Health care systems in transition III. Bangladesh, Part I.
An overview of the health care system in Bangladesh

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Introduction

Although the adoption of economic structural adjustment and health sector reforms have been a more recent phenomenon in Asia compared with many other developing regions, considerable concern has been raised about the impact of these policies on the poor in Asia. In Bangladesh, the influence of the World Bank and other donor agencies has also raised many questions about the role of the international aid community in the developing world.

Bangladesh is one of the most densely populated and poorest countries in the developing world. The population, which is estimated to be over 120 million, is projected to double to around 250 million before demographic growth stabilizes. Although Bangladesh is still in the early stages of both the demographic and epidemiological transitions, the government faces major issues concerning its capacity to plan and implement a broad range of both health and population services. The present GNP per capita is US$260. The capital city of Dhaka has grown rapidly and about 20 per cent of the total population now lives in urban areas. Nearly 40 per cent of the GDP comes from agriculture, with rice, jute, tea and fish being important commodities. The manufacturing sector has recently grown substantially, particularly the ready-made garment industry, which has resulted in a large rise in rural to urban migration for employment, especially by young women.

Before the partition of India at independence, most of present-day Bangladesh was within the province of East Bengal, but from 1947 until 1971 the country was known as East Pakistan. Bangladesh became an independent country in 1971 following a war of liberation, and it recently celebrated its 25th anniversary. Present-day Bangladesh occupies large parts of the Ganges river delta area and, although surrounded on most sides by India, it also shares a border with Myanmar. The country is subject to annual river flooding, which on occasions can be very severe, and to cyclones from the Bay of Bengal to the south. Although there have been long periods of military rule from 1975 to 1990, democratic parliamentary elections were held in early 1991 and, despite episodes of considerable political unrest, civilian governments have ruled the country since then. The last general election was held in June 1996. Islam is the faith of 85 per cent of the population, with Hindus, Christians and Buddhists making up most of the remaining 15 per cent.

Health status indicators

Although there have been notable improvements in some health indicators since the 1970s, mainly as a result of large-scale government programmes, health status remains poor, thus making health and population among the most important development issues. For instance, in the 1995 national Health and Demographic Survey the incidence of low birthweight babies (2500 g or less) was about 50 per cent; maternal mortality was estimated to be about 500/100 000 live births, one of the highest in Asia; infant mortality was about 80–90/1000 live births; and average life expectancy at birth was about 58 years for both males and females. In addition, average nutritional calorie intake was estimated to be 88 per cent of requirements, only 34 per cent of the population had access to sanitation and adult literacy was 35 per cent. On the basis of a number of criteria, including a daily caloric intake of only 1600 per person, approximately half of the rural population lived in absolute poverty in 1994, 44 per cent of whom fell into the category of the very poor. However, Bangladesh has also achieved some

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notable successes. The average total fertility rate had fallen from 6.3 in 1971–1975 to 3.4 in 1998. The rate of natural population increase is close to replacement level and the national contraceptive prevalence has been estimated to be between 45 and 50 per cent. Immunization coverage with diphtheria–pertussis–tetanus (DPT) vaccine and measles vaccine is at high levels, and maternal tetanus toxoid coverage has improved rapidly in the last few years. Safe water is available, mainly through hand pumps, to about 90 per cent of the population, but recent evidence suggests that many of these tube wells are contaminated with high levels of arsenic. Although about three-quarters of young children are enrolled in primary schools, female literacy remains at only about 25 per cent. Moreover, three-quarters of pregnant women do not receive antenatal care or assistance from a trained attendant for infant delivery, and less than 40 per cent of the population has access to basic government health care services.7

