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RESEARCH ARTICLE

REVIEW OF BANGLADESH HEALTHCARE SYSTEM.

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Abstract

Bangladesh health system is still undergoing reforms for more than 47 years after its independence in 1971, and is struggling to build up a broad health care infrastructure in both public and private sector. After adopting the Millennium Development Goals (MDGs), Bangladesh achieved great success in MDG4 target of reducing infant mortality by 2015. There was a quick response towards enhancing the other key indicators which are maternal mortality, vaccination coverage, and life-expectancy from several fatal communicable diseases that includes TB, malaria, and Diarrhea. Notwithstanding, heath system of Bangladesh is still facing some difficulty to cope up with some basic challenges in public health issues. For instance, Bangladesh has two Ministries supervising the implementation of health policies and financial support for rural and urban areas, with absence of coordination amongst each other. Moreover, health system has insufficient healthcare workers who are trained with appropriate skills particularly in public health sector, which is further being affected by broad increment in unregulated healthcare suppliers. Additionally, low health care budget distribution from annual Gross Domestic Product (GDP) growth by the government and high out of pocket payments to get heath care by the families accompanied by discrimination in healthcare access in rural and urban sectors. Likewise, inefficient health financing mechanism along with other challenges is affecting the universal health coverage targets in Bangladesh. Though, there may be a chance to diminish the healthcare workforce shortage for short time period through expansion of private sector and coordinating the social insurance provider with standard healthcare framework, public health sector still needs to be focused through increased funding and administer private and informal health care provider.

Introduction:-

After the liberation war in 1971, independent nation “Bangladesh” got its new boundaries from surrounding nations like, India, Myanmar and Bay of Bengal. A remarkable demographic transition in Bangladesh led to rapid decline in fertility rate per woman in early 1970s to late 2010 (1). Rapid urbanization with increased population density in cities has occurred with vast public health system development which is not competent due to available human and health resources (2). Despite the economic growth in Bangladesh measured through increased Gross National

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Income (GNI) annually (3), there are still some challenges such as poverty and income inequality which are compelling the overall growth of the nation in terms of health and education.

WHO Health System Building Blocks:

Governance:

After 1971, independence of Bangladesh, major reforms occurred in the government to make Bangladesh a unitary state and parliamentary democracy (1). As a consequence, power transfer to local government was left incomplete (4) which confines the sovereignty and efficiency of state government. Central government preserves extensive control over health system as Ministry of health and family welfare which possesses the responsibility of dual actor in general health and family planning services. On the contrary, Local Government manages the urban primary health care which has limited political power (4), and limited budgetary allocation for its institutions from Central Government. Funding to local government is largely focused on rules and regulation rather than actual situation of health system or demand of health services expanding the economic inequalities between rural and urban areas (5). Central Government is accountable for both setting up policies and regulation, and implementing comprehensive healthcare services which also includes financing and recruiting health staff (6). The central ministry manages the actions of public, private and NGO health services via acts and legislation which cover the health services in both rural and urban areas varying from primary to tertiary level, but primary health care in rural areas is still being in control of Local Government (4). This results in compensated health services in rural areas in terms of infrastructure and workforce. As a consequence to this lack of balance between local and central government, private and NGOs got the opportunity to expand their network (7). Despite overall health service in country has been influenced or being regulated by central government, private sectors taking the grounds mostly for profit services through its both formal and informal sector, resulted in increasing health care cost (8). Local Government in partnerships with private and NGO's is delivering the health services in certain sectors without being oversighted by the central government (9). Local government is performing their action on basis of their own resources and donor-funds from NGOs (4).

Health services Delivery:

Health infrastructure includes the health care service delivery through different administrative patterns that begins from national to district, upazila, union to the ward levels (9). Primary, secondary and tertiary level health care services are being delivered in public health facilities network in forms of public hospitals to tertiary level institutes and multi-specialized hospitals (9). Promotive, preventive and curative services are available for people with increased capacity to accommodate hospitalized patients. Public health facilities in Bangladesh are accessible to the citizens of the country as per the constitution but are not readily used. Government introduced the Essential Service Package (ESP) plan, "one-stop shopping" (10), to enhance the multiple services for the people but the constricted focus of ESP towards rural areas only led to creation of wide space between primary healthcare for poor living in cities. Limited workforce to these multiple service delivery spots with lack of supervision for health related disparities resulted in bad experience by the user with chief complaints about non-responsiveness, long waiting times, exclusion of marginalized groups and many more (11).

