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MedCOI

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Disclaimer

This report was written according to the EUAA COI Report Methodology (2023). The report is based on carefully selected sources of information. All sources used are referenced.

The information contained in this report has been researched, evaluated and analysed with utmost care. However, this document does not claim to be exhaustive. If a particular event, person or organisation is not mentioned in the report, this does not mean that the event has not taken place or that the person or organisation does not exist.

Furthermore, this report is not conclusive as to the determination or merit of any particular application for international protection. Terminology used should not be regarded as indicative of a particular legal position.

'Refugee', 'risk' and similar terminology are used as generic terminology and not in the legal sense as applied in the EU Asylum Acquis, the 1951 Refugee Convention and the 1967 Protocol relating to the Status of Refugees.

Neither the EUAA, nor any person acting on its behalf, may be held responsible for the use which may be made of the information contained in this report.

The drafting of this report was finalised on 25 March 2024. Any event taking place after this date is not included in this report.





Glossary and abbreviations

Term	Definition
BDT	Bangladeshi Taka
BiPAP	Bilevel Positive Airway Pressure
BSMMU	Bangabandhu Sheikh Mujib Medical University
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Airway Pressure
ENT	Ear, Nose and Throat
GOLD	Global Initiative for Chronic Obstructive Lung Disease
IPD	Inpatient Department
LLN	Lower Limit of the Normality
MOH	Ministry of Health
OSAHS	Obstructive Sleep Apnoea/Hypopnoea Syndrome
OPD	Outpatient Department
Upazila	An administrative unit, which is a subdivision of a district formerly known as "thana". Bangladesh has 495 <i>Upazilas</i> .





Introduction

Methodology

The purpose of the report is to provide information on access to pulmonology treatment in Bangladesh. This information is relevant to the application of international protection status determination (refugee status and subsidiary protection) and migration legislation in EU+ countries.

Terms of reference

The terms of reference for this Medical Country of Origin Information Report can be found in Annex 2: Terms of Reference (ToR). The initial drafting period finished on 09 November 2023, peer review occurred between 09-30 November 2023, and additional information was added to the report as a result of the quality review process during the review implementation up until 25 March 2024. The report was internally reviewed subsequently.

Collecting information

EUAA contracted International SOS (Intl.SOS) to manage the report delivery including data collection. Intl.SOS recruited and managed a local consultant to write the report and a public health expert to edit the report. These were selected from Intl.SOS' existing pool of consultants. The consultant was selected based on their experience in leading comparable projects and their experience of working on public health issues in Bangladesh.

This report is based on publicly available information in electronic and paper-based sources gathered through desk-based research. This report also contains information from oral sources with ground-level knowledge of the healthcare situation in Bangladesh who were interviewed specifically for this report. For security reasons, all oral sources are anonymised.

Quality control

This report was written by Intl.SOS in line with the European Union Agency for Asylum (EUAA) COI Report Methodology (2023),¹ the EUAA Country of Origin Information (COI) Reports Writing and Referencing Guide (2023)² and the EUAA Writing Guide (2022).³ Quality control of the report was carried out both on content and form. Form and content were reviewed by Intl.SOS and EUAA.

The accuracy of information included in the report was reviewed, to the extent possible, based on the quality of the sources and citations provided by the consultants. All the

¹ EUAA, Country of Origin Information (COI) Report Methodology, February 2023, [url](#)

² EUAA, Country of Origin Information (COI) Reports Writing and Referencing Guide, February 2023, [url](#)

³ EUAA, The EUAA Writing Guide, April 2022, [url](#)





comments from reviewers were reviewed and were implemented to the extent possible, under time constraints.

Sources

In accordance with EUAA COI methodology, a range of different published sources have been consulted on relevant topics for this report. These include academic publications, as well as websites of Bangladeshi facilities.

In addition to using publicly available sources, two oral sources were contacted for this report. The oral sources are both professors and they are anonymised in this report for security reasons. The sources were assessed for their background and ground-level knowledge. All oral sources are described in the Annex 1: Bibliography. Key informant interviews were carried out in October 2023.





