explain to what extent you could explain your problem? Please rank by using the following scale from '0' (Low communication) to '5' (High communication).

(Low) 0 — 1 2 3 4 5 (High)

34. To what extent you are satisfied and think the OPD services of UHC as trustworthy? Please rank by using the following scale from '0' (Low satisfaction) to '5' (High satisfaction).

(Low) 0 1 2 3 4 5 (High)

35. To what extent you are satisfied and think the Ward/IPD services of UHC as trustworthy? Please rank by using the following scale from '0' (Low satisfaction) to '5' (High satisfaction).

(Low) 0 1 2 3 4 5 (High)

36. Do you think that the doctors at UHC have been compassionate to you during treatment? Please rank by using the following scale from '0' (Low compassion) to '5' (High compassion).

(Low) 0 1 2 3 4 5 (High)

37. Please state the level of your trust on the availability and accessibility of medicines at UHC. Please rank by using the following scale from '0' (Low trust) to '5' (High trust).

(Low) 0 1 2 3 4 5 (High)

38. What is your experience about the conduct, behavior and demeanor of the nurses at UHC and the quality of their services? Please rank by using the following scale from '0' (Low satisfaction) to '5' (High satisfaction).

(Low) 0 1 2 3 4 5 (High)

39. Please state if there are any observations on the services of UHC about its trustworthiness or lack of it.

-End-



Appendix-2

**Format for writing cases on selected patients**

Date:

**Personal Profile:**

Name:	Male/Female	Village:
Upazila:	District.	Age:
Marital Status:	Number of Children:	Current Family Size:

1. Tell me how are you today?
2. Do you always go to UHC whenever you feel sick?
3. When did you go last?
4. Why do you go to Upazila Health Complex and not to other places?
5. Do you have to buy medicines?
6. What are your monthly expenses on medicines?
7. How do you meet those expenses?
8. When you go to the UHC, do you find difficulty in seeing a doctor?
9. Could you explain your health problem to the doctor?
10. Do you think that the doctor (when you saw him last) gave adequate time in examining you?
11. How do you feel now after the treatment from UHC?
12. Do you trust the doctor(s) who treated you?
13. Why do you trust the doctor?
14. Do you think the doctors treated you well and with kindness?
15. Do you think that UHC generally treat patients with compassion and care?
16. How did you find the services of UHC?

**Format for response of key informants**

**Occupation:**

**Age:**

**Upazila:**

**District**

1. Have you ever visited UHC? Yes/ No ( if the response is "yes" when?
2. What impression do you have about the Upazila Health Complex Services?(Your own impression)
3. What is the widely held view of the community about trusting the services of Upazila Health Complex (responsiveness, treatment etc.) (Please answer as objectively as possible)
4. For your health emergency where do you generally go? Why?
5. Do you have any other observation(s) about the health services offered by UHC as far as trust is concerned?

Appendix- 4

**Questions for UHFPO**

**Upazila:**

**District:**

1. What are the key challenges of UHC for providing services to the people? Do you think that UHC despite its challenges has been able to keep up with the growing expectations of the people of the locality in getting primary health care?
2. Do you get adequate resources on a regular basis for delivering treatment to the patients?
3. Do you think that the local residents get proper treatment and depend on UHC for meeting their health needs?
4. What according to you would lead UHC to become a more trustworthy institution?  
(Please tick below as appropriate)
  - a. Ability and competence of the doctors to diagnose, prescribe drugs and take prompt required action.
  - b. Benevolence of doctors and other officials to the poor people,
  - c. Integrity of the Upazila Health Administrator or other doctors
  - d. Commitment and compassion of doctors towards patients,
  - e. when sufficiently resourced (supply of medicines and other supplies)
  - f. when it has full organizational strength in terms of manpower and have the right work environment,
  - g. Offer kind and responsive service to the patients,
  - h. For female patients and young children, what specific measures have been taken by UHC to provide faster and reliable health services?
  - i. Do you think the introduction of mobile phone services have put Upazila Health Services one step ahead in trusting their services?
  - j. For developing a healthy and trustworthy doctor-patient relationship what suggestions you have?
  - k. For developing Upazila Health Complex as a trusted institution what suggestions you have?

