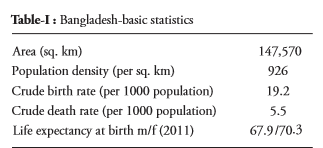
**Assignment-01**

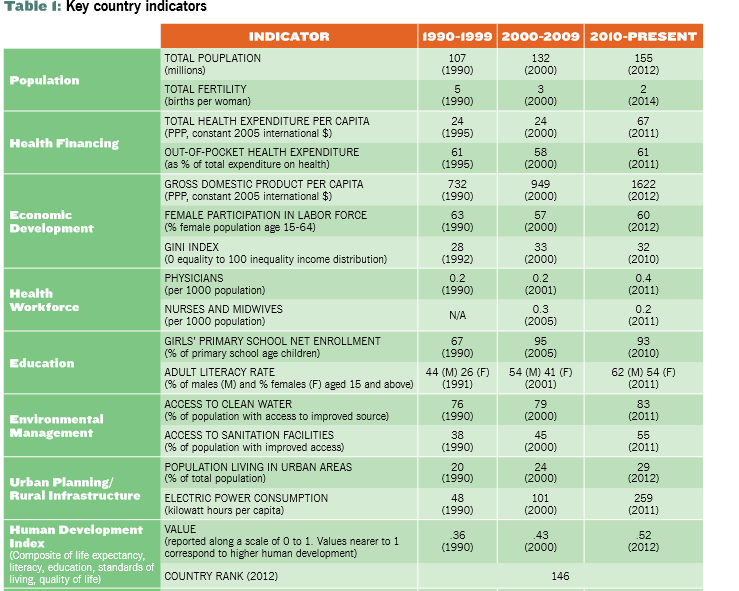
**Introduction**

The health system of Bangladesh relies heavily on the government or the public sector for financing and setting overall policies and service delivery mechanisms. Although the health system is faced with many intractable challenges, it seems to receive little priority in terms of national resource allocation. According to the World Health Organization (WHO 2010) only about 3% of the Gross Domestic Product (GDP) is spent on health services. However, government expenditure on health is only about 34% of the total health expenditure (THE), the rest (66%) being out-of-pocket (OOP) expenses. Inequity, therefore, is a serious problem affecting the health care system .Bangladesh has achieved its Millennium Development Goal (MDG) 4 (to reduce child mortality) and is on track to MDG 5a (to reduce maternal mortality).3 This multi-stakeholder review was undertaken to identify key enabling factors contributing to the improvements observed over the past 40 years. The health system is the societal response to the determinants of health. Every society believes in a set of determinants of health, not always following science or logic. The fundamental premise of a health system is the value of human life. The value that a society puts on human life largely determines the resources - human, material and financial - that it allocates for the health system. The effectiveness of a health system depends on the availability and accessibility of services in a form which the people are able to understand, accept and utilize. The Government of Bangladesh is constitutionally committed to “supply the basic medical requirements to all segments of the people in the society” and the “improvement of the nutritional and the public health status of the people” . In its early phase, the health system in Bangladesh was primarily focused on providing curative services targeting maternal, child and newborn health. Since the 1990s, with the development of modern science and technology and with the greater role of United Nations agencies and non-government organizations, the health systems gradually shifted its emphasis equally on health promotion and preventative services. The health services also expanded its reach. Yet a large number of the people of Bangladesh, particularly in rural areas, remain with little access to health care facilities . There have been significant gains in terms of polio & small pox eradication. Extensive vaccination, case isolation has resulted in diminishing number of diphtheria and tetanus. With improvement of overall hygiene and sanitation standard there is a discernible reduction in cholera, typhoid and dysenteries. A great no of tuberculosis satellite clinics now offer free treatment with contribution from NGO’s. HIV & AIDS are at a low level of prevalence but remains a threat because of international employment. Kala Azar and malaria has been significantly curbed down. . It is difficult to list and comment on all these challenges. This paper is concentrated on an analysis of a number of major challenges faced by the health system in Bangladesh.