On the other hand, private sector with limited infrastructure accommodates more resources and workforce as compared to public health facilities. Despite the availability of modern medication in private sector, traditional medicine is widely practiced by two sectors. These sectors are differentiated as formal, those who have degrees or diplomas to provide basic care and informal which includes untrained allopath and homeopaths that are mostly available in rural areas (12). This resulted into geographic inequity in health services in country (13), and as a consequence of lack of availability and accessibility of services in public sector, private health care costs are rising.
Furthermore, NGO, as a third sector for health care facilities provided country with new approach and ideas to breach the incapability to provide universal health care (14). NGOs are working in Bangladesh to serve health and nutritional sector in close relationship with local government (14). Overall, the health delivery system of Bangladesh, either it is public or private, is considered to be not good in terms of quality of care provided.

Health Information System:

There are nine executing authorities out of which two are directly linked to the Ministry of Health and Family welfare (4), which are liable for overall information network development and check through routine Management information system (MIS) and its subsystems (2). However, both of these top level divisions are working independently from central to peripheral levels which is the major reason for summarization of separate and distinct data to Central Ministry (9). There is no specific policy in the country for MIS in health despite of legislative

framework for health information check on some fatal disease and vital registration (15). Patient health information in public health facilities is almost null along with unwillingness of other healthcare providers in providing the vital health data to MIS. So, final reports, annually and periodically, with inappropriate information about the availability and accessibility to healthcare have been submitted to central level through their national, divisional, district and lower levels.

Medicines, Vaccination and Technology:
Despite of free availability of medication for people at public healthcare, the supply of medical equipment and instrument to public healthcare facilities in Bangladesh is inadequate along with common excuse of drug shortage due to frequent disruption in supply chain of medicines (16). On the contrary, private sectors have adequate diagnostic equipment and medication which are beyond the reach of patients. The National Drug Policy has been introduced by the highest supervisory authority of the Bangladesh for Drug-associated affairs in 1982 (17) which was supposed to deal with licensing, production, import, export, quality control and pricing of the drug but the ill-equipped laboratories put a question on reliability of the medicine dispensed (18). Thereafter, deregulation of control over non-essential drug by Government led to shooting up of drug prices by the pharmaceutical companies (17) which is predominant contributor to out-of-pocket share as majority of direct payment goes for pharmaceutical and medical goods purchase.

Health Financing:
Despite of gradual rise in health spending in Bangladesh, health financing is the key driving factor for the efficiency of the health system and public health (19). Majority share of health services has been financed by people themselves as out-of-pocket payments to private health care provider and being mostly spent on medicine (20). Government shares remained same even after growth in country's GDP. Ideally, government expenditure in tangible terms should develop on similar pace as GDP of country to make an impact on the healthcare cost but Bangladesh government spending on healthcare remained about 1% of GDP from 1997-2007 (3). Major share of out-of-pocket, around 64% (21), along with informal payments in public and private sector without any financial risk protection are underlying factors for impoverishment in millions of families. Despite of freedom among people to select health care providers, low user fee charges and free medicine at public facilities, rural areas are predominantly occupied by the informal health care provider due to inadequate supply of medicine and equipment at public health facilities (22). In addition, Informal payments at public facilities for various reasons are driving the people to seek informal health care providers with resultant increase in cost of private health care sectors. On the other hand, major source of finance for health is taxes which is allocated to primary and tertiary level care by central health ministry. Apart from this, government came up with user fee at primary level to upgrade the health infrastructure as well as health insurances, which is still not significant, for both public and private sectors (23).

Healthcare Workforce:
Bangladesh healthcare workforce can be described in terms of shortage, unprofessional and unskilled workers along with disparity in distribution of workforce. Bangladesh Medical and Dental council is the only training authority behind production of skilled workforce which are deployed in both urban and rural area via two-year lead time in recruitment (13). The distribution of this health workforce further being inequitable in urban and rural areas (6). All major health care institutes are situated in capital city and other major cities with concentration of mainstream of workforce although about 70% of population lives in rural areas (13). Given the shortage and discrepancy of workforce resulted in dominance of informal sector in rural area comprising of semi-qualified and unqualified workers (24). Despite of independent entity, informal sectors serving at a community level with vast range of services like birth attendance etc. As per WHO recommendation for doctor, nurses and technologist's ratio, Bangladesh is still facing the shortage of 90,000 doctors, 273000 nurses and 455000 technologists (13) due to attrition of professional workers because of mobility, brain drain, failure in rural retention. Moreover, current tendency of health workforce towards feminization, particularly in female doctors, which led to create a difficulty to recruit women in remote area due to infrastructure deficiency and socio-cultural reasons. Additionally, female healthcare professionals not practicing after marriage makes them inactive for health care system. Government has been focusing to improve efficiency by training health workers along with focus on retention in rural areas through HRH planning (25).