Appendix-5

**Interview guide for Director, DGHS)**

1. What are the key challenges of primary health care (PHC) at the level of Upazila Health Complex (UHC) in terms of access, quality and service delivery? (Access, quality and service delivery)
2. Is there any institutional framework to make the primary health care more trustworthy? Such as standard operating procedure, manuals, protocols for patients at OPD or IPD at Upazila Health Complex? (Clinical protocol, operating procedure for outdoor such as patients screening etc. can lead to uniform or patterned treatment).
3. Is there any code of conduct which is mandatorily observed by all doctors to ensure sound medical practice at UHC?
4. Please state current training facility available for doctors posted at UHC for upgrading their professional competence?
5. How long it takes or what conditions must be fulfilled to post a doctor at UHC?
6. What is the current backlog of doctors to be posted at UHC yet to have any foundational training?
7. Is there any training module which is incorporated in Foundation Training Course that stresses on good medical practice and good code of conduct?
8. What are the major complaints that you are aware of about the service delivery at UHC? (such as medicines non-availability, poor quality of food at IPD, absenteeism of doctors and nurses, negligence, corruption etc).
9. Please comment to what extent UHC's have been able to provide responsive and effective primary health care to the citizens?
10. Do you think the services delivered at UHC have met satisfactory levels of primary health care? Please provide evidence in support of your argument.
11. What is the current patient-doctor ratio at UHC level and how it impacts service delivery? What is the desired level of patient-doctor ratio at Upazila level in Bangladesh? How this may be bridged in future?
12. What is the usual tenure of a medical officer posted at UHC?
13. What policy is usually followed for posting and transfer of doctors at UHC?
14. Please state how patients trust in the services of UHC can be built and sustained?

## Appendix-6

## Vacant positions of medical professionals in several upazilas of Bangladesh

District	Number of Upazilas	Total Sanctioned positions of doctors	Total current vacant positions
Lalmonirhat	5	96	70
Jhinaidah	6	161	97
Chudanga	4	74	37
Bagerhat	9	183	140
Dhaka	6	189	-
Narayanganj	5	86	4
Gazipur	5	129	12
Thakurgaon	5	103	88
Rangpur	8	176	50
Panchagarh	5	119	92
Nilphamary	6	135	85
Kurigram	9	148	84
Gaibandha	7	148	89
Dinajpur	13	238	149
Shirajganj	9	158	55
Rajshahi	9	215	65
Pabna	9	199	101
Natore	6	127	57
Naogaon	11	263	197
Joypurhat	5	96	62
Chapai Nababganj	5	102	65
Bogra	12	293	188
Rangamati	10	138	99
Laxmipur	5	99	59
Noakhali	9	248	105
Khagrachari	8	102	72
Feni	6	115	61
CoxsBazar	8	180	120
Comilla	17	407	47
Chittagong	14	444	127
Chandpur	8	192	72
BBaria	8	173	71
Bandarban	7	77	41
Tangail	12	282	42
Sherpur	5	91	43
Shariatpur	6	123	62
Rajbari	5	104	49
Netrokona	8	238	141
Narshingdi	6	130	2
Mymensingh	12	320	49
Munshiganj	6	177	16
Manikganj	7	137	7
Madaripur	4	97	37
Kishorganj	13	259	108
Jamalpur	7	171	99
Faridpur	6	166	77
Kushtia	6	146	66
Jessore	8	195	91
Sylhet	12	235	107
Sunamganj	11	169	105

Moulvibazar	7	138	65
Pirojpur	7	130	79
Potua khali	7	163	102
Jhalkathi	4	73	44
Bhola	7	164	118
Barishal	10	206	90
Hobiganj	8	148	75
Barguna	5	107	77
Satkhira	7	171	83
Narail	3	72	53
Meherpur	3	55	44
Khulna	9	175	84
Gopalganj	5	131	More than half
Magura	4	64	39

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### Hypotheses

**Hypothesis 1: 'Greater is the doctors commitment to patients treatment, higher will be the trust in UHC'.** The null hypothesis is doctors commitment can play little role in patients' trust building. 'Doctors commitment' has been operationalized by the degree of sincerity in dealing with patients when they are examined and also making themselves available on duty at UHC. Commitment is measured through patient's response in a Likert scale having options such as 'completely agree' 'partially agree', 'completely disagree' and 'partially disagree' and 'do not know'.

**Hypothesis 2: 'More competent a doctor is, more will he be trusted'.** The null hypothesis is that competence of doctor have minimal role in patients' trust building. 'Doctors competence' has been operationalized by the patients perceived notion and reputation of the doctors that they are capable of providing treatment to the patients and they have requisite qualifications as registered doctors. It is measured in a Likert scale having options such as 'completely agree' 'partially agree', 'completely disagree' and 'partially disagree' and 'do not know'. Competency involves knowledge and skills necessary for effective operations or treatment.

**Hypothesis 3: 'Greater is the general level of satisfaction on UHC, higher will be patients trust'.** The null hypothesis is level of satisfaction has no relationship with patients' trust. 'General level of satisfaction' has been operationalized by the degree of fulfillment of patients' expectations with regard to treatment and quality of services at UHC. Patients' will be satisfied when health response and care in the UHC are seen to be prompt, efficient, reliable, appropriate and consistent. Friendly professional services in patient care and overall cleanliness of the hospital contribute to patients' satisfaction. Level of satisfaction for services at UHC has been measured through patient's response in a five point scale ranging from '1' as 'unsatisfactory' to '5' is 'highly satisfactory'.

