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BARRIERS TO WORKING IN PRIMARY AND SECONDARY HEALTH CARE FACILITIES BY THE DOCTORS OF SERVICES HOSPITAL LAHORE

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Abstracts:

Background*: This research was conducted in Services Hospital Lahore to find out the barriers to working in primary and secondary health care facilities. Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford .The objectives were to assess the problems faced by doctors in rural health facilities as well as suggesting to cater these problems.*

Objectives: *The object of this study is to identify the barriers to working in primary and secondary health care facilities in the doctors of Services Hospital Lahore.*

Methodology*: It was a Case Series Study Design. It was conducted in Services Hospital Lahore, in the various wards of SHL which were observed for three weeks to interview the doctors. A detailed structured questionnaire was used for data collection. SPSS 21 was used for entry, compilation, and analysis of data.*

Results*: The result of research that 67% of the doctors lied in the age group 21-25, male and unmarried respondents are dominant. The questionnaire had 3 questions (each having 10, 12 and 10 parts each), the questions were divided on the basis of barriers identified. It was scored on Likert scale, a percentage less than 80% was considered ineffective and greater than equal to 80% was considered to have an influence with mean summary score ± SD (25 ± 6.9) for level of satisfaction and (37.6 ± 11.6) for social barriers and (31.6 ± 7.06) for personal barriers affecting the willingness of the respondents.*

Conclusions: *After a detailed workup, multiple analysis of data collected it has been seen that the the infrastructure of our rural health facilities is so poor that a doctor thinks he is being wasted in a rural health facility. He has nothing to offer to his patients, he is clinically deteriorating and a rural posting does not play any role in post-graduation. This adds to the reluctance of the doctors which he had developed from family, social and financial reasons*

Keywords: Primary Health Care, Secondary Health Care, BHU, RHC, THQ, DHQ, Barriers, Rural Health Care.

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INTRODUCTION:

Improved health plays a key role in human's personal, familial and societal development. A healthy person also has a sturdy clutch in role performance in accord to status. Health is the basic ingredient of victory in any society. Better health is also the basic right of every individual of a society to enjoy a victorious life.To promulgate those standards, the WHO and United Nations International Children's Emergency Fund (UNICEF) affirmed many declarations. [1]

Health Care includes Services provided to individuals or communities by agents of the health services or professions to promote, maintain, monitor, or restore health. Health care is not limited to medical care, which implies therapeutic action by or under the supervision of a physician. HEALTH FOR ALL, enshrined in the Alma-Ata Declaration1 (1978), was interpreted as a goal to be achieved by the year 2000, or as a slogan or aspiration that might be realized by implementing primary health care for all the people of the world, or a country or region.[2]. Two themes have emerged in the delivery of Health services through health system. Firstly, health services should be organized to meet the needs of entire population and not merely selected groups [3]. Secondly, the best way to provide health care to the vast majority of underserved rural people and urban poor is to develop effective "primary health care "services supported by appropriate referral system. Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community. Primary Health Care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly. [4]

Primary Health Care Facilities ensure Health Care to patients and essential health care is provided. This is at BHU and RHC.As a level of care, it is close to the people, where most of their health care will be more effective within the context of the area's needs and limitations. [5] Typically, each Union Council has a BHU which has 2 beds and serves a catchment population of about 10,000 to 25,000. It is charged with the roles of first level referral for patients referred by LHWs, primary level organized curative care using approved essential drugs list. BHU refers patients to RHC as and when necessary, provides MNCH services.[6] There is no institutionalized referral system within the primary healthcare facilities and beyond in Punjab. This has resulted into unnecessary burden on the secondary and tertiary level hospitals.

World Health Report (WHO, 2006) estimated a global shortage of health workforce to be approximately 4.3 million, particularly pronounced in 57 countries including India, Iran and Pakistan etc. Globally, about one-half of the population lives in rural areas but is served by less than 25% of the total doctor workforce [7]

According to World Health Organization (WHO), as of 2000, Iran ranks 58 in healthcare and 93 in health-system performance. Iran has been able to extend public health preventive services through the establishment of an extensive Primary Health Care Network. [8] There are 1.4 million doctors in India. Yet, The Healthcare system of India is lacking in three factors related to access to healthcare: provision, utilization, and attainment. Provision, or the supply of healthcare facilities, can lead to utilization, and finally attainment of good health. However, there currently exists a huge gap between these factors, leading to a collapsed system with insufficient access to healthcare. [9].

This problem of reluctance of doctors to work in rural health facilities is an international phenomenon, as the same was observed in countries like Brazil, India, Indonesia, and Zambia according to the World Bank, 2000 report. Akbar Zaidi found that only 17% of the medical students interviewed were ready to practice in rural areas after their graduation. The staff posted in rural health facilities had a high rate of absenteeism according to a study conducted by the MoH / WHO (1993) out of 58 medical officers (MO) posted at rural health facilities only 64% were present.

Pakistan has a relatively larger PHC infrastructure including 5,000 BHUs, 600 RHcs , 7500 other FLCFs and over 100,000 LHW's .PHC services are supported by a network of 989 secondary care hospitals for referrals with Punjab having total 2863 health facilities including 2454 BHUs , 291 RHCs, 84 THQs and 34 DHQs [10]. There are 160,289 registered doctors, 12,544 dentists, 82,119 nurses and around 100,000 community health workers in Pakistan. There is skewing of the health workforce, particularly doctors and nurses, towards urban areas, with both the private and government health sector in rural areas facing shortages of licensed practitioners. These urban–rural discrepancies are particularly high for doctors, with 14.5 physicians per 10,000 population in urban areas, compared to 7.6 in rural areas.

Secondary Health Care Facilities include Tehsil Head Quarter (THQ) and District Head Quarter. Currently, the registered number of doctors in PMDC is 169696 and Dental surgeons being 19539 up to 28th February, 2018.[11] Information collected

by The News, out of 1011 Basic health units in these major districts of Pakistan's largest province around one third are operating without a medical officer. Around 72% BHUs in provincial capital's neighbouring district of Nankana Sahib are working without doctors. The district with 1.5 million people has 48 BHUs but only 13 have doctors available while 35 are just buildings. In Sargodha, one of the larger districts of the province, 51 Basic health units have no doctor available. The district has 127 BHUs in total. According to certified information 47 BHUs of Okara district have no doctors available while in Jhelum 27 are working without doctors. [12] It is an observation that most doctors working in Pakistan prefer to work in Tertiary health care facilities or move abroad, due to various reasons.

