Sociology of health care decision: Exploration at a public hospital dispensing traditional medicine in Bangladesh

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Introduction

Health and development of diseases have long been of interest to mankind. Genetic predisposition, social conditions, and other environmental factors influence health and disease. People through the ages have generally viewed health problems from the perspective of their own particular society and culture, and have responded to diseases in predictable ways. Studying the norm, value, belief, social structure, social action, functional integration, and life-style of people have provided insight into the organization of resource that interplay in coping with health problems. Optimum utilization of resource involves careful consideration and decision-making on the part of the sufferers and the persons responsible for ensuring resource allocation and distribution, and maintaining the rights and obligations of the society. In this study, emphasis has been placed where patients turn to the unani and ayurvedic systems of traditional medicine and the weight that is placed on the existing complex medical pluralism in Bangladesh.

Classifying the existing health facilities available in Bangladesh, Paul (1983) observes that an overwhelming majority of the population of rural and urban areas depends on both public and private medical services. These services are rendered by-

(a) allopathic practitioners with Bachelor of Medicine and Bachelor of Surgery (MBBS) or higher degrees or Medical Board Licenses;
(b) practitioners without medical degrees or licenses who use allopathic drugs;
(c) practitioners using homeopathic medicine who are institutionally trained or self-taught;
(d) unani and ayurveda practitioners who are institutionally trained or self-taught;
(e) traditional midwives who learnt their craft by apprenticeship and personal experience;
(f) spiritual healers who do not use medicines but heal through ritual chanting, charms and amulets; and
(g) others who do not fall into any of these above categories.

Like in most developing countries, the existing public health care facilities available to the people of Bangladesh are inadequate, both in terms of quality and quantity (Paul, 1983). Sarder and Chen (1981) comment that the non-government health practitioners in Bangladesh provide availability, social access, and social perception of illness-causation and are consequently utilized more than the government services that have poor availability, access, and quality, and high cost (Sarder and Chen, 1981). In view of the inadequacies of health care facilities and the inequitable distribution between urban and rural areas, the five consecutive Five Year Plans with their extended periods between 1973-2003 aimed at building up physical infrastructure; developing comprehensive health care (in the light of the concept of Primary Health Care (PHC) put forward by World Health Organization (WHO)); and developing health manpower and ensuring its best utilization. Development of health manpower in unani, ayurvedic, and homeopathic systems of traditional medicine was emphasized along side that of modern medicine, writes Khan (1989). To support the objectives of Third Five Year Plan, Saki (1996) pointed out that the Government Unani and Ayurvedic Degree College Hospital (GUADCH), which is a one of its kind, has been set up in the capital city of Dhaka. GUADCH was established in 1987 following the recommendations of WHO to further the concept of PHC. This institute was established with the objectives of developing trained manpower in the field of unani and ayurvedic medicine together with service delivery to the society in these systems of medicine (Saki, 1996).

The health care received by the members of the society and their health care needs are influenced by several factors. Society is never static. Socio-economic changes have influenced the family, the basic functional unit of society, such that the once common joint and extended families are fast retreating and are being replaced by nuclear families. With this change, arises the need to know the shift in the decision-making role. For the family, the decision-making role was initially with the senior-most male member of the family. Now a shift is observed in some instances where the decision-making role has moved away from the senior-most member. Again, the medical treatment received by society is decided by the available options for health care. Ryan (1998) points out that much of the world's medical care is in the hand of lay people rather than professionals. Lay people are from among the general mass and do not have any formal medical schooling. Professionals are the trained personnel who have variable academic background in medicine. Ryan considers that in every society, medical pluralism exists in many different ways. In pluralistic medical settings, it is the lay people who choose what to do first, second, or third from a variety of treatment options delivered by lay or professional people (Ryan, 1998). An attempt is being made in this study to gain insights into the sociology of decision-making through the health care decision-making regarding the traditional system of medicine suitable for patients. Decision-making in health is a process that is closely related to the people who make decision, on whom the decision is taken, and the other social and economic variables that directly or indirectly influence the process. The persons who take the decision are usually the ones who either hold the power or are experienced enough to recommend and/or give decisions. Again, situations that necessitate decision-making rests on the nature of the condition.