A high proportion of child deaths are caused by poverty-related infectious diseases and malnutrition. The main causes of death, particularly in children, remain diarrhoeal diseases, acute respiratory infections, malnutrition, neonatal conditions, and accidents and injuries. Cardiovascular diseases, hypertension and diabetes are at a lower level than in other surrounding Asian countries but these diseases are emerging as important causes of adult morbidity. HIV transmission in Bangladesh is believed to be at a low level but reliable surveillance data are lacking by which to assess the situation.8 Malaria transmission is largely under control but there has been a large rise in the incidence of visceral leishmaniasis. Tuberculosis is widespread and the national control programme is being strengthened with involvement of non-government organizations (NGOs).9

With increasing urbanization and industrialization, HIV and other sexually transmitted diseases, environmental pollution and occupational health are all becoming much more important.10

Ministry of Health and Family Welfare

The Ministry of Health and Family Welfare (MOHFW) has overall responsibility for health sector policy and planning, and until recently there have been two separate directorates – also called the ‘two wings’ – for health services and family planning. This division of responsibilities between the two directorates was originally established in the early 1970s, since when there has been considerable independence and competition between them. They are both largely organized into vertical programmes and each has developed separate services, particularly for primary health care at thana or district level, and at union (sub-district) and village levels. This separation of services also led to the development of specialized cadres of health personnel and training institutions, together with separate health facilities, supporting services and information systems. However, in recent years considerable efforts have been made to achieve greater integration by organizing more joint services at the thana level and below, which started with expanded programmes of immunization (EPI) and family planning clinics.

Health services

Health care provision in Bangladesh is highly pluralistic and a plethora of treatment options exist, but non-government service provision predominates, which includes both for-profit and non-profit organizations, and traditional and non-formal practitioners. The site of first access for most services, other than maternal and child health (MCH) and family planning (FP), is non-governmental, with a wide choice of providers depending on the symptoms, gender, socio-economic standing and geographic location (rural or urban) of the individual. Although allopathic practitioners are consulted in about 80 per cent of cases when treatment is sought, the existence, length and quality of their training is as variable as the treatments they provide. A significant proportion, in some cases the majority, of treatments are sought from non-allopathic practitioners. Indigenous systems of medicine constitute a considerable proportion of the market.11

By contrast, the control of the Government of Bangladesh (GOB) health services is highly centralized in the MOHFW and the two directorates in Dhaka, including financial aspects and matters relating to health care professionals. Because administrative capacity at thana level requires strengthening and there is neither an elected nor appointed local government, the two directorates have been directly responsible for the implementation of most services, programmes and projects. However, recent proposals for health sector reforms include greater decentralization and the strengthening of the role of the thana health centres. Decentralization and increasing the efficiency of the bureaucratic structure are common themes in reform discussions.

There has been a massive GOB investment in the rural health infrastructure, with the construction of almost 400 thana health complexes since the 1970s, together with a network of family planning services, mainly in the form of fixed union and family welfare centres. By contrast, the investment in urban facilities and services was largely neglected until recently, even by NGOs. Human resources, including primary health care personnel, are relatively well developed in the public sector but there is a notable lack of suitable nurses at all levels. However, salaries are low and many positions remain unfilled. Although geographical access is reasonable for health facilities, they are characteristically under-utilized, services are commonly perceived to be of poor quality, they suffer from shortages of drug supplies and are inefficiently managed. Although GOB health facilities are supposed to provide most services free of charge, informal and unofficial charging is widely practised. A study undertaken by the MOHFW found that informal fees are common at all levels of the health system and they can amount to more than ten times the official charges.12

There are also a large number of NGOs that operate
separately from the MOHFW. However, there is an increasing tendency for the GOB to contract these NGOs to work in specific under-served areas and to carry out service programmes, particular those for MCH–FP and disease control programmes, such as for tuberculosis. Many of the NGOs working in family planning have been directly supported by funds from bilateral donor agencies, particularly USAID. A number of such NGOs also receive donor funding for primary health care and disease control programmes.