In district Abbottabad there were 52 sanctioned posts of medical officers in rural health facilities but only 33 were filled. About 38% posts were lying vacant, depicting a very high proportion of medical officers unwilling to work against rural posts. This is exactly in line with international situation illustrated in literature. [13]The doctors who are unmarried are more likely to opt for the rural posting than the doctors who are married. The basic infrastructure and presence of the utilities is important for the retention of the doctors in the rural health facilities. This study showed that the electricity was present only at 33.3%, functional toilets at 36.5%, safe water at 20.6% and telephone at 6.3% of the facilities while gas was present at only one of the facilities .The availability of these utilities was lower than the MoH / WHO figures of 1993, where electricity was available in 55.2% of BHUs; piped water was available in 60.9% of RHCs and 27.6% of BHUs; and telephone was available in 7 out of 23 RHCs and no BHU had this facility. This difference may be because the MoH/WHO study was conducted at the national level and this study was focused only in one district. The infrastructure of our rural health facilities is so poor that a doctor thinks he is being wasted in a rural health facility. He has nothing to offer to his patients, he is clinically deteriorating and a rural posting does not play any role in post-graduation. [14]

While the government has the largest network of PHC facilities, there are staff vacancies in rural areas as well as frequent absenteeism, and political patronage over appointments and postings has adversely affected staff attendance. Administrative control over staff appointments, postings and suspension is largely centralized at province level. [15] Majority of the doctors choose to practice in urban settings as they are neither trained to work in a rural setup nor are given facilities and services to work there. To improve this situation, different policies and incentive packages have been developed within available health sector budget such as hard area allowance, pay for performance and performance-based allowances. The utility of these interventions, however, needs to be tested for cadre specific preferences. [16]

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. [17]

Pakistan has pretty diverse healthcare system from tertiary care centres down the road to primary care centres; but unfortunately, they have lost their credibility at the hands of ill-administration. Resource constraints are one of the important barriers to quality healthcare but mal-governance, negligence, unjust and unaccountability are the deadly poisons that not only restrict more allocation of resources but also injure the existing ones.

Though it is important to increase health budget and produce more resources over the next years in order to cope up with escalating health issues, but what is far more needed is the scrutiny of the existing healthcare structure. According to previous surveys, there exists an imbalance in-between and within private and public healthcare setups in terms of burden of patients. As primary and secondary health offices, especially on the peri-urban and rural side, have been quite infamous for absenteeism of medical staff and doctors or unavailability of basic medicines and equipment; therefore, incompetent and mal- or non-functioning primary and secondary health centres have ripple effect, and people are forced to take their patients to tertiary health centres, majority of which are located in major cities. All that result in further increase of workload and limitation of services in tertiary care hospitals and add to patients' and their families' agonies and frustrations as disease burden as well as overall cost increases.

This study focuses on the problem of absence of doctors in various Primary and Secondary Health Facilities. Since it is an integral part of health care to the community and any lack in these areas overall will put burden on Tertiary Health Care and effective treatment making it impossible to cater the needs of all individuals. As so far no work has been done on this issue this study will help to find out the barriers to working in Primary and Secondary Health Facilities so that these may be addressed. Since this study has not been done before in this region, this study will explore the attributes that freshly graduated doctors of Services Hospital, Lahore, look for in a job when deciding to work in Primary and secondary health care facilities. It will highlight the retention factors for uptake of employment in rural areas.

LITERATURE REVIEW:

An imbalance exists between offered medical services and needed health care for the people in rural areas of Pakistan. Many studies have found non-availability, of health care providers as major contributors to the poor health indicators of the rural areas. An endeavour to attend the issue has been made through a cross-sectional survey of the Medical Officers working in the different health facilities. The studies found that the doctors are neither trained to work in rural setups nor they are given proper facilities and service structure to work there. They perceive to face disadvantages affecting their social, professional and family life, if they join in rural areas. The provision of adequate, accessible, appropriate and affordable health is one of the fundamental rights, recognized by global leadership under banner of World Health Assemblies of 1978 and 1998[1]. The current technologically advanced global village of earth is still challenged by inadequacies of appropriate and efficient medical care facilities in most developing countries. This picture is even more complex in rural areas due to imbalances between offered medical services and health care needs of the communities.

A research done in Abbottabad Pakistan titled as "Doctors Perception about Staying in or Leaving Rural Health Facilities in District Abbottabad" has suggested that Pakistan is facing similar situation in rural areas, where 66% of the population is residing The national health plan is based upon the concept of Primary Health Care (PHC), which forms a network of First Level Care Facilities (FLCF) in the rural areas.[2] In Pakistan, the utilization of rural public sector health facilities had been estimated to be as low as 27%, in situation analysis report published by Ministry of health during 1995. The same report realizes that the under-utilization is mostly due perceived quality of care being offered at rural health facilities· The Ministry of Health and World Health Organization (WHO) conducted a study in 1993 on utilization of rural health facilities in Pakistan, which showed that out of 58 medical officers (MO) only 64% were present giving an absenteeism rate of 36%.[3] In 41% of the facilities, the doctors were residing within the institutions. Electricity was available in 91% of Rural Health Centers (RHCs) and 55% of Basic Health Units (BHUs) piped water was available in 61% of RHCs 28% of BHUs; and telephone was available in 7 out of 23 RHCs and no BHU had this facility. Although 65% of the RHCs have official accommodations for Women Medical Officer (WMO), no WMO was utilizing the accommodation facilities. In BHUs utilization of the official accommodation by the M.Os was 18.6%. It was found that electric power, drinking water and sanitation are the prerequisites in the BHU / RHC· The root of the problem starts with the education of doctors, as medical students majority have an urban background and so prefer to work in the areas where they are reared. Their education does not provide them with any exposure to rural areas. There is no attraction in working in rural areas and they prefer tertiary health care facilities. Their lifestyle is suited to a life in urban cities. Lack of proper infrastructure in rural areas, marriages and gender played important role in preventing doctors from opting to work in rural areas.