Challenges and Opportunities:
Impressive growth pattern has been seen in public health in last few decades as the statistical figures revealed the improvement in life-expectancy, reduction in fertility and mother and child mortality (9). However, maternal and

neonatal mortality figures are still being a huge problem for the country along with increasing recurrence of emerging non communicable diseases (26). Although, the four key actors i.e. Government, private sector, NGOs and donor agencies are playing varied role and actions to organize the health care system (2), Bangladesh is as yet falling behind regarding financial security for poor and equity in financing health (20). Ideally, every Bangladesh citizen have rights to access health care but clubbing of certain actions like ignorance towards increasing health care funds, application of user charges, inadequate supply of medicine and increasing cost of private sector led to a significant inequality and inequity in access to services. Various reforms had been carried out including community clinics (27) and voucher scheme for maternal care (28), but this had very little impact on improvement in accessibility to health services. Though maternal, infant and under five mortality rates have fallen to marked figures as per the MDGs target for 2015 through increased coverage with special interventions (27), but maternal death rate and prevalence of under-weight births and deaths are yet far away from the targets (10). Other disease such as HIV, malaria and TB are also within reachable target limit but arrangement and scope of administration for developing burden of NCDs is just barely starting. Lack of financial protection, seems to be a major challenge as governmental policies are focused only on vulnerable groups at public and private health centers but OOP still being progressing high (19). This might be due to tax based health expenditure system of Bangladesh which is exerting more pressure on poor with their increased contribution which is further resulting in poverty (20). Moreover, health financing mechanism which includes health insurance are being in a state of promising future to reduce OOP. The existing condition of health care providers and their resources in terms of infrastructure and supplies considered to be another major reason behind the attitude towards health care system and decreased use of available services (29). Lack of awareness about available services and negative perception due to user fee, geographic disparities in service availability and quality care preclude the access to care (22). Despite the huge public health care network at a primary level, low quality, non-availability of health care workers caused informal private sector enlargement. Moreover, absorption of professionally trained doctors, nurses by the private sectors constrained the public sectors with not only one doctor to serve 3000 populations (30) as well as limited supply of medicine and vaccinations (29). On top of this human workforce crisis, inadequate basic resources at public health facilities encouraged the informal sectors development and poor public health outcomes. Bangladesh heath delivery system failed in addressing the disease burden from heath transition which has now being doubled (31).

Conclusion:-

Bangladesh Government has achieved remarkable success through reforms which had been done with limited health budget, to improve outcomes in some focused groups interventions but health status of the poor remained un-affected. There are many factors which are the key players to obstruct the assumed health outcomes and general wellbeing of the country.

Firstly, the complexity in health system due to poor combination of multiple health care providers and poor governance. The Ministry of health and welfare empowered to operate the health system but the existing framework of governance lacks coordination, discouraging stakeholders. All these factors made the public health system of poor quality with high absenteeism rate of health workforce, corruption and poor performance in service delivery. So, close coordination among Ministries should be established by the Government with decentralization of some political powers to local governments. Moreover, NGOs, which are linked to local government directly or indirectly, must be supported and encouraged through funds to improve and maintain health services. Additionally, NGOs can be the main driving forces in changing the behavior towards services, promoting health on a mass scale and wider coverage in rural areas.

Secondly, shortage of health resources especially in rural settings and inadequate supply of medicine and vaccination in public sector are creating an alarming situation and resulted in development of informal sector and deviation from expected health outcomes. Apart from this, system is still inefficient to tackle with upcoming burden from health transition due to its untrained, limited workforce. Therefore, this informal sector should be regulated within the mainstream health system and private sector should be encouraged to produce more health workforce. For all these, fund allocation must be increased to public sector, especially to local level to change the service quality perception and private sector services must be monitored to ensure equality in delivering services.

Furthermore, people are bound to use their earning only to chase health care services rather than spending it on other domestic products. Majority of spending is in form of direct payments to medical providers and little to others health care resources. Likewise, informal payments with high OOP further exaggerate the impact on poor and their health. In addition, certain health care facilities are contracted by user fee which is giving rise to inequitable access and

hinds the universal coverage. Structural re-alignment of services to create a link between primary to tertiary level care through referral system, developing secondary and tertiary level care to district level and equitable allocation of funds will improve the equity in provision of healthcare services.

