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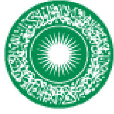

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Review Article

Health seeking behaviour and health services utilization trends in National Health Survey of Pakistan: what needs to be done?

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Abstract

In developing countries, health seeking behaviours and health care services utilization patterns have been studied and the determinants have been classified in physical, socio-economic, cultural and political contexts. This paper is based on a systematic review of peer-reviewed literature on the relationship of factors affecting health service utilization and the focus has been on Pakistan. For this purpose, National Health Survey (NHS) of Pakistan, conducted in 1990-1994, has been critically reviewed. The review reveals specific behaviours following gender differences, socio-cultural milieu, disease patterns, household economics etc. Thus it becomes imperative to design evidence based policies by developing the understanding of health behaviours and health care utilization trends and to give enough credence to all determinants in the background. Health sector reforms therefore necessitate developing mechanisms to deliver more need based and quality services, considering thoughtfully users' concerns and perspectives. The advent of decentralization in Pakistan provides a unique opportunity for tackling multi-faceted issues by multi-sectoral approaches.

Introduction

Health seeking behaviour and health care utilization is determined by the organization of the health system. Health system does not merely represent the structures that provide health care but it encompasses various other elements which constitute the system as a whole. These are economic conditions, family system, social support network, cultural forces, environmental conditions, political systems and so on, which invariably affect the health care seeking patterns.[1] As for health care system, in almost all the developing countries, the public and the private health sector co-exit, complementing or conflicting with each other. Yet, in health planning, least consideration is given to harmonize this co-existence in the larger benefit of the users.[2] In developing countries, health seeking behaviours and health care services utilization patterns have been studied and the determinants have been classified in physical, socio-economic, cultural and political contexts.[1] Number of studies show that trends in utilization of a health care system, public or private, formal or non-formal, by and large, vary depending on factors such as age, gender, women's autonomy, urban or rural habitat, economic status, severity of illness, availability of physical infrastructure, type and cadre of health provider, etc.[3,4]

Methods

This paper is based on a systematic review of peer-reviewed literature on the relationship of factors affecting health service utilization and the focus has been on Pakistan. For this purpose, National Health Survey (NHS) of Pakistan, conducted in 1990-1994, has been critically reviewed.[5] A brief introduction of health care system of Pakistan is given and then various determinants of health services utilization have been discussed. A search of peer-reviewed, indexed papers was done using MEDLINE. A combination of the keywords was used: social determinants, public health, health outcomes, health systems, health policy, health seeking behaviours, developing countries, and Pakistan. Official documents of Government of Pakistan and reports from World Health Organisation, World Bank and other international organizations have also been referred to. Conclusions are drawn relating to the health services utilization patterns observed in NHS of Pakistan.

Health Care System in Pakistan

There is a clear dichotomy of the health care system in Pakistan; public sector financed by the state and private sector working independently for profit. Government of Pakistan spends less than 1% on health care, even lower than Bangladesh and Sri Lanka.[6,7] Even then, some health indicators have been improving such as immunization coverage and the knowledge of family planning.[8] For 66% living in the rural part of the country, poverty along with illiteracy, low status of women and inadequate water and sanitation facilities had remarkably slowed down the progress in health indicators.[9] Cultural and social barriers hinder health seeking from an effective and modern health care service.[10,11] At the community level, the Lady Health Worker programme has gained international reputation due to its grass root level coverage and the support by an elaborate network of primary to tertiary level health facilities.[12] However, the basic level facilities' restricted hours of operation and distant locations have been unable to change the picture. Most of these facilities lack trained personnel especially female health providers.[13] In private sector, besides few accredited outlets and hospitals, many unregulated hospitals, medical general practitioners, homeopaths, traditional/spiritual healers, Unani (Greco-arab) healers, herbalists, bonesetters and quacks provide unchecked health care. As a consequence, improvements in health behaviours and practices, especially of rural population groups have been very slow.

The health status of women and children

The low social status of women results in a toll of unacceptable and preventable maternal deaths, one of the highest in south Asia. This certainly has severe repercussions on health in particular, and self-respect in general, of the women and their children. In countries of the region, women suffering from an illness report less frequently for health care seeking as compared to men.[14] Having a subjugated position in the family, women and children need to seek the permission of head of the household or the men in the family to visit health services.[3,11] Maternal and child health issues are quite prevalent, yet unaddressed because of various reasons issuing from within the health system. Dearth of qualified female health providers has by and large curtailed women to seek appropriate and timely health care. In Pakistan, more than 80% of deliveries are performed by untrained or semi-trained dais or traditional birth attendants.[15,16] Appropriateness of services vis-à-vis the gender specific cultural norms and client's needs is also not much visible.[17] However, contrary to other countries in the region, a Pakistani female visits health care provider (of any cadre) 6 times and a male 5 times a year.[5] Besides reproductive health issues, an important reason for higher rate of consultation might be a perpetuating ill health, generalized weakness, depression and anxiety due to domestic and sexual violence.[18] As research have shown that burden of multiple cardiovascular disease risk factors in women is greater than men, validates more number of visits to health provider.[19] Upper respiratory tract and gastrointestinal infections are frequently observed among children under 5 years (on average 6 episodes a year).[5] Moreover, fulfilling the responsibility of taking their child to doctor, gives women an opportunity to consult for themselves too.