The Results of their studies stated that in Completion of compulsory periphery service out 14% males and 20% females and a total of 14% would choose to work in this setting. When concerned with private practice in rural areas 13% males and 10% females and a total of 13% would choose it. Marital Status being single and having no liabilities would cause 11% to choose this. Less work load promoted 10%, time to study in rural health facilities proved as a promoting factor in 9%, rural background in 8%. 16% of people from rural areas and 14% from urban areas were willing to work in rural health facilities while rest from both rural and urban areas were unwilling. 16% unmarried and 13% married were willing to work while rest were unwilling to work in rural health facilities. No professional growth (15%),No clinical experience (14%),Delay in post-graduation (14%),Facility away from family residence (10%),Poor living conditions (9%),Decrease in earning (9%),Poor schooling for children (9%),Spouse job (6%),High qualification (5%),No exposure to rural life (5%),Poor infrastructure of rural facilities(4%) and Poor transport facilities were the major barriers that were stopping these people from working in these setups.[18]

Another research done in Nigeria titled " Facilitators and barriers to effective primary health care in Nigeria" discusses the health care system which is very similar to Pakistan, the training of various health care professionals and also stresses on the inadequate doctors available in rural areas, the causes being internal conflict in parts of the country, crime and corruption, multiplicity of governmental and donor agencies, vertical programmes, low political commitment to implementation of approved health policies, differences in remuneration between levels of care, inequality in infrastructure that favours urban areas, poor working conditions, maldistribution of health care workers including emigration, inadequate training facilities in parts of the country and inter-professional conflict. [19]

Another research titled Matching Supply to Demand: Addressing the U.S. Primary Care Workforce Shortage stresses the shortage of primary health care workers in rural areas of America as well as makes suggestions in increasing the work force

by providing incentives such as increasing the number of trainees who are likely to pursue careers in primary care, scholarships for medical students opting to work in primary health care facilities, creating new primary health care residency programs, loan forgiveness for doctors working in primary health care facilities encouraging graduates to practice primary care, particularly in underserved geographic areas and adding to the skills of practitioners already working in primary care. It also points out the benefits of improving facilities in primary health care facilities such as overall increase in payment for PHC. [20]

Another research done in America titled "Shortage of Medical Personals at Community health Centres" states Rural CHCs had a higher proportion of vacancies and longer-term vacancies and reported greater difficulty filling positions compared with urban CHCs. Physician recruitment in CHCs was heavily dependent on National Health Service Corps scholarships, loan repayment programs, and international medical graduates with J-1 visa waivers. Major perceived barriers to recruitment included low salaries and, in rural CHCs, cultural isolation, poor-quality schools and housing, and lack of spousal job opportunities. Results show that in 2004, CHCs were understaffed and were having difficulty recruiting essential health care personnel. This inability to fill budgeted vacancies could become a rate-limiting factor as they seek to expand their clinical activities to care for needy populations, particularly in rural areas. The clinical role of CHCs is dependent on primary care clinicians' .Physician turnover in CHCs is rapid, with a large proportion of physicians leaving after discharging their scholarship obligations or paying off their loans. Because family physicians have traditionally been much more likely than other disciplines to provide care to underserved populations, the declining production of family physicians may lead to serious workforce shortages. Solutions proposed include programs that provide financial incentives for health care clinicians who serve in underserved locations. Augment the use of nurse practitioners and physician assistants as physician substitutes, particularly in urban clinics where the proportional use of physicians is higher. Experiment with new approaches to loan repayment to improve retention of physicians who satisfactorily complete their initial contractual obligations, such as a loan repayment program that continued to pay year-to-year retention bonuses. Financial incentives as a magnet. [21]

A research work done in Pakistan titled "Reluctance to Serve in Rural Areas: Doctors' Perspective" stated that Pakistan's health care system has been adversely affected by the non-availability of doctors in its rural and remote areas. 200 doctors comprising of 113 males and 87 females were recruited for the study. The mean age was 30 years. Majority (86.5 %) of the doctors were of the view; that indeed it was the non-availability of doctors at rural health care centres for poor health services in such areas. 83.9 % agreed that basic facilities were lacking in rural areas. Other problems being Transportation. 72.5% agreed that extra hard area grant be given as motivation to doctors working in BHU's, RHC's etc. Doctors were reluctant to serve in rural areas because of the difficulties affecting their social, professional and family life. By developing the infra-structure of health centres and by providing some special incentives to the serving doctors, this issue can be resolved to a considerable extent. [22]

"Why medical students will not practice in rural areas: Evidence from a survey" a study in which a survey of medical students was held in order to determine the reasons why they were not willing to set up practice in rural areas after graduation. The reasons they gave were quite typical: lack of facilities, lack of opportunities for themselves and their family, poor income, etc. We also discovered that not many were acquainted with rural health conditions and a very great percentage wanted to go to the West for specialisation. We have tried to set their responses in light of the socio-economic and political system prevalent in a typical capitalist UDC. The conclusion that we have reached is that it is the class system in these societies which has determined the responses of the students, and it is the main factor which causes a dearth of medical manpower in rural areas. [23]

Another Study titled "Perceptions of Medical Students and Doctors Regarding Primary Health Care (PHC) Centre Placements "conducted in Rawalpindi Pakistan states that According to a Pakistani study, medical students and doctors highlighted some important reasons which prevented their PHC participation- the top three of which were "no professional growth, no clinical experience and delayed post-graduation" . An important conclusion drawn from this study was that students were willing to participate in the PHC. Many strategic challenges impeding the success of PHC are rooted in weak strategic inputs, including inter-sectoral collaboration. The lack of appropriate medical student training has been recognized as an important factor in them being reluctant to participate in PHC. Students, especially senior medical students have a fair view of the problems that the community of Pakistan at large is facing due to the lack of rural health care infrastructure available in Pakistan. It focuses on the importance of Primary Health Care Facilities along with the basic concept of PHC. The study was conducted on 151 final year student of Rawalpindi Medical College and 54 doctors of Allied Hospital Rawalpindi and it

was seen that most of the subjects preferred to work in urban areas. Most had not visited a PHC. Few were competent enough to work in a PHC. However they believed their education prepares them to work in a PHC facility and it groomed them professionally and made them experienced. The conclusion was that both the students were motivated by the fact that their service in a PHC would help the needy and under privileged. Also they believe that providing incentives in a PHC along with better living conditions will encourage doctors. They agreed that PHC will provide them additional experience in their career and they believe that students must be familiarised with PHC's in the course of their education. [24]

