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Barriers To Health Care In Bangladesh: A Concept Analysis

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I. Background

Throughout the pandemic, healthcare professionals (HCPs) around the world encountered numerous challenges (Das et al., 2025), highlighting the vulnerability of health systems globally and underscoring the urgent need to address systemic barriers to health care. This global crisis brought renewed attention to longstanding inequities in access to health care services, especially in low- and lower-middle-income countries like Bangladesh.

Barriers to health care remain a critical issue in Bangladesh, where millions of peoples particularly those from rural (Hamiduzzaman et al., 2022) and marginalized communities (Puja et al., 2024) struggle to access timely and quality health services. Despite some improvements in national health indicators, structural, economical (Islam et al., 2020), sociocultural, and political obstacles continue to hinder equitable health care delivery. The global advantages of Enterprise Resource Planning (ERP) systems in enhancing healthcare quality, cost-efficiency, and service delivery, the adoption of such systems in Bangladesh remains limited due to inadequate IT infrastructure and other systemic challenges (Karim et al., 2025). These barriers not only affect access and availability but also influence the acceptability of care, thereby reinforcing disparities in health outcomes.

This concept holds particular significance for nursing, as nurses are frontline health professionals who directly witness and experience the effects of these barriers in their everyday practice. Whether providing patient care, engaging in community outreach, educating future nurses, or participating in policy development, nurses are uniquely positioned to address these inequities and contribute to health system improvement.

Although the concept of health care barriers has been explored in public health literature, there is a lack of clarity and consistency in how it is understood, defined, and applied within the context of nursing, particularly in low- and middle-income countries like Bangladesh. There remains a gap in the nursing literature regarding a context- specific, theoretically grounded understanding of this concept that reflects the unique challenges of nurses working in resource-constrained environments.

As such, a formal concept analysis is necessary to define, clarify, and refine the notion of "barriers to health care" from a nursing perspective. This process will help disambiguate the term and develop a shared understanding that is both conceptually rigorous and practically applicable in health care settings.

Conducting this concept analysis will advance health care by providing conceptual clarity that can inform practice, education, leadership, and research. A clear definition will enable us to identify and assess such barriers more effectively, guide evidence-based interventions, and advocate for structural and policy-level changes to promote equitable and accessible care for all.

Purpose of Analysis

The purpose of this analysis is to explore the concept of barriers to health care in Bangladesh to provide clarity and direction for future research and policy development in this area. Furthermore, analyzing these barriers may inform more effective strategies in healthcare education, planning, and system-level interventions. A clear understanding of these barriers could lead to the identification of context-specific solutions to improve access to and quality of health care services for the population of Bangladesh.

Strategy Used for Concept Analysis

This paper uses the concept analysis framework developed by Walker and Avant (2005, p.65), which consists of eight systematic steps. This structured approach allows for a clear and comprehensive understanding of the concept across different contexts and disciplines.

Walker and Avant Concept Analysis Method (2005, p. 65):
1. Select a concept.
2. Determine the aims or purposes of analysis.
3. Identify all uses of the concept that you can discover.
4. Determine the defining attributes.
5. Identify a model case.
6. Identify borderline, related contrary, invented, and illegitimate cases.
7. Identify antecedents and consequences.
8. Define empirical referents.

II. Literature Review

A systematic literature review was conducted to explore the concept of barriers to healthcare within the context of Bangladesh. Electronic databases such as MEDLINE, CINAHL, and Google Scholar were searched using combinations of keywords and phrases, including "healthcare barriers," "access to care," "Bangladesh," and "health inequities." Boolean operators (AND, OR) were employed to refine and broaden the search results where necessary. The literature review included peer-reviewed journal articles published from 2020 to 2025. The resulting 43 articles reviewed, and 28 articles used for this analysis. The selected studies specifically focused on healthcare access challenges within Bangladesh, ensuring the relevance of findings to the country's unique social, economic, and healthcare context. This focused approach helped in gathering up- to-date and contextually appropriate evidence related to barriers in healthcare access. The reviewed literature encompassed findings from public health and health policy perspectives. From the public health viewpoint, several studies highlighted how geographic disparities, gender-based inequities, cultural norms, and socioeconomic constraints hinder timely access to healthcare (Akter et al.,2022; Hinta et al.,2024).