Private practitioners of all kinds, including many medical graduates, are numerous in both urban and rural areas. Drugs are widely available through the large number of private pharmacies and shop outlets. The number of private medical practices and hospitals in urban areas, together with numerous unqualified practitioners, is growing rapidly. These practitioners are poorly regulated and there is no adequate system for registering or licensing them by the GOB. Moreover, financial incentives often militate against appropriate medical practice, as professional supervision and regulation is weak.

Health care expenditure

The MOHFW total expenditure for health and population has been growing as a proportion of total public expenditure, particularly in the last 5 years, and in 1994–1995 it reached 6.9 per cent of the national government total budget. The MOHFW allocates about 75 per cent of its total budget to recurrent costs, of which about three-quarters is accounted for by staff costs. About half of the total expenditure goes towards primary level care, which includes the thana health complexes.

For the 1994–1995 fiscal year, total expenditure in the health sector was estimated at US$855 million, or approximately US$7.1 per capita (not including food and commodity aid contributions). Of this total, 47 per cent was accounted for by household out-of-pocket expenditure, whereas the Government contributed 27 per cent and donors the remaining 26 per cent.

The main bilateral donors to the health and population sector in Bangladesh are the governments of Australia, Belgium, Canada, Germany, Japan, Netherlands, Norway, Sweden, the United Kingdom and the United States. The World Bank, European Union, UNICEF and Asian Development Bank are also major donors. Approximately one-third of donor funding was channelled through the former Fourth Family Planning and Health Project (FPHP4), which had been supported by a consortium of the World Bank and nine bilateral donors. The Bank had the responsibility for co-ordinating this consortium. The FHP4 lasted for over 5 years and consisted of 66 health sub-projects, of which 21 were implemented by the Bangladesh country office of the World Health Organisation in its capacity as an executing agency. FHP4 was completed in mid-1998. With donor support, SWAPS, or sector-wide approaches, have been adopted for the much larger Fifth Health and Population Sector Programme.

Health policy and planning

Although the MOHFW had responsibility for 110 separate health projects in 1997, of which 66 fell within the FPHP4, repeated attempts to formulate a national health policy have been undermined by political strife. In contrast, the sector has been governed by a plethora of planning documents, including annual, 3, 5 and 15 year plans. A formal national health policy did not exist until recently. Ministry of Health plans were based on agreed projects, which were then incorporated into the various plans. However, weaknesses in the planning process have undermined their utility as strategic instruments for the health sector, which has resulted in sector investments and allocative decisions being made ad hoc. There has been a lack of sector-wide co-ordination. As a result, the Ministry of Health planning process was dominated by individual projects, all of which also had to be approved by the GOB Planning Commission and Economic Relations Bureau, particularly if external donor funding was involved. This approval process often took up to 2 years to complete. The project process was considered by donors to be far too fragmented, and too time-consuming, expensive and counter productive in disbursing aid. The absence of a unified national health policy made this situation even worse. As the plans were a composition of agreed individual projects, they lacked clear overall development goals for the health sector.

Health sector reform programme

Although donors had periodically encouraged the GOB to adopt a national health policy, it was only in the 1990s that this became a condition of their support. In 1996, the World Bank and consortium members indicated to the GOB that they would not proceed with further credits until a comprehensive, sector-wide strategy had been adopted. This also included an agenda for substantive structural and organizational reforms by the MOHFW. The GOB agreed to these reforms, thus allowing more radical changes to be implemented.

During the late 1990s, consensus developed between the GOB, development partners and other stakeholders that a major new programme of health sector reforms was required if sustained progress towards improving health and slowing population growth in Bangladesh was to be achieved. This consensus emerged after it was widely agreed that the FPHP4 piecemeal reforms had failed to be implemented. The proposed reforms included greater integration within the health sector and further improvements in the quality, accessibility and sustainable financing of the health services. The GOB has recently formulated, therefore, the new Health and Population Sector Programme (HPSP) for 1998–2003, as a Sector Investment Plan (SIP), that follows on from the Fourth Plan. The HPSP is based on a sector-wide and integrated approach, which focuses on the provision and utilization of an essential package of services, mainly for under-served population groups such as women, children and poor households. It also aims to
complement government anti-poverty policies in other sectors, including improving girls’ education, water supply and sanitation, environment, infrastructure, communication and the legal status of women. 20