1. Prevalence of pulmonological diseases

A review of studies on chronic obstructive pulmonary disease (COPD) in Bangladeshi adults came up with a pooled COPD prevalence of 12.5 % using the Global Initiative for Chronic Obstructive Lung Disease (GOLD) criteria and 11.9 % using the lower limit of the normality (LLN) criteria.⁴ A 2022 study focused on COPD in a rural setting on the population aged 40 years or above reports its average prevalence rate as 2 %; however, prevalence increases with the increase of age. The prevalence was higher among males than females, and the prevalence was higher in low socio-economic groups, rural residents and those who use biomass fuel.⁵ Alam D.S. et al. conducted a cross-sectional study of people 40 years of age and older in rural and urban areas of Bangladesh and found that the overall prevalence of COPD was 13.5 % and prevalence was more than three times higher in males than females (22 % vs 6.4 %) and about 60 % more in rural populations compared to urban populations. The same study reported that higher prevalence of COPD exists in older age groups, males, rural participants, illiterate individuals, manual workers, low-income groups, smokers (current or former), those with a history of asthma and solid fuel users.⁶ The study results showed higher the age, more the prevalence rate, with 5.2 % in 40 to 49 years, 13.6 % in 50 to 59 years, and 27.5 % in 60 to 69 years' age group. The same study reported that the prevalence of COPD is higher in rural than urban (17 % vs 9.9 %) population.⁷

A national cross-sectional asthma prevalence study reported that in 2010, ever wheeze of the respondents was 7.73 %, while perceived asthma was 7.46 % and asthma diagnosed by qualified physician was 5.86 %.⁸ The same study reported that prevalence of asthma was higher in children (5 to 14 years) than in adults (15 to 44 years). A study result from obstructive sleep apnoea-hypopnoea syndrome (OSAHS) conducted in urban Dhaka between July 2007 and June 2008 stated that the overall prevalence of obstructive sleep apnoea in the screened population was 11.91 %, and that of OSAHS was 3.29 %. The same study reported that obstructive sleep apnoea-hypopnoea in habitual snorers was 48.33 % and in non-habitual snorers was 1.66 %.⁹

⁴ Sutradhar, I., et al., Prevalence and Risk Factors of Chronic Obstructive Pulmonary Disease in Bangladesh: A Systematic Review, January 2019, [url](#), p. 1

⁵ Haque, A., et al., Prevalence of chronic obstructive pulmonary disease (COPD) among rural population: A national survey in Bangladesh, November 2022, [url](#), p. 540

⁶ Alam, D. S., et al., Prevalence and Determinants of Chronic Obstructive Pulmonary Disease (COPD) in Bangladesh, September 2015, [url](#), p. 661

⁷ Alam, D. S., et al., Prevalence and Determinants of Chronic Obstructive Pulmonary Disease (COPD) in Bangladesh, September 2015, [url](#), p. 663

⁸ Khan, A. A., et al., Trends of Asthma in Bangladesh: Findings of the National Asthma Prevalence Study 1999 and 2010, n.d., [url](#),

⁹ Hossain, A. M., et al., A Community study of obstructive sleep apnoea hypopnea syndrome (OSAHS) in middle-aged Bangladeshi population, November 2016, [url](#), p. 13



2. Access to treatment

According to an interviewed professor, patients with symptoms of respiratory discomfort, wheeze, cough at night and tightness of chest visit an *Upazila* healthcare or union healthcare centre of public or private healthcare facility and are then clinically assessed through physical examinations and investigations by the attending trained healthcare provider in the facilities. After relevant examination of chest, breathing pattern and quality of breathing with spirometry, along with routine sputum test, patients are then confirmed for their exact diagnosis either in the *Upazila* or below healthcare level, or in private clinics. If the condition of the patient is serious, they are then advised to visit district hospitals or a specialised tertiary centre for further investigation and treatment. Usually, uncomplicated cases of pulmonary systems are treated at *Upazila* level and below at public health facilities. The interviewed professor stated that distressed COPD patients are always considered emergency cases and are treated in equal numbers in private and public hospitals.¹⁰