Vulnerable groups such as rural populations, indigenous communities, people with disabilities, and slum dwellers were often identified as disproportionately affected (Ali et al., 2025; Sen et al., 2023). Barriers were reported at multiple levels including individual, community, and system-wide domains.
Health policy-related literature focused on institutional and structural barriers.

Key issues included underfunded healthcare infrastructure, poor referral systems, lack of digital integration (e.g., ERP systems), political instability, and inadequate health workforce planning. For example, Karim et al. (2025) emphasized that the limited adoption of enterprise resource planning systems in the Bangladeshi healthcare sector stems from poor technological infrastructure and insufficient workforce training.

In total, 43 peer-reviewed articles were reviewed for the content about health care and barriers to health care. Each of the selected articles from the literature was read for themes and contributions to the body about health care and barriers to health care in Bangladesh. Highlights the need for formal concept analysis to consolidate insights and provide a clearer conceptual framework. A refined understanding of "barriers to healthcare" can help guide future research, inform policy decisions, and support more effective healthcare strategies in Bangladesh.

Relevance of Literature Reviewed to the Selected Concept

The literature reviewed for this concept analysis highlights key barriers to healthcare access in Bangladesh, including systemic challenges, socioeconomic inequalities, and cultural norms. These studies provide insight into how such barriers affect vulnerable groups and limit equitable access to care. By examining these issues, the analysis helps clarify the concept and supports future research and interventions aimed at improving healthcare access in the country.

Synthesis of Literature on the Use of the Concept

A synthesis of the literature reveals that the concept of barriers to healthcare access in Bangladesh is multidimensional, with varying conceptualizations across public health, sociology, economics, and health services literature. Public health scholars primarily conceptualize barriers as structural and systemic, emphasizing inadequate infrastructure, limited healthcare personnel, and geographical isolation (Akter et al., 2022; Hossain et al., 2024). Their focus is on expanding services and redistributing resources to underserved areas. In contrast, sociological perspectives frame these barriers within the context of social inequities such as poverty, gender roles, and ethnic discrimination, arguing that these social determinants deeply influence who receives care and who is excluded (Rahman et al., 2024; Alam et al., 2024). Economic literature conceptualizes barriers primarily through the lens of affordability, emphasizing the impact of out-of-pocket payments, lack of health insurance, and economic vulnerability on healthcare access (Das et al., 2025; Fahim et al., 2022). Meanwhile, literature from

health services research focuses on patient-provider dynamics, including communication breakdowns, cultural misunderstandings, and lack of provider training, which hinder service utilization and quality of care (Biswas et al., 2020; Islam et al., 2020). While each discipline emphasizes different dimensions, there is a consensus that healthcare access is constrained by a combination of interrelated social, economic, and structural factors. This synthesis highlights the need for an integrative approach to the concept one that draws from all disciplinary insights to develop holistic strategies for reducing barriers and improving equitable healthcare access in Bangladesh.

Identification and Explanation of Key Aspects

The concept "barriers to healthcare" refers to any obstacle that delays, limits, or prevents individuals from receiving appropriate and timely medical care. In the context of Bangladesh, a country facing both economic and systemic constraints, this concept manifests through a range of physical, social, economic, and institutional factors. This section presents a thorough analysis of the concept's key aspects: attributes, antecedents, and consequences, followed by a series of illustrative cases that clarify the scope and meaning of the concept.

Defining Attributes

The critical characteristics that consistently define barriers to healthcare in Bangladesh include:

Geographical Inaccessibility

Long distances to facilities, poor roads, and natural obstacles like rivers or hills make travel to health centers difficult, especially in rural, riverine, and hilly areas (Akter et al., 2022; Hossain et al., 2024; and Hamiduzzaman et al.,2022).

Financial Constraints

Most healthcare expenses are out-of-pocket. Many families cannot afford the cost of transportation, diagnostic tests, medicine, or hospital admission (Das et al., 2025; Fahim et al., 2022).

Shortage of Healthcare Personnel and Resources

Many public hospitals lack trained professionals, consistent drug supply, functional equipment, and hygienic facilities. Staff absenteeism and inadequate service coverage are common (Islam et al., 2020; Rahman et al., 2024).