The history of medicine can be traced to the prehistoric period when causation of disease and its control was based on magico-religious beliefs, records Kutumbiah (1971). The medicine of primitive people that was later passed on to the people in the literary period is known today as traditional medicine. Traditional medicine in South Asia dates back to circa 5000 BC (Kutumbiah, 1971). In the 1990s there was worldwide increase in the utilization of traditional medicine in both public and private sector. However, not much was done to understand the relevant sociology of the people responsible for taking the decision to utilize traditional medicine, notes Roan (2001). This is true for Bangladesh too. If the relevant sociology of the people for decision-making is known, it would help traditional medicine to be more people-oriented. A research question arises 'what then is the sociology of people of Bangladesh in decision-making to seek help from traditional medicine'? The answer might be related to social structure, action, and power of the people. This study was undertaken to examine the pros and cons of these social issues. The study was conducted among the health care seekers at GUADCH, with the hope of being able to make recommendations that would help firm up traditional medicine in Bangladesh and make it suitable as a parallel system of medicine alongside modern medicine.

Rationale

The study was undertaken to delve into the social interrelationship, group behavior, and capacity of people that prompt them in taking the decision to seek health care from traditional medicine. This approach will hopefully bring forth the social structure, action, power, and conditions that point to who to reach with messages on different aspects of traditional medicine. Such that knowledge gained may increase human freedom in selecting the necessary and desired from among the multitude of health care choice and thus help to firm up medical pluralism in Bangladesh. This concept is supported by the papers presented at the eightieth annual meeting of the American Anthropological Association that highlighted the application of human behavior in health and disease. Understanding human behavior in health and disease, and social cognition or role taking can help behavioral scientists comprehend the psyco-social make-up of a community (Schiamberg and Karl, 1982; Brown,1983). This study expects to highlight some of the social aspects that influence behavior leading to health care decision-making in favor of traditional medicine among the health care seekers in Bangladesh, so that effective implementation of PHC programs in reaching health care to the doorstep of every citizen of the country may be achieved. The ongoing Health and Population Sector Program (HPSP) of Bangladesh emphasizes increased utilization of the health services by the people. This cannot be achieved without going into the depth of the health care seeking behavior of the community. Review of current health-related literature reveals that advanced countries like Canada and United States take cognizance of the fact that traditional medicine is definitely a part of the sociology of the people. As such it is included as an informed option in the health care services (Roan, 2001). To keep Bangladesh abreast of the changing views in the delivery of health services cross-culturally, this study will be a step forward.

Conceptual Framework and Scope

The social structure, social action, and power of health care decision-makers in seeking care from unani and ayurvedic medicine is dealt with in this study. In social structure the social relationship of the sick person with the decision-maker was seen, while social action was seen in the light of group decision taken on behalf of a family or community. Besides, power was seen in the decision taken on the initiativeness and capacity of the sick person or kin. This study covered three of the five key concepts of sociology - social structure, social action, functional integration, power, and culture - as elaborated by Calhoun, Light, and Keller (1994). This study also limits itself to health care seekers of ayurvedic and unani medicine at GUADCH, from among those who use an assortment of traditional medicine practiced in Bangladesh.

The conceptual framework and the scope for this study can be shown as the association of the main variables related to health care decision.

This is an exploratory survey of the prevailing situation. It is neither a retrospective nor a prospective study. Like the still photograph of a camera, the study views the existing situation that stands on the pillars of the past. Though social structure, action, and power of the health care decision-makers was delved into in this study - these are the intervening variable in the above schemata, but it brought forth certain other associated cofactors too.