The contact rate

In Pakistan, the average number of contacts with a health provider over the age of five years is 5.4 visits per year.[5] This number of visits is even more than the number of visits made in US.[20] This fact may be attributed to the burden of disease (both communicable as well as non-communicable) in urban and rural areas of Pakistan. Rural areas are generally marked with poverty and under-development related diseases such as nutritional deficiencies, diarrhoea, dysentery, immunization avertable diseases, hepatitis, tuberculosis and other acute and chronic respiratory problems.[21] Besides, health issues of women which remain by and large unaddressed, oblige women to seek health care from a variety of health providers, both formal as well as non-formal.[10] Urban population, on the other hand, faces principally the diseases of affluence such as diabetes, hypertension, cancers, arthritis and stroke. Compounding all these are environmental pollution and colossal burden of road traffic injuries.[21]

The non-communicable disease burden

Hypertension and diabetes are the two main contributors in chronic disease burden. Both the diseases are under recorded and highly under recognized in Pakistan.[5] The epidemic of cardiovascular diseases in South Asia, engulf Pakistanis rendering maladies of hypertension, diabetes, smoking, and dys-lipidemia.[22] Rather women in Pakistan have a greater burden of clinical cardiovascular risk factors than men.[19] Chronic bronchitis is another cause of death. In age group over 65 years, prevalence is as high as 14% among rural females and 6% in rural males; whereas in urban areas, it is 9% for both sexes. This could be a likely cause of higher number of visits to a health provider among the older age group (6-8 per annum).[5] Even Pakistani children have higher blood-pressure levels, adjusted for body-mass index, than white children in the United States.[23] One could thus argue that it may be this non-communicable disease burden, for which so many visits to a health

provider are recorded in NHS.

Public vs. private health care utilization

Under-utilization of health services in public sector has been almost a universal phenomenon in developing countries. NHS shows similar trends, where overall government doctors provide 21% of the total care. Residents of rural areas depend largely on government dispensers and paramedics; women ought to rely on them because of the limited social mobility. Yet a government doctor is consulted 1.2 times a year as compared to other health providers which are visited 4.2 times a year. Moreover, government doctors' utilization is even lower in rural areas (1.1) as compared to urban (1.3).[5] Firstly, there are no doctors found in many of the primary health care facilities. Secondly, when it comes to women patients, there are very few female doctors employed in the public sector.[14] Non-availability of qualified staff, medicines and quality of care most of the times compel patients to make multiple visits to multiple doctors for the treatment of same illness. Patient's own health related behaviour especially that of compliance with medication is another factor to be considered. However, the number of visits neither depicts the access and equity aspects; nor does it mean that health care is accessible and available to all. The deplorable quality of care provided in the public and private sector both, has been a ground reality for the last many years. In developing countries, generally a higher pattern of utilization of private sector allopathic health facilities could be attributed to easy access, shorter waiting time, longer or flexible opening hours, availability of staff and drugs, better attitude and more confidentiality in socially stigmatized diseases.[24,25] In spite of this fact, the responsiveness and discipline of the health provider has been dubious in private hospitals of developing countries.[26,27] Affordability, nevertheless, remains an issue. NHS findings disclose that the private doctors are most commonly consulted as much as by 65% of the population. Low economic status women consult private doctors for 30% of all visits, while high status women do so for 68% of all visits5.[5]

Health and economics of Pakistan

In south Asia, magnitude of household out of pocket expenditure on health is at times 80% of the total amount spent on health care per annum.[28] Economic ability to utilize health services has not been very different in Pakistan too. For health expenditure in Pakistan, 76% goes out of pocket.[29] This very factor also determines the measure of ability of a person or a family as a whole to satisfy their need(s) for health care. The cost has undoubtedly been a major barrier in seeking appropriate health care in Pakistan.[3,22] This complexity is reflected in the health seeking behaviour, including the use of home-prescriptions and self-medicating with medicine borrowed from a neighbour or purchased form the chemist shop. In NHS, little difference is observed in terms of health service utilization by economic status.[5] This negligible difference in trends of utilization of health services between rural and urban population does not reflect that both strata of population enjoy the same health status. Though rural poor have more needs, yet they actually lack quality services and need based treatments. The distance separating patients from the nearest health facility has been remarked as an important barrier to use, particularly in rural areas.[30] In NHS, findings reveal that at least 5% go to hakims, homeopaths and faith healers.[5] This representation looks very diminutive because the traditional beliefs tend to be intertwined with peculiarities of the illness itself and a variety of circumstantial, economic and social factors. Nearest and most available health provider in a rural proximity would be a non-formal practitioner, who would be consulted mainly because of the low cost incurred. Household economics certainly limit the choice and opportunity of health seeking.[13]

Conclusion

With this intricate picture of health system utilization and health seeking behaviour in Pakistan, a more coordinated effort is imperative in designing health promotion campaigns through inter-sectoral collaboration focusing more on vulnerable segments of the population. A comprehensive health care system, therefore, must focus on the rural population who becomes visible only when programmes are signed with international donors; as well as urban population which is evenly suffering from its own disease burden attributed to fouled urban environment. Emphasis needs to be given on reorienting health systems in support of non-communicable diseases prevention and control. Hitherto, public sector has always been struggling with growing health care costs, for that reason, public-private partnerships in operating and managing public hospitals can provide a window to share financing, improve performance and ultimately enhance the quality of services. Investing in health necessitates an in-depth research to visualize the real picture of the habits and practices of the people towards health. The advent of decentralization in Pakistan provides a unique opportunity for tackling multi-faceted issues by multi-sectoral approaches. It is of utmost importance to design policies by developing the understanding of behaviours and health care utilization trends at the district levels and to give enough credence to all the determinants in the background. More challenging would be translating such research and understanding into

policy and action.

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