Sociocultural and Gender Norms

Women's mobility is often restricted by family norms. Cultural stigma, particularly surrounding mental health and reproductive health, limits service utilization (Akter et al., 2022; Rahman et al., 2024).

Low Health Literacy and Awareness

Many individuals do not recognize the severity of symptoms, are unaware of available services, or hold misconceptions about treatment, leading to harmful delays (Alam et al., 2024; Hossain et al., 2024).

Discrimination and Poor Provider Behavior

Patients especially the poor, elderly, disabled, Indigenous, or gender-diverse often face verbal abuse, neglect, or judgmental behavior from healthcare staff (Biswas et al., 2020).

Antecedents

Antecedents are events or conditions that must exist before the concept emerges:

Widespread Poverty and Inequality

Chronic financial instability and wealth disparities reduce access to even basic care (Fahim et al., 2022).

Underdeveloped Health Infrastructure

Inadequate investment in the healthcare system leads to resource shortages and poor delivery service (Islam et al., 2020).

Low Educational Attainment

Low literacy among the general population contributes to reduced awareness and ineffective navigation of healthcare systems (Alam et al., 2024).

Historical Marginalization and Weak Governance

Indigenous populations, persons with disabilities, and refugees have been historically underserved due to discriminatory policies and lack of targeted initiatives (Akter et al., 2022; Rahman et al., 2024).

Consequences

These are the outcomes that result from the presence of barriers to healthcare:

Delayed or Forgone Care

Health conditions often worsen as people delay treatment or opt for informal care (Das et al., 2025).

Preventable Morbidity and Mortality

Lack of access to emergency, maternal, and chronic disease care leads to avoidable deaths (Rahman et al., 2024).

Economic Hardship

Medical expenses deplete savings, force loans, and deepen cycles of poverty (Fahim et al., 2022).

Diminished Trust in the Health System

Repeated poor experiences discourage individuals from seeking care in the future, reducing health-seeking behavior across communities (Hossain et al., 2024).

Cases

Model Case

Rubina, a 28-year-old pregnant woman from rural Sylhet, experienced high blood pressure and swelling in her seventh month of pregnancy. Her husband, a day laborer, hesitated to seek formal care due to the high cost of transportation and the family's unstable income. Initially, they consulted a local unqualified provider who prescribed herbal remedies. As Rubina's condition worsened, they borrowed money and traveled 35 kilometers to the nearest district hospital. Upon arrival, they discovered that no gynecologist was available, and the staff referred them to a private clinic. At the clinic, treatment was expensive and delayed. Tragically, Rubina delivered a stillborn baby due to untreated preeclampsia. This scenario reflects multiple defining attributes of barriers to healthcare in Bangladesh: geographical distance, financial hardship, gender-based delays in care-seeking, low health literacy, and inadequate public health services. The antecedents include poverty, poor health literacy, restrictive gender norms, and weak healthcare governance. The consequences of these barriers were profound worsening maternal health, preventable infant death, emotional trauma, and long-term financial burden.

Borderline Case

Hasan, a middle-aged man residing in a semi-urban area of Khulna, experienced chest pain and sought medical attention at a nearby government clinic. The clinic was geographically accessible and financially affordable. However, upon arrival, Hasan found that the attending physician was absent. After waiting for several hours, he was provided with only basic care and subsequently referred to a district hospital for further evaluation. This case demonstrates some of the defining attributes of healthcare barriers, particularly inadequate staffing and prolonged waiting times. However, it lacks more severe and defining barriers such as extreme financial hardship or geographic inaccessibility. While Hasan encountered certain obstacles, he was ultimately able to access necessary medical care, making this a borderline example of the concept "barriers to healthcare" in the Bangladeshi context.

Related Case

Fatima, a woman living in Dhaka, sought mental health support for anxiety and successfully booked an appointment with a private psychologist through an online platform. Although she found the cost of therapy to be relatively high, she was able to attend sessions consistently without experiencing any significant delays, administrative hurdles, or resistance from her social or family environment. This case illustrates an individual engaging with the healthcare system effectively, with timely and appropriate care. While it involves utilization of health service, it does not reflect any of the defining attributes of barriers to healthcare such as geographic inaccessibility, financial constraint severe enough to limit access, or systemic inefficiencies. Therefore, this case is considered related to the concept but does not exemplify the presence of actual healthcare barriers.

