Executive Summary

Bangladesh is one of the most densely populated countries in the world. It is a unitary state and parliamentary democracy. Health and education levels are relatively low, although they have improved recently as poverty levels have decreased. Most Bangladeshis continue to live by subsistence farming in rural villages. Bangladesh faces a number of major challenges, including poverty, corruption, overpopulation and vulnerability to climate change. However, it has been lauded by the international community for its progress on the Human Development Index. Bangladesh has made more notable gains in a number of indicators than some of its neighbours with higher per capita income, such as India and Pakistan.

The joint donor funded Health, Population, and Nutrition Sector Development Programme (HPNSDP) has contributed to significant improvement in a number of health indicators including reduction in under-five mortality, immunization coverage, maternal mortality and total fertility. The country has improved women’s education, and economic conditions and life expectancy. Despite current economic growth, poverty and income inequality remain persistent challenges in Bangladesh. Simultaneous with the demographic transition, Bangladesh is undergoing the health transition and manifesting the double burden of disease attributable to the emergence of noncommunicable diseases.

The health system of Bangladesh is a pluralistic system with four key actors that define the structure and function of the system: government, private sector, nongovernmental organizations (NGOs) and donor agencies. The Government or public sector is the first key actor which by constitution is responsible not only for policy and regulation but for provision of comprehensive health services, including financing and employment of health staff. The Ministry of Health and Family Welfare, through the two Directorates General of Health Services (DGHS) and Family Planning (DGFP), manages a dual system of general health and family planning services through district hospitals, Upazila Health Complexes (with 10 to 50 beds) at subdistrict level, Union Health and
Family Welfare Centres at union level, and community clinics at ward level. In addition, the Ministry of Local Government, Rural Development and Cooperatives manages the provision of urban primary care services. Quality of services at these facilities, however, is quite low due to insufficient allocation of resources, institutional limitations and absenteeism or negligence of providers.

Since 1976, to complement the Government’s limited capacity and resources to provide basic health services, the private sector and NGOs have established a network of facilities to provide health and family planning services. The private sector consists of the formal sector which provides both western and traditional (Unani and Ayurvedic) services through a range of facilities from hospitals to clinics, laboratories and drug stores; and the informal sector, which consists largely of untrained providers of western, homeopathic and traditional (kobiraj) medicine. However, private services are poorly regulated. The formal sector is concentrated in urban areas, and the informal sector is the principal provider in rural areas.

In response to the low quality of public services and their inability to reach the entire population, particularly the poor, a vibrant and large NGO sector has emerged as “third sector” of health providers in Bangladesh. The role of NGOs is growing as donors are channeling significant and increasing amounts of funding directly to them. In 2007, 9% of total health expenditure was managed by NGOs, up from 6% in 1997. As a response to both external and internal pressures, partnerships between the Government and NGOs in the areas of financing, planning, service delivery, capacity building, and monitoring and evaluation have produced some health gains.

The Bangladesh public health system remains highly centralized, with planning undertaken by the Ministry of Health and Family Welfare and little authority delegated to local levels. The Health Information System suffers from the bifurcation of the Ministry into DGHS and DGFP, with separate and distinct reporting systems for each Directorate General. While there exist a number of acts and ordinances to regulate the health system, including regulation of different types of providers, practice facilities and NGOs, many of these legal instruments date from several decades ago. Separate councils for the registration and licensing of medical practitioners, dentists and nurses have been established, but their authority to investigate or discipline providers is weak. A number
of initiatives have been undertaken through the joint Government-donor pooled programmes to encourage and support community empowerment and accountability, with limited success. However, a number of NGOs remain active in public reporting on government handling of the health sector.

According to the latest Bangladesh National Health Accounts, Bangladesh spends US$ 2.3 billion on health or US$ 16.20 per person per year, of which 64% comes through out-of-pocket payments. While, according to WHO estimates, Bangladesh currently spends US$ 26.60 per person on health per year. Public funding for health is the main prepayment mechanism with scope for risk pooling, which constitutes 26% of total health expenditure. The other major funding source is international development partners. Chronic underspending of the Ministry of Health and Family Welfare’s budget indicates inefficiency in utilization of resources as observed in the public sector review of the health sector.

Except for through the public budget, the existing funding mechanisms of Bangladesh only slightly address (0.2% of total health expenditure) any prepayment method, such as health insurance, either by private or community initiatives. Several community initiatives for ensuring low-cost services exist, while a number of private insurance companies offer individual and group insurance to private persons and corporate clients. These health insurance initiatives cover a very small share of the total population.

The statutory health system, in principle, covers all citizens with a range of services. However, many sick people every year are left untreated in practice. In response to insufficient and unsatisfactory services in the public sector, private initiatives have been taken since the 1980s. The cost of services in private health facilities is unaffordable to many. Bangladesh, therefore, still needs to travel a long way to reach universal health coverage.