**Current health management system situation**

An effectively performing health system is essential in im¬proving the population’s health status, providing safe¬guard against health-related financial threat and enhancing the health sector’s responsiveness to customer’s needs.4 Health sector reform is not only a health-related issue but also a development issue as health care systems account for 9% of global production and a sig-nificant portion of global empowerment .Bangladesh has a population of about 153 million, and is the eighth most populous country in the world . Satistics shows that it’s annual Population growth rate is 1.37%.2 Male: female ratio is 104.9/100.0. Most people are living in the rural area (74%). Crude birth rate is 19.2 per 1,000 population and crude death rate is 5.5 per 1,000 population with net reproduction rate (NRR) per woman (15-49 year) is 1.03. Life-expectancy at birth (year) is 69.0 for both sexes: 67.9 for male and 70.3 for female.3 (Table-I)





**Methods to Improve Bangladesh’s Health Systems**

1. Establish a level of service delivery affordable by the poor through government regulations on private clinics/hospitals.
2. Make private sector health service accountable to DGHS.
3. Decentralization of health professional’s recruitment process – from doctors to nurses.
4. Install and use MIS through central level for greater transparency and accountability.
5. A structured referral system, starting with a prescription from the Community Clinic/Community Health Worker, linked with a national level health database.
6. Invest to establish the referral linkage – from Community Clinics to urban level public, private specialized hospitals.
7. Access to quality healthcare through a digitized service delivery system.
8. Quality assurance of drug companies.
9. Create a National Health Service database with patients’ medical history to reduce the need for multiple diagnostic tests.
10. Increase doctor-patient counseling hours.
11. Ensure primary health care for the urban poor.
12. Subsidize primary healthcare.
13. Deal with malaria in Bandarban and other Hill Tract areas.
14. Provide universal health insurance coverage.
15. Incentives for public doctors working in hard-to-reach areas.
16. Health awareness campaigns through SMS.
17. Private clinics and hospitals to allocate a certain percentage of free beds for the poor. Private sector to allocate a certain percentage of their profits for serving the poor.
18. Clarifying the roles of public and private sector as per the middle-income country (MIC) vision.
19. Monitor compliance of the village and district level hospitals/clinics with DGHS’s regulations.
20. LGED and MoHFW to coordinate working on urban health care system.
21. More public health specialists, not doctors, for better administration and coordination.
22. Better primary healthcare - more and better doctors in rural areas, more front line health workers.
23. Retain service providers at the Upazila level through incentives for career development.
24. Ensure accountability of doctors at the Union level through available means (e.g. mobile phones, social media, UDCs, etc.).
25. Develop institutional health system arrangements for respective Hill District Councils.
26. Financial support for Community Clinics to reduce donor dependency.
27. Use of electronic records to supplement the national health/medical database.
28. Utilize existing informal sector of health service delivery particularly for hard-to-reach areas.
29. For containment of population

(i) focus on long acting permanent method (LAPM);

(ii) target newly-wed couples, particularly adolescents to delay the first birth.

1. Continue and expand counseling on population control and reproductive health and behavior in health care centers.
2. Make effective use of government trained Community Skilled Birth Attendants (CSBAs) and deployment of newly trained midwives in newly created posts at union and upazila.
3. Buildstrategic partnerships with NGOs and private sector for strengthening and expanding newborn care.
4. Expansion of medical waste management to cover all medical installations.
5. Tribal-friendly health services through appropriate initiatives.
6. Incorporate counseling, health rights and ethics in all medical, nursing and other education curricula along with proper sensitization initiatives for the existing health service providers.
7. Capacity building of health managers at district and sub-district levels on data analysis, health planning and monitoring. A population based database for community health management information system.
8. Strengthening Bangladesh Medical Research Council to steward and coordinate all health sector research.
9. Strengthen BSMMU’s research capacity to make best use of its resources.
10. Address maldistribution of health personnel across regions.
11. Steps for empowering women’s decision making over reproductive health through proper education and information.
12. A 'disability' budget for each ministry.
13. Increase public expenditure to US$ 54 per capita to cover a basic package of services, including interventions targeting NCDs.
14. Free healthcare for RMG workers.
15. A comprehensive mental health service delivery plan to address the growing psychological needs.
16. Expand TB diagnosis and treatment. Shorten multi-drug resistant TB treatment to 9 months from current 24 months (to be able to treat more MDR-TB patients).
17. Continue implementation of Health, Population and Nutrition Sector Development 5.