Methods and Materials

This is a qualitative study in medical sociology. This study was conducted from July 1999 to June 2000. This period was utilized to collect data and taking care of other conventionalities. The place of study is the Government Unani and Ayurvedic Degree College Hospital (GUADCH), Dhaka, Bangladesh. A cross-section of people attending GUADCH for their health care needs were interviewed in-depth on the person(s) most involved in the decision-making that brought them to the hospital. Intuition formed from the verbal and nonverbal communication of persons involved in care-giving and receiving was also taken as a source of data. A sample size of 120 interviewees, 30 from each of the departments - unani outpatient, unani inpatient, ayurvedic outpatient, and ayurvedic inpatient - were taken by haphazard sampling procedure. After informing the interviewees of the different aspects of the study, their verbal consent was taken. They were also informed that they were free to withdraw at any time from the study. A pre-tested in-depth interview outline was used to conduct the interviews, while a note-book was used to assist formation of intuition. To make the respondents communicative, one or more of the probing techniques - silent probe, neutral probe, grand tour, leading questions, and phrased assertion - as outlined by Bernard (1988), was used as suitable for each health care seeker interviewed. Prior to the initiation of data collection, necessary site preparation was done for the smooth conduction of the study. These included taking permission from the appropriate managing authority to work at the hospital, rapport building with the staff at GUADCH, and arranging the venue where the interviews could be held without disturbing the normal functioning of the hospital. The data were computerized after necessary cleaning and editing. The data was analyzed both statistically and illustratively. Both etic and emic interpretation of the analyzed data is done.

Data Analysis and Interpretation

The relationship of the sick persons with the person(s) who took the decision to attend GUADCH was noted in Table 1. Besides the sick persons themselves, relations of the patient such as mother, father, brother, sister, son, and daughter also played their role in the decision-making process for treatment modality of the sick persons. Also, husband, wife, mother-in-law, father-in-law, brother-in-law, sister-in-law, son-in-law, and daughter-in-law's help in the decision process is noted. Persons with fictitious relationship were also seen to have sufficient influence on the system of health care that would be suitable for the sick person. All the different relations taking part in the decision-making process can be considered to be consanguinal, affinal, or fictitious kin. The Table further highlights that, in most instances it was the consanguinal kin who took the decision as to the health care needed for the sick person. In almost equal number of instances, decisions were taken by the patient and affinal relations. But when the broad groups of consanguinal and affinal relations are considered on the basis of each relation, then it is seen that 'self' (or patient) took the decision in most instances followed by husband, father, mother, and fictitious relations. As the sample of health care seekers taken from each of the departments of the hospital was the same, the association between decision-making and the choice of department was not focused. It was observed on-site that the sick persons attending the outpatient of both ayurvedic and unani medicine far outnumbered those in the inpatient.

It is interesting to note that the sick persons themselves took the decision to seek ayurvedic or unani forms of traditional medicine at GUADCH. This is probably because the sick persons suffer and can perceive whether the other forms of treatment, if received, would help them. Moreover, when the sick persons hear tales and anecdotes from relatives, friends, or neighbors where 'such and such person' was treated successfully by the practitioners at GUADCH, they are motivated to take similar decisions. Here, the decisions came from the sick persons but the motivating factors probably were others around them. Another point that is noted is that besides 'self', in most instances it is the male members of the family - husbands and fathers - who are responsible for taking the decision of where the sick persons should be taken for treatment. This points to the male-dominated society of Bangladesh where the decision-making authority lies with the male members. When viewed collectively, among the consanguinal and affinal relations' role in decision-making, it is seen that in some cases the females took decision. These instances of females taking the decision, in all likelihood, occurred where a female was head of the family or when the sick person had come from a distant place to a female relative's house in Dhaka and had acted on her advice. Another aspect of society of Bangladesh is also partially discerned - that of setting up of fictitious relationship. Multiple socio-economic conditions are responsible for change in the social structure notable among which is the rural to urban migration of people. With a population growth rate of 1.49 percent, the per capita agricultural land is fast dwindling, the number of landless and marginalized people in the rural areas is increasing (Ministry of Health and Family Welfare, Bangladesh, 2000). Male earning members or nuclear families are moving out to urban areas where they are cut-off from other kith and kin. They come across people with similar backgrounds of poverty and migration which acts as a new social bonding for understanding and sharing. In the absence of near kin or when a person is away from the immediate kin, more often than not, one sets up fictitious relationships with neighbors, friends, or colleagues. This gives one a feeling of being among relatives. It also gives a sense of security, where each feels that in case of any misfortune it will be these neighbors, friends, or colleagues who will extend all support and help. This relationship is mostly mutual. It is seen that fictitious relations also accompanied the sick persons to the hospital, which again emphasizes the role of fictitious relations in cities and towns. In the rural set up too, fictitious relationships are established due to long standing dwelling association. The decision to seek health care from traditional medicine was seen to be taken by the sufferer of the condition, near and distant kin, and fictitious relations. A question may arise as to why fictitious relations are set up in some instances in Bangladeshi society where familial ties are strong. The answer may be found in the close association of people that leads to caring and sharing of delights and sorrows.