Another research titled "Primary Care: Proposed Solutions To The Physician Shortage Without Training More Physicians" states that The adult primary care "physician shortage" is more accurately portrayed as a gap between the adult population's demand for primary care services and the capacity of primary care, as currently delivered, to meet that demand. Given current trends, producing more adult primary care clinicians will not close the demand-capacity gap. However, primary care capacity can be greatly increased without many more clinicians: by empowering licensed personnel, including registered nurses and pharmacists, to provide more care.it proposes that this can be done by non-licensed health personnel, such as medical assistants, to function as panel managers and health coaches to address many preventive and chronic care needs; by increasing the potential for more patient self-care; and by harnessing technology to add capacity. The health policy literature has been inundated with articles on the worsening shortage of primary care physicians. One projection estimates that by 2020 the shortage will balloon to 40,000 physicians. A more recent estimate suggests a gap of 52,000 primary care physicians by 2025. The problem particularly affects primary care for adults more so than for children. Growing demand for adult primary care comes from eighty million aging baby boomers, insurance expansion, and the diabetes and obesity epidemics. Capacity is declining because only 9 percent of US medical students choose family medicine and general internal medicine—the two adult primary care careers. By 2016 the number of adult primary care physicians leaving practice will exceed the number entering, and more primary care physicians are choosing to work part time. Common policy recommendations include increasing primary care reimbursement, improving the stressful primary care work life, and graduating more nurse practitioners (NPs) and physician assistants (PAs). These policy prescriptions, although laudable, are insufficient. A 50 percent increase in primary care Medicare payments would be needed to greatly narrow the primary care-specialty income gap as the work load is considered a burnout. The problem can be solved also by improving the technology available in a primary health care, making work easy for the physicians. The improvements suggests include improving the salary package, changes in scope of practice, training non clinicians to assume new responsibilities, personal limitations in small practices, tension between adding capacity and improving care, innovative culture and improving technology.[25]

Another research termed "A case study of outsourced primary healthcare services in Sindh, Pakistan: is this a real reform?" states that has stated that In Pakistan, public sector often lacks capacity to effectively & equitably manage the healthcare services. It led the government to outsource the administration of primary health care services to a semi-autonomous government entity i.e. Peoples' Primary Healthcare Initiative (PPHI). This small scale study has assessed the quality of healthcare services at the contracted Basic Health Units (BHUs) with the PPHI and compared it with those managed by the local district government in the province of Sindh. The result of which are There was a significant difference between the PPHI and the district government administered BHUs with regard to infrastructure, availability of essential medicines, basic medical appliances, mini-lab facilities and vehicles for referrals. These BHUs were found to have sufficient number of trained clinical staff and no punctuality and retention issues whatsoever. The district government administered BHUs presented a dismal picture in all the aspects. The results were PPHI administered BHUs as compared to district administered BHUs showed significant differences in terms of infrastructure and the availability of essential services. PPHI managed BHU's although have a longer waiting time and are far for the patients have better qualified physicians, Infrastructure, availability of drugs, vehicles for referral, provided neonatal and obstetric care, immunization, anti-natal care and dental care facilities. So out sourcing the BHU's provides a better primary health care to the patients and a better working environment to the physician. [26].

Objectives:

The object of this study is to identify the obstacle that prevents movement or access to working in primary and secondary health care facilities in the doctors of Services Hospital Lahore with respect to their Job satisfaction, Social, Environmental and Personal Factors.

Operational definitions:

The various barriers to working in primary and secondary healthcare facilities in doctors were defined on the following basis:

The **Job Satisfaction** is scaled according to Likert scale with maximum score of 50 and minimum 10,

- Satisfied: those scoring ≥ 80% (40/50 on the questionnaire)
- Dissatisfied: those scoring < 80%

The **Social and Environmental Barrier** is scaled according to Likert scale with maximum score of 60 and minimum of 14,

- Yes: those scoring ≥ 80% (50/60)
- No: those scoring < 80%

The **Personal Barrier** is scaled according to Likert scale with maximum score of 50 and minimum 10,

- Yes: those scoring ≥ 80% (40/50 on the questionnaire)
- No: those scoring < 80%

METHODOLOGY:

Study Design:
Cross Sectional Study will be conducted.

Study Setting:
The study will be conducted in Services Hospital Lahore. It is a tertiary care hospital in Lahore providing health care services to the public. It has 1196 beds and 31 departments.

Study Duration:
The study duration will be two months**.**

Sample Size:
The sample size is estimated by using WHO statistical software S-size by using formula of estimating population proportion with specific relative precision at confidence level of 95%, anticipated population proportion of 32% and relative precision (relative error) of 10%, minimum sample size of 385 doctors will be taken**.**

Sampling technique:
Non-probability, convenient sampling will be applied.

Inclusion criteria:
Doctors (MBBS) including House Officers, Medical Officers, Post Graduates working in various departments of Services Hospital Lahore.

Exclusion criteria:
Professors, Associate professors, Assistant Professors, Senior Registrars, Paramedical Staff of Services Hospital Lahore.

Data Collection Procedures:
A detailed questionnaire and observational check list will be used to collect data. The questionnaire will be pretested in various settings. A face to face interview will be conducted. All data will be collected by research group by five students. The questionnaire will be checked on daily basis by researchers for its completeness.

Data collection Plan:
SPSS v.20 computer software will be used for entry compilation and analysis of data. Quantitative variables mean and standard deviation will be calculated. For qualitative variables frequency and percentage distribution tables will be generated. Then data presentations diagrams will be made. Scoring, if required will be mentioned. Test of significance will be applied (Qualitative Chi Square, Quantitative: T-test). P-value of 0.05 or less will be taken as significant.

Data Collection Tool:
A questionnaire will be used to extract information about the subjects.