**Overview of methods**

The challenges faced by the health system are multifarious and varied. Bangladesh has severe shortage of physicians, nurses, midwives, and health technicians of various kinds. The deficit will keep on rising as the population increases. Inadequate number of appropriately trained human resources for health in Bangladesh is a strong limiting factor for population health [31]. In terms of health technicians of various kinds (from laboratory technicians to physiotherapists) the deficit is almost half a million. Midwives and community health workers are also in short supply. The gap between what the government has assessed (sanctioned) as requirement for providing healthcare services and the positions vacant clearly shows that Bangladesh has to make much greater efforts in ensuring accessibility to essential health care services. Moreover, the human health resources are heavily concentrated in urban centers, depriving rural areas of much needed human resources for health. According to Bangladesh Health Watch report (BNHA 2011) 62% of medical doctors in Bangladesh are working in the private sector. In addition, the health workforce is skewed towards doctors with a ratio of doctors to nurses of 1:0.4, and that of doctors to technologists of 1:0.24, in stark contrast to the WHO recommended ratio of 1:3.5. Statistics on private sector appointment of medical staff are not available. However, the physicians in public sector often provide services in private hospitals. Moreover, Bangladesh has only 0.4 hospital bed per 1,000 population compared to that of 0.9 bed per 1,000 population in Ghana (WHO, 2011). Likewise, although at a similar economic level as Bangladesh, Kenya has 35 percent higher number of hospital beds per 1,000 populations. Another problem plaguing the health system is the sorry state of infrastructural facilities. It should be noted that the government has a policy of establishing 1 Community Clinic for every 6,000 population covering rural Bangladesh. However, it is yet to be fully implemented. In most cases, community clinics consist of two rooms with drinking water and lavatory facilities, and a covered waiting room. Unfortunately it remote areas of Bangladesh community clinics usually do not have even such meagre infrastructural facilities. So far as human resources for health is concerned, it is not even clear if the sanctioned positions are sufficient to provide healthcare services to all citizens covering their needs. It is more important to look at the distribution of health care expenditure of Bangladesh. In Bangladesh, the major sources of healthcare funding include: households, government, NGOs and development partners. Insurance makes up a small share of the total source of health care financing in Bangladesh (BNHA 2003). The continued absence of social insurance and a minuscule private insurance market are compelling the house-holds, particularly the rural poor, to bear a large proportion of the national health expenditure through direct or out of pocket (OOP) payments. Household OOP expenditures constitute by far the largest component of the Total Health Expenditure (THE) - its share was around 69% in 2001 (BNHA 2003). The share of out-of-pocket expenditure in the total health expenditure increased from 57% in 1997 to 64% in 2007 .It should be noted here that while basic health care service is supposed to be free in public hospitals, patients end up bearing the costs of medicine and laboratory tests, as well as some additional unseen costs .Moreover, 5,122 registered diagnostic centres are currently operating in Bangladesh (along with many unregistered ones). Apart from these, there are a large number of private clinics and hospitals in different districts and cities that are not registered. Private for profit clinics/hospitals, geared toward maximizing profit, usually target middle- to high income segments of the society. According to Health Bulletin 2013 there are 2,983 registered private hospitals and clinics in the country with about 45,485 beds. Only a few among these have free beds for the poor. The health system information technology (IT) is primarily focused on family planning, safe motherhood, child health, and immunization. Unfortunately the health information system does not cover chronic non-communicable diseases.I think it should focus on non-communicable disease also.

**Conclusion**

In the light of the findings of this paper, it can be fairly argued that Bangladesh faces a lot of challenges in its health system. These challenges must be resolved in order to improve the existing health system, so that the disadvantaged and vulnerable people can get better access to basic health care services. Health is a fundamental human right, and regardless of their socio-economic status everybody has the right to enjoy optimal health status. The paper emphasizes once again the issue of equity in health systems, and the importance of a multisectoral comprehensive approache to improve the health system. The health system in Bangladesh desperately needs a dynamic leadership that is prepared to design and enforce evidence-based policies and programs. The steward of the health system must have a strategic vision and determination to improve and strengthen both the public and private health sectors of the country. Equity must be the overarching guiding principle underpinning the health systemProgram (HPNSDP) to strengthen and expand nutrition specific interventions among pregnant and lactating women, newborn babies, under-5 children and adolescent girls. In the back drop of such a changed scenario, there are newer health issues which needs to be urgently addressed. Non communicable diseases has shot up as a result of increased longevity, life style changes, industrialisation and work stress. Various types of cancer, coronary artery diseases, strokes, chronic renal diseases, chronic liver diseases, COPD has taken over mortality figures in contrast to infectious diseases in both urban and rural environments. These factors present both prevention and therapeutic challenges for a slowly adapting public health system . Bangladesh has achieved a lot in health sector but has a lot to be achieved also in future. A national human resources policy and action plan, a national health insurance system and an interoperable electronic health information system are among the necessities in future.

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