Patients visit *Upazila* health complexes and their downstream health facilities in the Unions and below, under the Ministry of Health (MOH), in Bangladesh to get health services for diseases of the pulmonary system. Private hospitals, clinics and private practices by specialist from public facilities after office hours also meet demands of health service requirements for patients with lung diseases. There are no cultural, geographical or ethnic barriers to access to treatment.¹¹

With an increasing patient load, due in part to the country's large population, waiting times to visit specialists for lung diseases are likely to be high. The typical route for a patient with lung disease is to visit the *Upazila* health complexes or their downstream health facilities and get advice from the attending health personnel about the need to see a specialist either in district health facilities or specialist hospitals. The same process is applicable for a citizen returning to the country after having spent a number of years abroad.¹²

¹⁰ Source A, telephone interview, 2 October 2023, Dhaka. Source A is a Professor of Respiratory Medicine and Chest Diseases at LabAid Hospital. The person wishes to remain anonymous.

¹¹ Source A, telephone interview, 2 October 2023, Dhaka. Source A is a Professor of Respiratory Medicine and Chest Diseases at LabAid Hospital. The person wishes to remain anonymous.

¹² Source A, telephone interview, 2 October 2023, Dhaka. Source A is a Professor of Respiratory Medicine and Chest Diseases at LabAid Hospital. The person wishes to remain anonymous.



3. Cost of treatment

For consultation of pulmonology patients either at outpatient departments (OPDs) or inpatient departments (IPDs), for diagnostic services and, if patient is admitted to a hospital, then patients have to pay for all the fees and charges, including hospital bed charges and for purchase of emergency medicine. This applies to both public and private health facilities.¹³

A waiver for any discounted payment for any of the elements of consultations either in OPD or IPD, hospital charges for admittance, laboratory charges in the public hospitals and other healthcare facilities can be available if the Social Welfare Departments evaluate and certify. Private facilities do not offer any waivers for payment of hospital services and charges to patients seeking pulmonology care. For pulmonology patients, additional cost is due to the immediate nature of disease that requires immediate relief. Extra cost due to costs of food, transportation and accommodation for accompanied attendants is a burden for the poor. Since a wider range of poor people due to long-standing smoking habits suffer from COPD and asthma for which they need immediate inhalers, it is common to find poor patients with COPD begging for money from hospital attendants of other patients to purchase inhalers for immediate relief from the breathing difficulties.¹⁴

Official prices are fixed for laboratory investigations, fees for consultations, rents for patients' bed and operation charges in public facilities; these are strictly implemented. Health insurance coverage for pulmonology diseases is not available in Bangladesh.¹⁵

For the treatments listed below, there is usually no exemption, but in public health facilities the Social Welfare Department can recommend a partial or full discount to the fee.¹⁶

¹³ Source A, telephone interview, 2 October 2023, Dhaka. Source A is a Professor of Respiratory Medicine and Chest Diseases at LabAid Hospital. The person wishes to remain anonymous.

¹⁴ Source A, telephone interview, 2 October 2023, Dhaka. Source A is a Professor of Respiratory Medicine and Chest Diseases at LabAid Hospital. The person wishes to remain anonymous.

¹⁵ Source A, telephone interview, 2 October 2023, Dhaka. Source A is a Professor of Respiratory Medicine and Chest Diseases at LabAid Hospital. The person wishes to remain anonymous.

¹⁶ Source A, telephone interview, 2 October 2023, Dhaka. Source A is a Professor of Respiratory Medicine and Chest Diseases at LabAid Hospital. The person wishes to remain anonymous.