Ethical Considerations:
Formal Approval will be taken from ethical committee of SHL. Written informed consent will be taken from all the respondents. Confidentiality of the respondents will be maintained.

RESULTS:

Table 1: Sociodemographic Profile of Respondents:

Socio Demographics		Frequency (n=)	Percentage%
Age of Doctors	Range 21-25 26-30 31-35	 258 124 3	 67.01 32.2 0.77
Total		385	100
Gender	Male Females	189 196	49.1 50.9
Total		385	100
Marital Status	Married Unmarried	64 321	16.6 83.4
Designation	HO MO PGR Senior Registrar	222 80 81 2	57.7 20.8 21 0.5
Total		385	100

Table no 1. Sociodemographic Profile of Respondents

The Research was conducted in the various wards of SHL to assess the various barriers towards working in primary and secondary health care facilities of SHL. We visited the wards for four consecutive weeks and interviewed 385 doctors. We divided 385 doctors into 3 groups depending on their ages, the first age group ranged from 21 to 25 years and had 258 doctors (67.01%), the second age group ranged from 26 to 30 years and had 124 doctors (32.2%) and the last group ranged from 31 to 35 and had 3 doctors (0.7%). Out of 385 Doctors 189 (49.1%) were males and 196 (50.9%) were females, 64 (16.6%) were married and 321 (83.4) were unmarried. Considering the designation of the doctors 222 (57.7%) were HO's, 80 (20.8%) were MO's, 81 (21%) were PGR's and 2 (0.5%) were SR's.

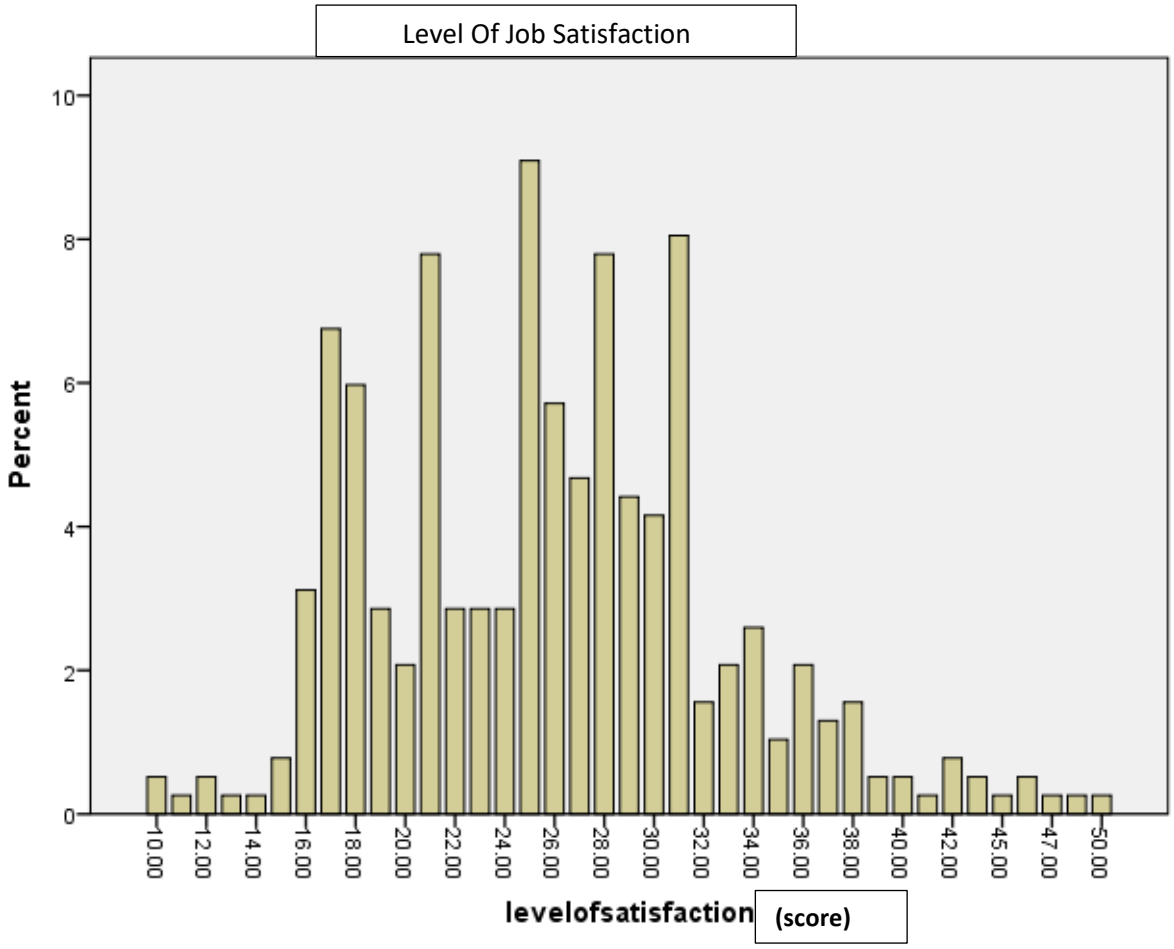
Table 2: Frequency Distribution of the Respondents According to the Barriers Identified

Barriers Identified		Frequency (n=)	Percentage %
Job Satisfaction	Satisfied (≥ 80%)	14	4%
	Dissatisfied (< 80%)	371	96%
Total		385	100%
Social And Environmental Barriers	Yes (≥ 80%)	301	78.1%
	No (< 80%)	84	21.8%
Total		385	100
Personal Barriers	Yes (≥ 80%)	346	89.9%
	No (< 80%)	39	10.1%
		385	100%

Table No.2. Social and Behavioural Barriers

We used a detailed structured questionnaire to collect data. There were 3 questions in the questionnaire each having 10, 12 and 10 parts respectively. We interviewed 385 doctors and there was no missing value for any item and the respondents responded completely to the questionnaire and it was well tolerated. Out of 385 doctors 14(4%) said they were Satisfied with their Job in a rural health centre while 371 (96%) said they were dissatisfied. Social and Environmental Barriers did not exist for 84 (21.8%) of the doctors while 301 (78.1%) were affected by this. When asked about personal barriers that stopped doctors from opting for rural health centres 346 (89.8%) were affected while 39 (89.8%) were not affected.