Contrary Case

Dr. Karim, a retired government officer residing in Chattogram, experienced minor health issues and promptly contacted his personal physician. The physician arranged a home visit, conducted the necessary diagnostic tests at Dr. Karim's residence, and ensured that all care was delivered efficiently and comfortably. Dr. Karim paid for the services with ease using his pension funds and did not face any obstacles in accessing the care he needed. This scenario lacks all defining attributes of barriers to healthcare.

There were no issues related to geography, financial hardship, systemic inefficiencies, or sociocultural constraints. As such, this case represents the opposite of the concept and is a clear example of seamless and privileged access to healthcare, making it a contrary case.

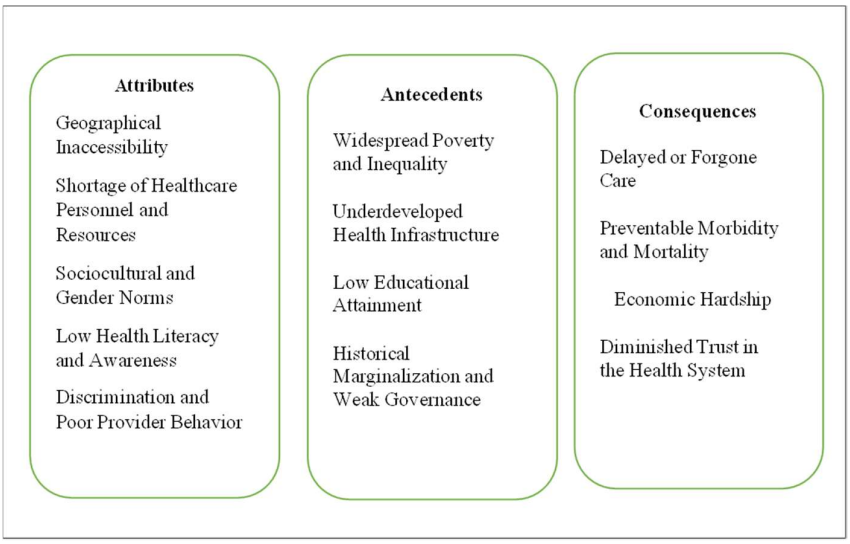

Figure 1 Attributes, Antecedents, Consequences of barriers to health care

Empirical Referents

Empirical referents are a critical component of concept analysis, as they provide observable and measurable indicators that reflect the defining attributes of a concept (Walker & Avant, 2005). These referents demonstrate how a concept exists in the real world and enable researchers to validate and assess it in practice. Walker and Avant (2005, p. 46) emphasize that when a concept is highly abstract, it is important to ask, "If we are to measure this concept or determine its existence in the real world, how do we do so?" In relation to the concept of Barriers to Healthcare in Bangladesh, empirical referents may include several tangible conditions and experiences. For instance, the inability of low-income individuals to afford healthcare services, shortages of essential medicines and skilled personnel at primary health centers, and poor infrastructure in rural and remote regions are all practical examples. Additionally, sociocultural barriers, such as women's hesitation to seek care from male providers, and a general lack of trust in public healthcare services, also represent significant manifestations of these barriers.

These real-world indicators provide measurable evidence of the concept's presence and impact, allowing for targeted strategies to address and overcome them in the Bangladeshi healthcare system.

Factors associated with barriers to healthcare access among ever married women of reproductive age in Bangladesh: Analysis from the 2017-2018 Bangladesh Demographic and Health Survey. More than two-thirds (66.3%) of women reported having at least one perceived barrier to accessing healthcare (Hussain et al., 2023). Lack of knowledge about healthcare needs, geographical barriers, poor financial conditions, higher cost of medical services, scarcity of hospitals nearby and communication barriers all contribute to inadequate access to healthcare services (Hossen et al., 2023). A hospital-based survey was performed from April 2019 to June 2019. A total of 500 females aged >18 years were recruited to the study. The participants had a severe lack of knowledge and awareness, and perceived barriers regarding breast cancer screening (Amin et al., 2020). National Survey on Persons with Disabilities. The outcome variable was healthcare services access within three months of the survey, categorized as either "yes" or "no" based on perceived needs. The main reasons for not accessing services were healthcare costs (52.10%), followed by lack of family support (27.0%), and absence of healthcare facilities in their areas of residence (10.10%). Among those who did receive healthcare services, the majority reported accessing them from governmental hospitals (26.49%), followed by village practitioners (20.52%), and private healthcare centers (19.87%). (Rahman et al., 2024).