Bangladesh has an extensive PHC infrastructure in the public sector but facilities are not adequately provided with human and other resources such as drugs, instruments and supplies. During 2007–2013, the number of both hospitals and total number of beds in the public sector has steadily increased. The number of beds in PHC facilities at upazila level and below reached 18 880 across 472 facilities in 2013, and 27 053 in 126 facilities at secondary and tertiary level. In the private sector, there were 2983 registered hospital and clinics, with 45 485 beds. Taken together,
there is now one bed for every 1699 population, which is still inadequate. Meanwhile, to bring health facilities closer to the doorstep of the population, there is a community clinic for every 6000 population (n=12 527) which provides primary health care services.

In the public sector, the Central Medical Store is responsible for procurement and supply of medical and surgical equipment and products, including drugs. The public sector health facilities in Bangladesh lack medical equipment and instruments. Many of the lower-level facilities lack basic instruments like clocks and height-measuring scales. Supply of drugs is also inadequate and the supply chain is frequently disrupted. On the other hand, the private sector, especially the recently emerging high-cost hospitals and clinics in the urban areas, have all the major state-of-the-art diagnostic equipment and facilities.

Bangladesh is characterized by “shortage, inappropriate skill mix and inequitable distribution” of its health workforce. At present there are 64 434 registered doctors, 6034 dentists, 30 516 nurses, and 27 000 nurse-midwives in the country (cumulative figures unadjusted for attrition due to deaths, retirements, migration, change of profession, or inactivity). In addition, the health workforce is skewed towards doctors with a ratio of doctors to nurses to technologists of 1:0.4:0.24, in stark contrast to the WHO recommended ratio of 1:3:5. The involvement of the health workforce in the private sector has increased over the years, as revealed by an estimated 62% of the medical doctors working in the private sector in 2013. The formal health workforce (doctors, dentists, nurses) is mostly concentrated in the urban areas, with variation among regions. Retention and absenteeism are two major problems in rural areas.

There is a large cadre of health care providers in the country in the informal sector. This comprises semi-qualified allopathic providers (e.g. community health workers, medical assistants, trained midwives), unqualified allopathic providers (drug shop retailers, rural doctors, etc.), traditional healers (practitioners of Ayurvedic, Unani and homeopathic medicine) and faith healers. They are not a part of the mainstream health system but a major health care provider for the poor rural population, especially in remote rural and hard-to-reach areas.

Health services are delivered by both the public and non-public sector in Bangladesh. In the public sector, the Ministry of Health and Family Welfare is the main agency providing public health services, including health promotion and preventive services. The public health services
include programmes for the control of tuberculosis, now covering all upazilas with the Directly Observed Treatment Strategy (DOTS); the National Leprosy Elimination Programme, which reduced prevalence rates to 0.24/10 000 by 2010; the Malaria and Parasitic Disease Control Programme which targets approximately 11 million people in high risk areas; Kala-azar (visceral leishmaniasis) control which has now expanded to cover 27 districts; and the HIV/AIDS programme which has managed to keep the incidence of HIV below 1% among high-risk populations. These programmes are supported by National Public Health Institutes, while health promotion is organized by the dedicated sections of DGHS and DGFP.

Primary and ambulatory care is delivered through the public network of facilities, particularly through the community-based health care programme delivered by the community clinics; and by the private formal and informal and NGO providers. In urban areas, patients tend to use the outpatient units of the major urban hospitals for ambulatory care. Secondary and inpatient care is provided through public facilities at upazila, district, medical college and specialist urban hospitals, as well as private hospitals mainly in urban areas. There is no structured referral system, so that patients with minor ailments may also present directly to hospitals for treatment.

Due to epidemiological and demographic change, Bangladesh is facing the double burden of communicable and noncommunicable disease including the emergence and re-emergence of other diseases. Moreover, with recent incidents in garments factories, the focus is shifting towards the occupational health and safety of workers in the ready-made garment sector. The public health programmes need to be revisited and redesigned to effectively address emerging challenges.

Bangladesh has made significant progress in the development of its domestic pharmaceutical sector, with the introduction of the National Drug Policy (NDP) in 1982. Domestic manufacturers now provide 75% of total drug sales, and are expanding to develop an export market. The Central Medical Store procures and distributes drugs to public sector hospitals and facilities where they are provided free of charge. However, outside the public sector, there is a chaotic market of some 64 000 licensed pharmacies and 70 000 unlicensed drug stores, selling all types of medicines without requiring prescriptions. Polypharmacy and dispensing by the prescriber is also common in the private sector and constrains the rational use of medicines.
Recent health reforms in Bangladesh commenced with the Health and Population Sector Strategy, developed by the government and donors in 1997. This strategy advocated a number of institutional and governance reforms, notably the shift from a project basis towards a coordinated sectoral programme. These reforms were then implemented through a series of five year sectoral programmes, commencing with the Health and Population Sector Programme (HPSP) of 1998–2003. Key reforms included: pooling of donor funds in a Sector Wide Approach (SWAp), provision of selected primary health care services under an Essential Services Package to the poor, introduction of one-stop services through community clinics, and unification as well as bifurcation of health and family planning wings of the Ministry of Health and Family Welfare. Under the latest five-year programme, the Health, Population and Nutrition Sector Development Programme (HNPSDP), health sector activities have been grouped into 38 operational plans implemented by 38 Line Directors. While the SWAp has improved coordination and alignment among multiple donor projects, there remains fragmentation within the vertical programmes of the Ministry, continuation of a number of vertical programmes funded outside the SWAp, and a lack of a comprehensive ministerial plan.