Job Satisfaction



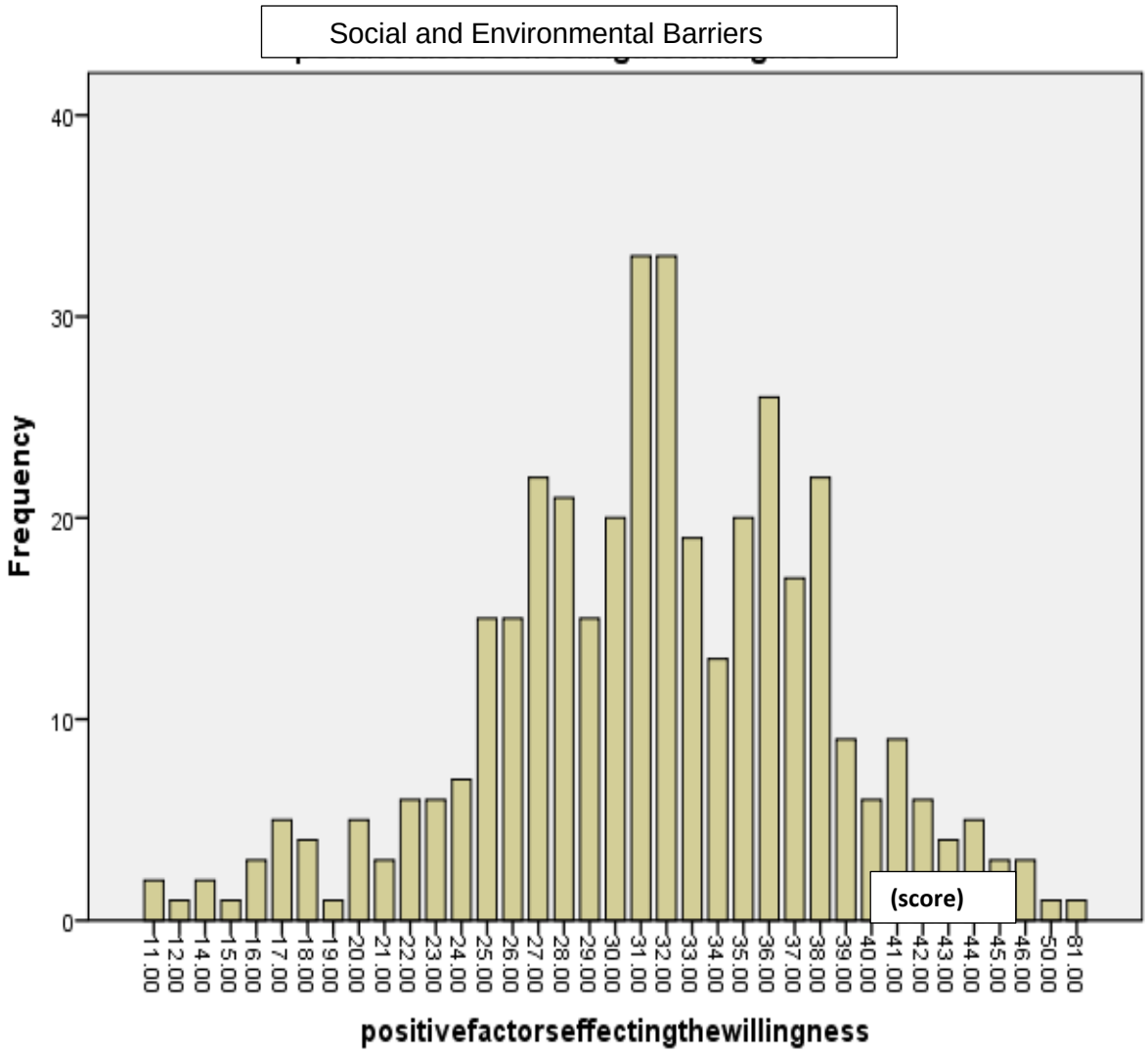
Descriptives:

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation
Level of satisfaction	385	40.00	10.00	50.00	25.8961	6.96641
Valid N (list wise)	385					

n=385

Social and Environmental Barriers



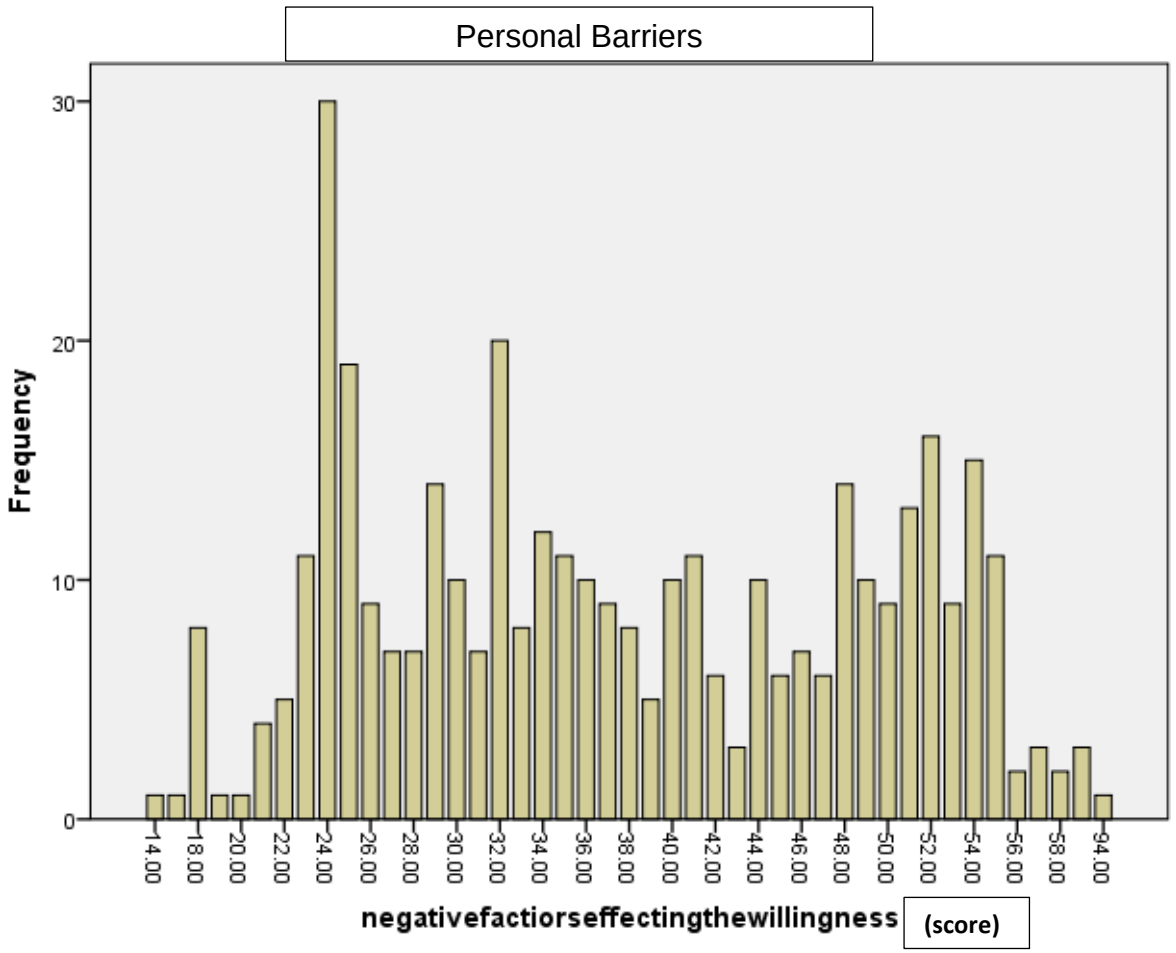
Descriptives:

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation
Positive factors effecting the willingness	384	70.00	11.00	81.00	31.6172	7.06123
Valid N (list wise)	384					

n=385

Personal Barriers



Descriptives:

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation
Negative factors effecting the willingness	385	80.00	14.00	94.00	37.6727	11.68497
Valid N (list wise)	385					

n=385

DISCUSSIONS:

We studied Barriers to working in primary and secondary health care facilities to measure the quality of life of doctors that worked in rural health centres, all the problems that were faced in their tenure, their reasons to working there, all factors that promoted and all the factors contributing to their resistance to working in these health care facilities. The interview revealed the problems in the setup of these health areas particularly working environment, transportation, administrative setup, lifestyle, career opportunities etc. Also the various factors that decreased the willingness towards work like sanitation, lack of career opportunities, children's education, spouse's job etc. Factors that increase the willingness towards working was also discussed for e.g. marks in CIP aggregate, increased pay, lesser work burden etc.

We divided 385 doctors into 3 groups depending on their ages, the first age group ranged from 21 to 25 years and had 258 doctors (67.01%), the second age group ranged from 26 to 30 years and had 124 doctors (32.2%) and the last group ranged from 31 to 35 and had 3 doctors (0.7%) while in our reference study the age range for all respondents was 27 to 45 years with the mean age of 33 ± 4 years. There were 13.6% (17) females with mean age of 32 ± 2.5 years whereas the males were 86.4% (108) with mean age of 33.5 ± 3.5 years

Out of 385 Doctors 189 (49.1%) were males and 196 (50.9%) were females, 64 (16.6%) were married and 321 (83.4) were unmarried, while in the reference study among the doctors interviewed 76 (61%) were married and this ratio of married: unmarried remained same in both sexes. Out of 32 medical officers working in rural facilities 20 (63%) were married with mean number of children as 2. Majority of MOs in BHU 18 (70%) were married, with only two not having any child till the time of interview Considering the designation of the doctors 222 (57.7%) were HO's, 80 (20.8%) were MO's, 81 (21%) were PGR's and 2 (0.5%) were SR's.

Out of 385 doctors 14(4%) said they were Satisfied with their Job and were willing to work in a rural health centre while 371 (96%) said they were dissatisfied and unwilling while in the reference study it was seen that 16% unmarried and 13% married were willing to work while rest were unwilling to work in rural health facilities more being married and from urban areas.

Social and Environmental Barriers did not exist for 84 (21.8%) of the doctors while 301 (78.1%) were affected by this while in our refrence study it was observed that Facility away from family residence (10%),Poor living conditions (9%),Decrease in earning (9%),Poor schooling for children (9%),Spouse job (6%),High qualification (5%),No exposure to rural life (5%),Poor infrastructure of rural facilities(4%) and Poor transport facilities were the major barriers that were stopping these people from working in these setups.

When asked about personal barriers that stopped doctors from opting for rural health centres 346 (89.8%) were affected while 39 (89.8%) were not affected. In our reference study it was seen that the results of their studies stated that in Completion of compulsory periphery service out 14% males and 20% females and a total of 14% would choose to work in this setting. When concerned with private practice in rural areas 13% males and 10% females and a total of 13% would choose it. Marital Status being single and having no liabilities would cause 11% to choose this. Less work load promoted 10%, time to study in rural health facilities proved as a promoting factor in 9%, rural background in 8%.. No professional growth (15%),No clinical experience (14%),Delay in post-graduation (14%),High qualification (5%),No exposure to rural life (5%), the major barriers that were stopping these doctors from working in primary and secondary health care facilities.

Improved health plays a key role in human's personal, familial and societal development. A healthy person also has a sturdy clutch in role performance in accord to status. Health is the basic ingredient of victory in any society. Better health is also the basic right of every individual of a society to enjoy a victorious life.

Poor availability of doctors in rural areas is an ongoing problem in Pakistan. The causes of this reluctance are many folds and all these combine making the problem a complex one. Majority of the students in medical colleges have an urban background, as they have more chance to get admission due to open merit policy in most of the medical colleges. As a result they prefer to work after their graduation in to areas where they are reared. In medical colleges the MBBS curriculum has no community orientation, the doctors thus produced have no orientation or experience of the rural health in other words the doctors are being trained to work only in big hospitals with sophisticated equipment. The service structure of the doctors is such that there are no attractions for working in rural health facilities, rather there are disadvantages affecting their social, professional and family life. This problem of reluctance of doctors to work in rural health facilities is an international phenomenon, as the same was observed in countries like Brazil, India, Indonesia, and Zambia according to the World Bank, 2000 report.