References:-

1. Alamgir J. Bangladesh's Fresh Start. Journal of Democracy 2009;20(3).
2. Anwar Islam TB. Health system in Bangladesh: Challenges and opportunities. American Journal of Health Research. 2014;2(6):366-74.
3. Asadullah MN, Savoia A, Mahmud W. Paths to Development: Is there a Bangladesh Surprise? World Development. 2014;62:138-54.
4. Panday PK. Local Government System in Bangladesh: How Far is it Decentralised? Journal of Local self-Government. 2011;9(3).
5. Islam N. Urbanization and Urban Governance in Bangladesh. 13th Annual Global Development Conference on "Urbanization & Development: Delving Deeper into the Nexus"; Budapest2012.
6. Dussault G, Franceschini MC. Not enough there, too many here: understanding geographical imbalances in the distribution of the health workforce. Human Resources for Health. 2006;4(1):12.
7. Zurn P, Dal Poz MR, Stilwell B, Adams O. Imbalance in the health workforce. Human Resources for Health. 2004;2(1):13.
8. ANDALEEB SS. Public and private hospitals in Bangladesh: service quality and predictors of hospital choice. Journal of HEALTH POLICY AND PLANNING. 2000;15(1).
9. Ssengooba F, Rahman SA, Hongoro C, Rutebemberwa E, Mustafa A, Kielmann T, et al. Health sector reforms and human resources for health in Uganda and Bangladesh: mechanisms of effect. Human Resources for Health. 2007;5(1):3.
10. Osman FA. Health Policy, Programmes and System in Bangladesh: Achievements and Challenges. South Asian Survey. 2008;15(2):263-88.
11. Andaleeb SSaS, Nazlee and Khandakar, Shahjahan. Patient satisfaction with health services in Bangladesh. Journal of Health Policy and Planning. 2007;22(4):263-73.
12. Syed Masud Ahmed TGE, Hilary Standing, Simeen Mahmud. Harnessing pluralism for better health in Bangladesh. The Lancet; 2013.
13. Ahmed SM, Hossain MA, RajaChowdhury AM, Bhuiya AU. The health workforce crisis in Bangladesh: shortage, inappropriate skill-mix and inequitable distribution. Human Resources for Health. 2011;9(1):3.
14. Alec Mercer MHK, Muhammad Daulatuzzaman, Joanna Reid. Effectiveness of an NGO primary health care programme in rural Bangladesh: evidence from the management information system. Journal of Health Policy and Planning. 2004;19(4):187–98.
15. Kruk ME, Freedman LP. Assessing health system performance in developing countries: A review of the literature. Health Policy. 2008;85(3):263-76.
16. Hussain A, Ali SMK, Kvåle G. Determinants of mortality among children in the urban slums of Dhaka city, Bangladesh. Tropical Medicine & International Health. 2002;4(11):758-64.
17. Islam N. On a National Drug Policy for Bangladesh. Tropical Doctor. 1984;14(1):3-7.
18. Ahmed SM, Islam QS. Availability and Rational Use of Drugs in Primary Healthcare Facilities Following the National Drug Policy of 1982: Is Bangladesh on Right Track? Journal of Health, Population and Nutrition. 2012;30(1):99-108.
19. Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J, Murray CJL. Household catastrophic health expenditure: a multicountry analysis. The Lancet. 2003;362(9378):111-7.
20. Rahman MM, Gilmour S, Saito E, Sultana P, Shibuya K. Health-Related Financial Catastrophe, Inequality and Chronic Illness in Bangladesh. PLOS ONE. 2013;8(2):e56873.
21. Xu K, Evans DB, Carrin G, Aguilar-Rivera AM, Musgrove P, Evans T. Protecting Households From Catastrophic Health Spending. Health Affairs. 2007;26(4):972-83.
22. Stanton B, Clemens J. User fees for health care in developing countries: A case study of Bangladesh. Social Science & Medicine. 1989;29(10):1199-205.
23. CREESE AL. User charges for health care: a review of recent experience. Health Policy and Planning. 1991;6(4).
24. Amin ATMN. The Role of the Informal Sector in Economic Development - Some Evidence from Dhaka, Bangladesh International Labour Review. 1987;126:611.
25. Ahmed SM, Hossain MA. Knowledge and practice of unqualified and semi-qualified allopathic providers in rural Bangladesh: Implications for the HRH problem. Health Policy. 2007;84(2):332-43.

26. A Mushtaque R Chowdhury AB, Mahbub Elahi Chowdhury, Sabrina Rasheed, Zakir Hussain, Lincoln C Chen. The Bangladesh paradox: exceptional health achievement despite economic poverty. The Lancet; 2013.
27. Nahar B, Hossain MI, Hamadani JD, Ahmed T, Huda SN, Grantham-McGregor SM, et al. Effects of a community-based approach of food and psychosocial stimulation on growth and development of severely malnourished children in Bangladesh: a randomised trial. European Journal Of Clinical Nutrition. 2012;66:701.
28. Shakil Ahmed MMK. A maternal health voucher scheme: what have we learned from the demand-side financing scheme in Bangladesh? Health Policy and Planning. 2011;26(1).
29. Ensor T. Overcoming barriers to health service access: influencing the demand side. Journal of Health Policy and Planning. 2004;19(2).
30. Nazmul Chaudhury JSH. Ghost Doctors: Absenteeism in Rural Bangladeshi Health Facilities. The World Bank Economic Review. 2004;18(3).
31. Khan Shusmita H, Talukder Shamim H. Nutrition transition in Bangladesh: is the country ready for this double burden. Obesity Reviews. 2013;14(S2):126-33.