Table 1. Prices for consultation¹⁷

Specialist	Public outpatient treatment price in BDT	Public inpatient treatment price in BDT	Private outpatient treatment price in BDT	Private inpatient treatment price in BDT
Pulmonologist	200	300	1 200	1 800
General practitioner	200	200	1 200	1 800

Table 2. Prices for treatments and diagnostic tests¹⁸

	Public treatment price in BDT	Private treatment price in BDT
Diagnostic research		
Diagnostic test: lung function tests (e.g. spirometry)	250	750
Diagnostic imaging: bronchoscopy	2 200	6 500
Laboratory test: measuring arterial blood gas for arterial pH, pCO ₂ , "base excess", arterial oxygen saturation	2 000	4 000
Diagnostic test: measuring of blood oxygen level (e.g. pulse oximetry)	80	200
Diagnostic test: measuring of blood oxygenation for home use	1 750	2 200
Diagnostic test: examination in a sleep laboratory (e.g. polysomnography)	10 000	18 000
Medical devices pulmonology		
Breathing machines (ventilator, respirator etc.)	8 000	12 000

¹⁷ Source A, telephone interview, 2 October 2023, Dhaka. Source A is a Professor of Respiratory Medicine and Chest Diseases at LabAid Hospital. The person wishes to remain anonymous.

¹⁸ Source A, telephone interview, 2 October 2023, Dhaka. Source A is a Professor of Respiratory Medicine and Chest Diseases at LabAid Hospital. The person wishes to remain anonymous.

	Public treatment price in BDT	Private treatment price in BDT
Medical devices pulmonology: CPAP maintenance and repair	8 000	10 000
Medical devices pulmonology: CPAP therapy	2 000	5 000
Medical devices pulmonology: nebuliser	1 500	2 000
Spacer (with mask) for inhaler with asthma medication	400	600
Medical devices pulmonology: oxygen therapy with device and nasal catheter	2 500 <ul style="list-style-type: none"> • Daily cost of medical oxygen therapy with insertion of cannulas. • Excludes admittance charges in hospital cabins/beds. • Provision of medical oxygen therapy requires admission in hospitals. 	3 000 <ul style="list-style-type: none"> • Daily cost of medical oxygen therapy with insertion of cannulas. • Excludes admittance charges in hospital cabins/beds. • Provision of medical oxygen therapy requires admission in hospitals.
Medical devices pulmonology: oxygen therapy with O2 pressure tank	18 500	18 500
Medical devices pulmonology: BiPAP therapy for home use	65 000	75 000
Medical devices pulmonology: CPAP therapy for home use	65 000	75 000
Treatment		
Clinical admittance in pulmonology department (daily rates)	1 500	3 000

4. Cost of medication

Prices from online medicine shops are provided in Table 4. Cost of medications. These are taken from the following websites:

Table 3. Online medicine websites

Website name	Web address
Lazz Pharma Limited	https://www.lazzpharma.com
MedEx	https://medex.com.bd
ePharma	https://epharma.com.bd
Arogga	https://www.arogga.com

Relating to all medicines in the table below; medication prices are usually not reimbursed by any public health insurance mechanisms, but the Social Welfare Department can recommend free or partial payment for the public facilities.¹⁹

Table 4. Cost of medications²⁰

Generic Name	Brand name	Strength of unit	Form	Number of units in the container	Price per box in BDT	Place (pharmacy, hospital,...)
Combined anti-asthmatics and/or COPD medications						
Acclidinium + formoterol	Aclitol®	400 mcg acclidinium bromide, 12 mcg formoterol	capsule	20	500	Pharmacy
Beclometasone + formoterol (combination)	Decomit Plus®	200 mcg beclometasone, 6 mcg formoterol	inhaler	1	550	Pharmacy

¹⁹ Source B, telephone interview, 6 October 2023, Dhaka. Source B is a Professor of Respiratory Medicine Head of Research in BIRDEM. The person wishes to remain anonymous.

²⁰ Source B, telephone interview, 6 October 2023, Dhaka. Source B is a Professor of Respiratory Medicine Head of Research in BIRDEM. The person wishes to remain anonymous.