The most fundamental component of the HDSP is the adoption of a new and integrated Essential Services Package (ESP), which aims to integrate all the priority interventions that were previously contained within the separate primary health care and family welfare services. The ESP covers reproductive and child health, communicable disease control, basic curative care and behaviour change communication. New services include comprehensive obstetric care, sexually transmitted diseases control and HIV prevention. Family planning will move to give higher priority to semi-permanent and clinical methods, such as vasectomy and tubectomy.

The Programme Implementation Plan (PIP) contains the broad details, but a number of areas, including the budget for the first year and the number of cost centres, were still being prepared in early 1999. In response to criticisms that the earlier efforts were too donor driven, the PIP was formulated by a participatory process involving task forces with members from the government, NGOs, private sector and development partners. The total cost has been estimated to be US$3200 million over the 5 years, with the GOB’s contribution to the revenue and development budgets being around US$2300 million (72 per cent) and the remaining $900 million being contributed by development partners and aid agencies. During the first year of the new HPSP plan, the emphasis will also be on restructuring the services, and the Ministry has established a Management Change Unit and Programme Co-ordination Cell to support this process. The main health sector reform initiatives to be implemented through the new HPSP are described in Table 1, and the additional components of the HPSP are described in Table 2.

Conclusion

Bangladesh has attached high priority to the development of its social sectors, including health and education, and with high-level political support, the MOHFW established its own 5 year plan in 1998, called the Health and Population Sector Programme. In terms of the national planning processes, this means that in 1998 the ministry re-established its lead role for the health and population sector.

The programme for HPSP requires major changes, including the establishment of the new integrated essential services package for primary level services. By early 1999, however, progress had been modest. Because of continuing resource constraints, the Government remains dependent on large-scale donor support to implement this ambitious plan for tackling poverty and ill health. The World Bank and other aid agencies remain very supportive, and such development partners will continue to be vital if this ambitious initiative for major health sector reform is to succeed.

However, securing improvements in health status will require far more than reorganization of the GOB health services, including regulation of private providers and practitioners. In addition, public health programmes will still be needed for improving such areas as health behaviours, nutritional status, and environmental and occupational health. Furthermore, these public health approaches will need to reduce the number of people living in absolute poverty. To achieve

Table 1 Main health sector reform initiatives of the New Health and Population Sector Programme, 1998–2003

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<td>Introduction of the Essential Services Package</td>
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<td>Restructuring and greater unification of the two ‘wings’ within the Ministry of Health and health services</td>
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<td>Redefinition of the roles and responsibilities of the health and family welfare directorates</td>
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<td>Greater decentralization of responsibility for financial management to thana level</td>
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<td>Improvement of hospital management through greater autonomy</td>
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Table 2 Additional components of the New Health and Population Sector Programme, 1998–2003

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<tr>
<td>Restructured health services under a unified and decentralized management structure, particularly at the thana and union levels, with construction of new community clinics</td>
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<td>Increased support for such areas as human resources training, logistics and supplies, health monitoring and surveillance, and systems for improving quality assurance</td>
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<td>Improved hospital management and improved services, including cost recovery and safety net provision for the poor</td>
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<td>Establishment of mechanisms for sector-wide management, with improved financial planning and accounting</td>
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<td>National policy and regulatory frameworks to be strengthened, including for the private sector and non-government providers</td>
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<td>Strengthening of public health programmes and intersectoral actions</td>
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<td>Intensification of nutritional and other community health services</td>
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this will need government development policies that are broad and redistributive, if they are to tackle such vital issues as household incomes, education and the status of women. These development issues continue to be the main future challenge for the health sector and for the society as a whole in Bangladesh.

References


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