

SEARCHING WAYS FORWARD FOR BANGLADESH IN THE TIME OF PANDEMIC



Public Health Sector in Bangladesh

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Pre-Covid era

Bangladesh has one of the best health net-work in the public sector. As many as 47,678 domiciliary workers with 13,907 community clinics at the ward level and 4,646 at the union level facilities are there to provide health services while 424 upazila health complexes, 59 district hospitals, 18 medical college hospitals and 12 specialized health institutes/hospitals are there to treat patients. Some other types of health service facilities are also there. However, shortage and skill-mix imbalance of human resources, limitations as regards equipment, medicines and other supplies often stand in the ways of accruing adequate benefits from these resources.



The public expenditure on health in Bangladesh stands at 0.47 percent of gross domestic product (GDP), which is not only one of the lowest in the world, but also lower than the average of the lower middle income countries (LMICs 2.8 percent) or even that of the South Asian countries (2.1 percent). In addition to all these, there is disparity in the distribution of resources by geographical (i.e. by division) and residential (i.e. by rural-urban) locations. This gap in the public expenditures leads to thriving of the private sector healthcare business across the country. The healthcare facilities under the Directorate General of Health Services (DGHS) are 2,258 while 5,321 registered hospitals and clinics are there are in the private sector. The number of hospital beds under the DGHS is 54,660 and the figure for private hospitals is 91,537.

The Household Income and Expenditure Survey (2016) reveals that the rate of people receiving health services in urban areas remains 34 percent from pharmacy/dispensary/compounder, 18 percent from qualified doctor's chamber, 15 percent from non-qualified doctor's chamber, 10 percent from private clinic/hospital, 5 percent from upazila health complex, 4 percent from government district/sadar general hospital and 4 percent from government medical college and specialized hospital. Bangladesh remains a negative outlier in financially protecting its population (especially the poor). This is evident from the high rate of the out-of-pocket (OOP 72 percent) spending by the households on health, which is one of the highest in the world, even much higher than the average in countries with similar income (i.e. 39.6 percent for low-income countries (LICs) or 39.4 percent for LMICs). The alarmingly large share of the OOP puts financial strain on households as a result of unforeseen and unprotected expenses for treatment of illness (es). Not surprisingly, about 7 percent of the population was forced into impoverishment due to OOP expenditures in 2016.

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The limited capacities of public sector, both in terms of service delivery and regulation of the ever growing private sector, are aggravated by the poor coordination of the fragmented public health systems spread over several directorate generals under two divisions of the ministry. Pervasive corruptions, coupled with lack of governance, transparency and accountability have worsened the situation further.



The Covid era

Bangladesh, like many other countries, did not have any preparedness, to deal with Covid. Moreover, the government was initially in a denial mode and therefore many minister publicly undermined the Covid, confusing millions about the destructive effect of the virus. Then, when it started attacking people, situation deteriorated further due to almost non-existence of the standard infection prevention/control measures in the healthcare facilities. This led to panic among the unprepared health care providers, resulting in the drastic reduction in service delivery, particularly by the private sector. The public sector's attitude to control everything, on the other hand, led to limited testing in the beginning, which is the foundation of other measures (contact tracing and isolation) for Covid management.

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Limited testing resulted in the spread of diseases as non-detected asymptomatic cases unknowingly keep on infecting others. Initial successes of tracing and isolation in Tollarbagh (Dhaka) and Shibchar (Madaripur) could not be continued. Similarly, the initial success from isolation of China returnees could not be maintained for the returnees from other countries. These all contributed to the spreading of diseases and thus created demand for testing and treatment. In the face of the demands, the public sector kept on setting new laboratories while allowing the private sector to carry out tests. The limited capacity of regulating the private sector, coupled with corruption, led to the scandalous development like JKG and Regent for doing fake testing. The greed of making money out of a pandemic inspired the authorities of many private hospital to charge enormous amount for the Covid treatment while corrupt practices resulted in procuring almost ineffective personal protective equipment (PPE), masks, etc. Besides, there was inadequate distribution of the protective equipment among the service providers. Then, with no known treatment for Covid and inadequate support (not only standard and adequate PPE/mask but also oxygen supply, ventilation facilities, high flow nasal cannula etc.), the service providers struggled and suffered. More than 8,000 healthcare service providers, including around 3,000 doctors, have been reported to be infected while more than 100 doctors died in the battle against Covid.



Then, due to compromise about life for livelihoods, the lockdown was eased and everything (except education sector) was gradually opened. Meanwhile, inertia among most people to follow the health regulations keep on increasing the number of infection and death. Treatment facilities now remain unutilized.

Major challenges facing by the public health sector

The government's Health Care Financing Strategy 2012-2032 identified three challenges:

- i) inadequate health financing;
- ii) inequity in health financing and utilization; and
- iii) inefficient use of existing resources.

Together with these, management inefficiency, lack of governance, transparency and accountability and failure to regulate private sectors remain the major challenges of the public health management.

Ways to meet the challenges

1. Substantial increase in the government budget for health sector together with appropriate allocation and efficient utilization.
2. Strengthening the management capacities at different levels with the provision of reward and punishment.
3. Enhancing coordination among the different segments of the public health system together with the determinants of health.
4. Improving regulation for the private sector health management.

Ways forward for post-Covid era

The government authorities of the public health sector needs to regulate the growing private sector health management system properly so that adequate healthcare can be provided to the people. With enhanced finance and management efficiency, the public health sector needs to concentrate on providing care for the poor, the vulnerable and the marginalized sections of the people, on the one hand, and giving more emphasis on the public health interventions through promotion and prevention and coordination with the determinants for health, on the other.