Generic Name	Brand name	Strength of unit	Form	Number of units in the container	Price per box in BDT	Place (pharmacy, hospital,...)
Fluticasone + umeclidinium + vilanterol	Respimax Pro®	100 mcg fluticasone, 62.5 mcg umeclidinium, 25 mcg vilanterol	capsule	30	1 350	Pharmacy
Indacaterol + glycopyrrolate (combination)	Utibron Neohaler®	110 mcg indacaterol, 50 mcg glycopyrrolate	inhaler	30	2 490	Pharmacy
Ipratropium + fenoterol (combination)	Berodual N®	20 mcg ipratropium, 50 mcg fenoterol	inhaler	1	240	Pharmacy
Salbutamol + ipratropium	Ipralin®	200 mcg salbutamol, 20 ml ipratropium	inhaler	1	130	Pharmacy
Salmeterol + fluticasone (propionate)	Seraflo®	50 mcg salmeterol, 250 mcg fluticasone	capsule inhaler	30	120	Pharmacy
Tiotropium + olodaterol	Stiolto Respimat®	2.5 mcg tiotropium, 2.5 mcg olodaterol	inhaler	30	240	Pharmacy
Vilanterol + fluticasone furoate (combination)	Vilanti®	25 mcg vilanterol, 100 mcg fluticasone furoate	capsule	20	440	Pharmacy
Umeclidinium bromide + vilanterol (combination)	Anoro Ellipta®	55 mcg umeclidinium bromide, 22 mcg vilanterol	capsule	14	15 120	Pharmacy
Formoterol + glycopyrronium	Bevespi Aerosphere®	5 mcg formoterol, 7.2 mcg glycopyrronium	capsule	10	700	Pharmacy

Generic Name	Brand name	Strength of unit	Form	Number of units in the container	Price per box in BDT	Place (pharmacy, hospital,...)
Indacaterol + glycopyrronium + mometasone	Ultivent-M®	150 mcg indacaterol, 50 mcg glycopyrronium, 160 mcg mometasone	capsule	10	4 460	Pharmacy
Sympathomimetics						
Formoterol	Oxis®	12 mcg	capsule	30	210	Pharmacy
Salbutamol	Brodil®	100 mcg	inhaler	1	240	Pharmacy
Terbutaline	Tervent®	2.5 mg	tablet	100	50	Pharmacy
Indacaterol	Caterol®	75 mcg	capsule	30	540	Pharmacy
Inhalation corticosteroids						
Beclometasone	Beclomin®	100 mcg	inhaler	1	270	Pharmacy
Budesonide	Aeronid®	200 mcg	inhaler	1	419	Pharmacy
Ciclesonide	Cicloson®	50 mcg	inhaler	1	250	Pharmacy
Fluticasone	Fluair®	125 mcg	inhaler	1	500	Pharmacy
Parasympatholytics						
Glycopyrronium bromide	Supotaria®	0.2 mg/ml	injection	5	250	Pharmacy
Ipratropium	Ipramid®	250 mcg/ml	solution (nebuliser)	30	130	Pharmacy
Tiotropium (bromide) e.g. as brand Spiriva®	Tiotrop®	18 mcg	capsule	30	240	Pharmacy
Other agents						
Theophylline	Contine®	200 mg	tablet	100	160	Pharmacy
Montelukast sodium	Montair®	10 mg	tablet	30	525	Pharmacy



Annex 1: Bibliography

Oral sources, including anonymous sources

Source A, telephone interview, 2 October 2023, Dhaka. Source A is a Professor of Respiratory Medicine and Chest Diseases at LabAid Hospital in Dhanmondi. The person wishes to remain anonymous.

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Annex 2: Terms of Reference (ToR)

Pulmonology

Note for drafters: These are guidelines on the information to be included. If one aspect is not relevant, e.g., there is no national institute to treat this disease or no international donor programme, there is no need to mention it. Keep the focus on treating medicine – preventive care can be mentioned but is of less interest to the target group.