Other key reforms include: the establishment of community clinics to replace domiciliary visits; their withdrawal when coverage of major programmes fell, and their reinstatement together with domiciliary programmes by the new Government; unification of the DGHS and DGFP in 2000, and then subsequent re-separation in the face of poor performance by DGFP officers; attempts at decentralization of health services to the upazila level, although with limited delegated authority; and the recent maternal health voucher scheme.

Recently, in recognition that the high levels of out-of-pocket expenditure form a barrier to utilization, a Health Care Financing Strategy (2012–2032) has been developed to provide direction in achieving universal health coverage. The strategy puts emphasis on prepayment mechanisms with scope for risk-pooling, and separate mechanisms are suggested for people in different economic sectors (formal sector, informal sector and people in poverty). Taxes, social health insurance contributions and community-based health insurance schemes have been recommended. Over its 20-year implementation period, the strategy aims at reduction of out-of-pocket payments from 64% to 32% of total health expenditure, increase in government expenditure from 26% to 30%, increase in social
protection from less than 1% to 32% and reduced dependence on external funds from 8% to 5%.

The stated objectives in the National Health Policy of 2011 are: (i) strengthening primary health and emergency care for all, (ii) expanding the availability of client-centred, equity-focused and high quality health care services, and (iii) motivating people to seek care based on rights for health. While theoretically all Bangladeshi citizens have the right to receive health care according to need, low government investment in public facilities, some user charges and payments for medicines, and high use of the private sector have resulted in significant inequity in access to services. Existing reforms such as community clinics and maternal care vouchers provide access to only limited services, while the proposal for health insurance for formal sector workers will not address the majority of those engaged in the informal and rural sector. In relation to user experience and equity of access, the general public perception of the public health system is poor, with complaints of long waiting times, absenteeism, poor behaviour of providers, and exclusion of some marginalized groups. Access to care demonstrates much higher rates of utilization of public and private services by the wealthier quintiles, but there has been some improvement in equity in access over the last decade.

Though there have been commendable gains in health outcomes recently, grossly inequity remains. For example, differential levels of early childhood mortality were observed according to socioeconomic status (SES) (Demographic 2011). Neonatal mortality, infant mortality and under-five mortality in the highest wealth quintile households (23, 29, 37 respectively per 1000 live births) were much lower than among the lowest quintile households (34, 50, 64 respectively per 1000 live births). Similarly, vaccination coverage (BCG, measles and three doses each of DPT and polio) among children from highest quintile households was 93% compared to 77% among lowest quintile households.

The same trend in SES differentials was observed in the case of child nutritional status (Demographic 2011). Children of lowest quintile households were proportionately more stunted (54% compared to 26% for highest quintile households), underweight (50% compared to 21% for highest quintile households) and wasted (17% compared to 12% for highest quintile households). 51% and 64% of the pregnant women from highest wealth quintile households were assisted during delivery by a
qualified doctor or a medically-trained provider respectively, compared to only 5% and 11% respectively in case of lowest wealth quintile households (Demographic 2011). Only 10% of pregnant women from lowest quintile households delivered in a health facility compared to 60% for the other groups of women. The percentage of C-section deliveries was 3% and 41% respectively for the lowest and highest quintile households.

Despite many challenges, population health outcomes have shown marked improvement, with falls in maternal, infant and under-five mortality rates, and significant reductions in total fertility rate. In comparison with MDG targets, infant and under-five mortality and total fertility are on track to reach the 2015 targets; maternal mortality and prevalence of underweight are not on track to reach targets despite significant reductions, while targets for HIV, malaria and TB are still potentially achievable. These outcomes have been achieved by improvements in coverage with key interventions, such as delivery in a health facility, childhood immunization, and management of diarrhoea with oral rehydration salts, and treatment success rates for TB. However, the provision and coverage of services for the growing burden of noncommunicable diseases is only just beginning. Quality of care in both public and private services is poor, with little assessment of the quality of provider care, low levels of professional knowledge, and poor application.

Bangladesh has set an extraordinary example of gaining good health at a very low cost and has been proposed as a role model for other developing countries in the region. While the gains in health have been credited to the Ministry of Health and Family Welfare, the progress of other ministries relevant to public health catalyzed the success of the overall health agenda of the Government. It is a paradox that despite the lack of accountability of the Government to the public regarding health and little coordination of the health ministry with other sectors, a number of vertical health programmes, particularly in preventive care (such as immunization, control of diarrhoea, TB and other emerging infectious diseases) have been sustained successfully over a long period, impacting positively on health outcomes. Mobilizing the huge informal health cadres outside the official allopathic system would be a useful strategy for strengthening human resources in health, especially in the remote and hard-to-reach areas of the country and achieving universal health coverage.