**Hypothesis 4: 'Greater will be the level of cooperation of doctor and nurses, higher will be the patients trust in UHC'.** The null hypothesis is cooperation of doctors and nurses have minimal role in building patient's trust. 'Cooperation' of doctors and nurses has been operationalized by the degree of cooperative and

friendly attitude extended towards the patients during treatment such as during examination or when doses of medicines are administered by nurses. Cooperation is measured through patient's response in a scale from '1 to 5' where '1' is read as 'low' to '5' read as 'high'.

**Hypothesis 5: 'Greater the privacy during treatment, higher will be the level of patients' trust'.** The null hypothesis is that privacy during treatment in UHC has no implication in patients' trust building. 'Privacy' has been operationalized by the degree of attention and respect given to individual patients in keeping their confidentiality and not exposing their vulnerability to others. So that waiting patients do not overhear the conversation between doctor and a patient or the patient is not exposed in a manner during examination which may cause embarrassment. Privacy is measured through patient's response in a scale of '1 to 5' where '1' is read as 'low level of privacy' to '5' as 'high level of privacy'.

**Hypothesis 6: 'Greater is the rapport with the doctor, higher will be the patients' trust'.** The null hypothesis is that rapport and communication with doctor play a minimal role in patients trust building. 'Rapport and communication' has been operationalized by the degree of attention and time in listening to a particular patient during examination and asking relevant questions for proper diagnosis and providing treatment at UHC. Rapport is measured through patient's response in a five point scale from '1 to 5' where '1' is read as 'low rapport' and '5' read as 'high rapport'.

**Hypothesis 7: 'Greater is the level of doctor's compassion, higher will be the patients' trust'.** The null hypothesis is compassionate care has minimal role in patients' trust building in UHC. Doctors' compassion has been operationalized by the manifestation of sympathy and care to a patient by words and bodily touches in a manner that comforts a patient and gives him hope of quick recovery. Compassion is measured through patient's response in a five point scale from '1' to '5' where '1' is read as 'low' compassion to '5' as 'high' compassion.

**Hypothesis 8: 'Better the behavior and demeanor of doctors and quality of nursing services, higher will be the patients' trust in UHC'.** The null hypothesis is nursing services play minimal role and have no relationship with patients' trust in UHC. 'Behavior and demeanor of doctors and nurses' has been operationalized by the friendly and professional gesture of doctors and nurses in



dealing with patients during treatment. The quality of services delivered by nurses is often ignored or it has not been given adequate focus and attention in studying patients' trust. The doctors diagnose illness of patients and prescribe medicines. The service of nurses is crucial for effective health service delivery in any system. The nurses are responsible for administering doses of medicines as prescribed by the doctors. Behavior and demeanor is measured through patient's response in a five point scale from '1' to '5' where '1' is read as 'low' and '5' read as 'high'.

**Hypothesis 9: 'More fair and non-discriminatory the services of the UHC is, higher will be the patients trust'.** The null hypothesis is fairness have minimal role in patients trust building in UHC. 'Fair and non-discriminatory services' has been operationalized by the attitude of doctors and nurses in treating all patients equally irrespective of their social and economic status and giving proper treatment at UHC. 'Fair and non-discriminatory services' is measured through patient's response in a Likert scale of 'completely agree' 'partially agree', 'completely disagree' and 'partially disagree' and 'do not know'.

**Hypothesis 10: 'Greater is the doctors' integrity at UHC, higher will be the patients' trust'.** The null hypothesis is that integrity of doctors have no relationship with patients; trust in UHC. 'Doctors integrity and professionalism' has been operationalized by their full time physical presence in the UHC and non-negligence to duty from unauthorized absence. Integrity and professionalism is also measured through patient's perception and treatment experience of a particular doctor(s) in a Likert scale of 'completely agree' 'partially agree', 'completely disagree' and 'partially disagree' and 'do not know'.

**Hypothesis 11: 'More dependent a patient on UHC is, higher will be the patients trust'.** The null hypothesis is **dependency** on UHC has no relationship with patients trust building. 'Dependency' on UHC has been operationalized by the majority of the patient's reliance on UHC for treatment and emergency services in terms of cost and quality treatment and in absence of similar other health facilities at upazila. 'Dependency' on UHC is measured through patient's response in a Likert scale of 'completely agree', 'partially agree', 'completely disagree' and 'partially disagree' and 'do not know'.