General information

- Briefly describe prevalence and incidence of pulmonary diseases / types of this disease (epidemiologic data).
- How is the health care organized for pulmonary diseases?
- How are pulmonary diseases treated – at specific centres, in primary health care centres, secondary care / hospitals, tertiary care etc.?
- Which kinds of facilities can treat pulmonary diseases [public, private not for profit (e.g., hospitals run by the church), private for-profit sector]? Include links to facilities' websites if possible.
- How are the resources organized in general to treat patients with pulmonary diseases? Are there sufficient resources available to treat all patients?
- Is there a particular type of pulmonary disease for which no (or only partial) treatment exists in the country?
- Is there a (national) institute specialised in treating pulmonary diseases?
- Are there any national or international plans or (donor) programmes for pulmonary diseases; if yes, could you elaborate on such programme(s) and what it entails?

Access to treatment

- Are there specific treatment programmes for pulmonary diseases? If so, what are the eligibility criteria to gain access to it and what they contain?
- Are there specific government (e.g., insurance or tax) covered programmes for pulmonary diseases? If so, what are the eligibility criteria to gain access to it?
- Are there any factors limiting the access to healthcare for patients? If so, are they economic, cultural, geographical, etc.? Are there any policies to improve access to healthcare and/or to reduce the cost of treatments and/or medication? What is the number of people having access to treatment? Keep focus on e.g., waiting times rather than the exact number of specialists in the field.
- If different from information provided in the general section; is the treatment geographically accessible in all regions?
- What is the 'typical route' for a patient with pulmonary diseases (after being diagnosed with the disease)? In other words: for any necessary treatment, where can the patient find help and/or specific information? Where can s/he receive follow-up treatment? Are



there waiting times for treatments (e.g., spirometry, consultation by a pulmonologist, etc)?

- What must the patient pay and when?
- Is it the same scenario for a citizen returning to the country after having spent a number of years abroad?
- What financial support can a patient expect from the government, social security or a public or private institution? Is treatment covered by social protection or an additional / communal health insurance? If not, how can the patient gain access to a treatment?
- Any occurrences of healthcare discrimination for people with this disease?

Insurance and national programmes

- National coverage (state insurance).
- Programmes funded by international donor programmes, e.g., Gates foundation, Clinton foundation etc.
- Include any insurance information that is specific for patients with pulmonary diseases.
- Cost of treatment
- Guidance / methodology on how to complete the tables related to treatments:
- Do not delete any treatments from the tables. Instead state that they are not available or information could not be found if that is the case.
- In the table, indicate the price for inpatient and outpatient treatments in public and private facilities and if the treatments are covered by any insurance or by the state.
- For inpatient, indicate what is included in the cost (bed / daily rate for admittance, investigations, consultations...). For outpatient treatment, indicate follow up or consultation cost.
- Is there a difference in respect to prices between the private and public facilities?
- Are there any geographical disparities?
- Are the official prices adhered to in practice?
- Include links to online resources used, if applicable (e.g., hospital websites).

Note: a standardised list of treatments was also included in the original ToR, as can be viewed in the report. Any treatment without a found price was removed at the editorial stage.

Cost of medication

Guidance / methodology on how to complete the tables related to medications:

- Do not delete any medicines from the tables. Instead, state that they are not available or information could not be found if that is the case.
- Are the available medicines in general accessible in the whole country or are there limitations?
- Are the medicines registered in the country? If yes, what are the implications of them being registered?
- Indicate in the tables: generic name, brand name, strength of unit, form, pills per package, official prices, source, insurance coverage.



- Are (some of) the medicines mentioned on any drug lists like national lists, insurance lists, essential drug lists, hospital lists, pharmacy lists etc.? If so, what does such a list mean specifically in relation to coverage?
- Are there other kinds of coverage, e.g., from national donor programmes or other actors?
- Include links to online resources used, if applicable (e.g., online pharmacies).

Note: a standardised list of medication was also included in the original ToR, as can be viewed in the report. Any medication without a found price was removed at the editorial stage.

NGOs (include if relevant, otherwise delete section)

- Are any NGOs or international organisations active for patients with pulmonary diseases? What are the conditions to obtain help from these organisations? What help or support can they offer?
- Which services are free of charge and which ones are at a cost? Is access provided to all patients or access is restricted for some (e.g., in case of faith-based institutions or in case of NGOs providing care only to children for instance).



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