Cultural realization, dimensions of symptomatology and medical knowledge, perceptions of cost and benefit, lay referral and intervention, and access to health facility are few factors that influence decision-making in seeking health care, comments Scambler (1986). The health perception depends on the social meaning attached to it. According to Banerji (1986), social meaning also determines the group behavior in terms of institution that determines the individual behavior. The health care-seeking behavior is manifested through a systematic institution of family and group behavior or social action in association with the perceptions of the factors influencing illness behavior was observed in this study too. When viewed as a whole, decision for seeking health care is seen to be taken in most cases through a concerted effort on the part of more than one community member who maintain a social structure by way of kinship.

Supplementing Table 1, Illustration 1 shows the simplified role set of decision makers irrespective of the departments at GUADCH. The sick persons' treatment seeking decision is shown in the center and surrounding it are a whole set of people who took the decision regarding the treatment. 'Self', father, and husband played greater roles in the decision-making process. Other relations, including fictitious ones also play their role in decision making according to the situation. The Illustration shows all the members who are seen to frequently participate in the decision-making role. At the same time the illustration does not show how many participated in each instance.

When the role set of decision-makers for the sick persons wase seen irrespective of the departments at GUADCH, it once again emphasized that it is the male members who play the dominant role in decision-making as to where the sick members should seek treatment. The male-dominated society of Bangladesh is probably because it has always been so. When considered from the modern standpoint, this can be explained in the light of several issues - usually the males are culturally considered the bread-winners while the females are the dependents; males are physically strong by virtue of biological characteristics; females are considered as a commodity by the males; males have the prerogative of multiple simultaneous marriages, unlike females; and the overall male genderocentric influence in every sphere of life and society. Another reason lies in the general concept that females should either be confined to the four walls of a house or else be brought out in the streets to be exploited by all. Thus the males seem to take the rein of family and society. In other words, the males regulate food and sex, the basic biogenic needs. The sociogenic needs and controls are also held by the males. While the health care needs of people are associated either directly or indirectly with these biogenic and sociogenic needs - areas where males hold the reins of social power. This also gives the males the power to take the health care-seeking decision for the care of the sick kin. In the situation where 'self' took the decision of seeking health care from traditional medicine, it was observed that majority were males, which points to male-domination. It was in case of females that the decision was taken by father or husband. Besides the situation where decisions were taken by 'self', in all other instances, a democratic expression is reflected. But the democratic expression is not consistent because of different combinations of kin roles and influences. The care of the sick person does not end with the decision of seeking care, rather it begins there. After a decision is taken, agreement is reached among the kin, resources are mobilized, plans are laid, one or two persons are delegated to accompany the sick person, and finally the sick person is taken to a health care provider. Thus bringing about a collective coordinated democratic behavior or social action. The social system of Bangladesh may be seen from different perspectives. In the health care decision process, socio-demographic characteristics of health care seekers, and available health care system are mostly involved. The notions that bring about fruitful results are repeated by the health care seekers, and the same goes for the health care system. With advances in medical technology and care process, the social context and perceptions also undergo modification and shift away from the norm. The direction of the shift is largely determined by the social structure, action, and power in decision-making vested in the members of the society and the health care system.