Final Concept Analysis Definition

Barriers to healthcare in Bangladesh refer to the multifaceted and interrelated obstacles that delay, limit, or prevent individuals and communities especially the marginalized from accessing timely, affordable, and appropriate health services. These barriers are characterized by defining attributes such as geographic inaccessibility, financial constraints, shortages of trained personnel and resources, sociocultural and gender-based norms, low health literacy, and discriminatory behaviors. Antecedents to these barriers include widespread

poverty, underdeveloped health infrastructure, low educational attainment, and systemic marginalization of vulnerable populations. The consequences of these barriers are profound, often resulting in delayed or forgone care, preventable morbidity and mortality, financial distress, and eroded public trust in the healthcare system. Together, these elements form a critical public health issue requiring systemic, policy-driven, and community-based interventions in the Bangladeshi context.

III. Implications For Further Development, Clinical Practice, Education, And Administration

Clinical Practice

Nurses and frontline providers must be equipped to identify and address the multifaceted barriers patients face, such as financial constraints, sociocultural stigma, and geographic isolation (Das et al., 2025; Hossain et al., 2024). Culturally sensitive care, including community-based and mobile health services, can reduce these barriers and improve outcomes in underserved regions (Akter et al., 2022). Enhancing provider- patient communication and emphasizing non-discriminatory, respectful interactions are essential for rebuilding trust in the healthcare system (Biswas et al., 2020)..

Nursing and Health Education

Nursing and health professional curricula should include education on health disparities, social determinants of health, and advocacy for vulnerable populations (Alam et al., 2024). Educating future providers on the systemic and structural causes of limited healthcare access will empower them to provide context-aware care and engage in health system reform (Rahman et al., 2024).

Health Administration and Policy

Health administrators must prioritize equitable workforce distribution, improve infrastructure in rural and marginalized areas, and ensure accountability in public service delivery (Islam et al., 2020). Policies should focus on universal access, affordability, and inclusive health planning for minority groups such as Indigenous populations and persons with disabilities (Akter et al., 2022; Rahman et al., 2024).

Overall Development

Future research should aim to evaluate the effectiveness of context-specific interventions targeting healthcare barriers and to develop conceptual frameworks tailored to the Bangladeshi context (Fahim et al., 2022). Continued concept refinement will inform national health strategies and support evidence-based advocacy for health equity.

Innovation

In conceptualizing barriers to healthcare in Bangladesh, I propose viewing these barriers not as isolated logistical or structural obstacles, but as manifestations of deeply rooted sociopolitical inequalities embedded in the country's health system. This perspective introduces an innovative lens that integrates structural violence theory with access-to-care models, helping uncover how systemic neglect, marginalization of minority populations (e.g., Indigenous groups, persons with disabilities), and policy inconsistencies perpetuate inequities in care. This conceptualization will guide my future research by informing the development of a context-specific framework to assess both visible (e.g., geographic, financial) and invisible (e.g., cultural stigma, provider bias) barriers to healthcare. Such a framework could be empirically tested using mixed methods to identify intervention points at the policy, provider, and community levels.

Ultimately, this approach aims to support the creation of responsive, equitable healthcare delivery models in resource-constrained settings like Bangladesh.

IV. Conclusion

This concept analysis has illuminated the multifaceted nature of barriers to healthcare in Bangladesh, revealing a complex interplay of structural, socioeconomic, cultural, and systemic factors. By applying Walker and Avant's method, the defining attributes, antecedents, and consequences of the concept were clearly delineated, supported by

scholarly literature and illustrative cases. This analysis not only clarified the concept's theoretical dimensions but also emphasized its practical implications for health policy, service delivery, and research. In particular, the contextualization of barriers within Bangladesh's unique healthcare landscape underscores the need for targeted interventions that go beyond surface-level solutions to address deeper structural inequities. Moving forward, the conceptual clarity achieved through this analysis provides a critical foundation for empirical research and policy advocacy, aiming to dismantle existing barriers and promote equitable access to quality healthcare for all populations in Bangladesh.

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