The object of this study was to identify all the problems faced by doctors in these setups so that special attention can be drawn towards this with the hopes that in the future better facilities may be provided to the doctors and the general public for a better work environment for the doctor and a better health system for not only the rich but also the poor and for not only the urban dwellers but also the people living in the rural areas.

CONCLUSIONS:

Like all individuals, doctors have their own traits and characteristics that distinguish them socially and culturally. Education spanned over 5 to 6 years in medical colleges located in cities and expected living style after graduation, tilts them more to urban living. They develop acquaintances and links with their colleagues and seniors on technical introductions. When sent to rural areas they feel isolated and left out. Irene A identified difficulties in transferring staff to rural areas as many did not want to live in isolated areas. The urban dwellers would willingly go to rural areas of which they have no knowledge, is a killer assumption which might be contributing towards high absenteeism. The infrastructure of our rural health facilities is so poor that a doctor thinks he is being wasted in a rural health facility. He has nothing to offer to his patients, he is clinically deteriorating and a rural posting does not play any role in post-graduation. This adds to the reluctance of the doctors which he had developed from family, social and financial reasons. Excessive turnover of doctors in rural areas may be modified

by offering them good salaries and locum relief according to the hardship of the area in which they are posted

For this purpose an incentive package can be offered to doctors working in rural areas which include higher cash salaries, and special allowances according to the hardship of the post.
In this study doctors suggested incentives and salary increase as an important factor for attracting doctors to work in rural areas.

Recommendations:
Primary and Secondary health care facilities include BHU's, RHC's, DHQ's and THQ's. Primary Health Care Facilities ensure Health Care to patients and essential health care is provided. After studying the various interviews taken it is recommended that the doctors be given a better working environment in regards to the infrastructure, availability of drugs and staff. Salary must be raised as an incentive for people. Transportation to doctors especially females must be provided as these rural health areas are at remote areas where doctors usually don't live. The administrative should be such that it makes the doctor feels welcome, and is without any political influence or pressures, with seniors and colleagues that are cooperative. Adequate security should be provided to the doctor. Opportunities for recreation should be made as the doctors feel secluded or detached from their normal lifestyle.

Sanitation of the health centre be improved. Schools for the doctor's children's education should be constructed. The rural people should be urged to improve their behaviour towards the doctors. The doctors working in these areas should be given incentives in regards to earning, marks, better job opportunities so that they don't feel stagnant or behind their colleagues in their career. Post-graduation training should be started in these centres. Spouse's Job opportunities should be made. Facilities to start their private practices should be given.

The work burden in these centres should be decreased by increasing staff and increasing the catchment population per health centre. A system of making periphery service must be created and students in their education time frame be exposed to these centres so that they do not feel alienated later.There should be special emphasis in MBBS curriculum on primary health care.The MBBS curriculum should be made community oriented with more and meaningful visits to rural health facilities. The functioning of rural health facilities should be improved by regular and appropriate supply of medicines and diagnostic facilities.Provision of services for the houses and facilities such as electricity, safe water and functional toilets should be ensured Rural health Facilities where doctors cannot be posted due to absence of basic amenities in recent future might be identified and rather than a doctor a properly trained health technician might be posted there. Rural health academy should be made to train doctors for catering the needs of rural population there should be regular and meaningful supervision by appointment of properly trained health managers. No doctor should be allowed postgraduate training in any hospital without two years compulsory rural service. Rural posting should be made attractive by providing incentives, such as. Special rural allowances based on the hardship of the area to which doctor is posted. Priority should be given for post-graduation to the doctors who spend two years in a rural health facility. Special refresher courses should be launched for Medical officers working in rural areas to keep them in touch with the medical advancements.

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QUESTIONNAIRE:

Name:

Gender:

Age:

Marital Status:

Number of children:

Year of graduation:

Designation:

What do you think will be the level of satisfaction regarding the following with respect to your job in primary and secondary healthcare setup?

Choose from 1-5

1=very dissatisfied 2=dissatisfied 3=neither

4=satisfied 5=very satisfied

1. Working Environment	1	2	3	4	5
2. Salary	1	2	3	4	5
3. Working hours	1	2	3	4	5
4. Transportation	1	2	3	4	5
5. Hospital Administrative Setup	1	2	3	4	5
6. Cooperation of colleagues and seniors	1	2	3	4	5
7. Opportunities for recreation	1	2	3	4	5
8. Career Opportunities	1	2	3	4	5
9. Accommodation in the working area	1	2	3	4	5
10. Impact of your on your life	1	2	3	4	5

How many of these factors are effective in decreasing your willingness towards working in primary and secondary healthcare facility?

Choose from 1-5

1=not effective 2=slightly effective 3=somewhat effective

4=very effective 5=most effective

1.Poor Sanitation	1	2	3	4	5
2.Children's Education	1	2	3	4	5
3.Poor availability of Gas/Electricity	1	2	3	4	5
4.Short come of medical equipment and drugs	1	2	3	4	5
5.Lack of awareness and general behaviour of rural people	1	2	3	4	5
6.Lack of career opportunities	1	2	3	4	5
7.Post-Graduation	1	2	3	4	5
8.Poor governance of the system	1	2	3	4	5
9.Spouse's Job	1	2	3	4	5
10.Transportation Problems	1	2	3	4	5
11.Private Practice in Rural Area					
12.Low Quality Of learning or gaining skills					

How many of these factors are effective in increasing your willingness towards working in a primary and secondary healthcare facility?

1=not effective 2=slightly effective 3=somewhat effective

4=very effective 5=most effective

1.Marks in CIP aggregate	1	2	3	4	5
2.Sufficient time for further studies	1	2	3	4	5
3.Lesser work burden	1	2	3	4	5
4.Increased Pay	1	2	3	4	5
5.Rural Family Background	1	2	3	4	5
6.Community/social work	1	2	3	4	5
7.Spouse or family living in the rural area	1	2	3	4	5
8.Any family member working in that rural area	1	2	3	4	5
9.Respect from the villagers	1	2	3	4	5
10.Compulsory periphery service	1	2	3	4	5