The study did not delve directly into the rationality of using or not using the ayurvedic or unani systems of traditional medicine, rather, it tried to investigate the few sociological revelations that made the health care seekers decide to accept traditional medicine. Review of literature reveals a multitude of reasoning that influence the shift towards acceptance of traditional medicine. Even in advanced countries like the United States (US) in 1980s there was increased interest in traditional medicine and by 1990s it had established a seemingly permanent presence in American health care. Setting up of the National Center for Complementary and Alternative Medicine (NCCAM) in the US is in itself a reflection of the growing interest in traditional or alternative medicine. The review of literature further reveal that, in the past only the true believer or people about to die, were the ones to accept traditional medicine. But now it is the 'man-next-door'. Another aspect that is increasingly coming to the fore in the West, specially after the onset of HIV/AIDS epidemic, is that people seek cheaper treatment in traditional medicine when their condition is not covered by health insurance or when people do not have health insurance coverage at all. Again, it is seen that there is increasing dissatisfaction with the care provided by conventional medicine and the way it deals with particular problems such as chronic illness. Cognitive psychologists have noted that people use a number of strategies when reasoning about a problem that entails decision-making. These strategies are inductive, deductive, and heuristics reasoning (Chandra, 2000; Roan, 2001). In agreeing with cognitive psychologists, it may be said that, health care decision-making by the people in Bangladesh is the result of inductive, deductive, or heuristics reasoning. The above situation in the western world when applied to Bangladesh, seems to be equally true with respect to the low cost of treatment and the confidence in treatment procedure. The absence of health insurance schemes in Bangladesh does not preclude preference of low cost treatment. Thus, inductive and deductive reasoning of decision-making in health care seeking from traditional medicine raises questions about whether or not the social facets of developing country like Bangladesh and the developed countries are similar, which is not within the purview of this study. But the major social facets of social structure, action, and power appear to wield the decision process in such a way that the outcome is more or less the same. Studying the social facets in cross cultural situation in decision-making for health care seeking from traditional medicine remain open for further investigation

Conclusion

The closeness of social ties is evidenced by the decision to seek health care. In most instances, the decision to seek health care from the traditional medical system was taken by the sick person or a near kin. The other kin accepted the decision taken by sick person, and vice versa - the sick person accepted the decision taken by a kin. This goes a long way to emphasize the integrity of the social structure and action that exists in the society of Bangladesh. Though decision-making power was more among males, females were also represented. In answering the research question, we have shown that the various social facets have a relation with the decision to seek health care from traditional medicine. Further cross-cultural investigations could lead to greater generalization of the sociology in the health care decision-making process. The social interrelationship and group behavior existing in Bangladesh must be nurtured for the continuity of community participation in all health activity as conceived in the concept of primary health care of the World Health Organization, and adopted in the Health Policy of Bangladesh. In addition, the genderocentric disparity in health care decision-making needs to be obliterated and brought to an equal footing.

Implications for behavioral health services

This study identified a few aspects of sociology of people - social structure, social action, and power - involved in the decision-making for a sick person to seek health care from the traditional system of medicine in Bangladesh. Understanding the role of decision-making in seeking health care, brings few aspects to the fore. Based on which, the health messages can be communicated to the appropriate persons on whom the health care for the family or community depends. Moreover, as there is under-representation of females in the decision-making role in seeking health care from traditional medicine, the government and non-government organizations working for social uplift and gender equity can come forward with specific programs for greater involvement of females in the decision-making role particularly where health and disease is concerned. The social facets of health care seeking from traditional medicine have been discussed from the perspective of Bangladesh. If compared and collated with the findings of studies in the developed world, certain social differences emerge which will open up new vistas for social scientists working in the field. Overall, in-depth knowledge of medical sociology - sociology in medicine and sociology of medicine - of people will help to develop tools to ensure people's involvement in their own health related activities. The benefit that is thought to be achieved from this study is improvement in the quality of life that depends to a great extent on the health status of a person or community which in turn depends on the correct decision-making regarding maintenance of health. Life's quality is perceived as comprising a sound mind in a sound body that functions in a sound society.

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