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Public Health Administration in Bangladesh: Looking for a Pro-people Policy

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Introduction

People of Bangladesh, mostly living in the rural areas are very hardworking with proven capacity to preserve mental strength in the event of unexpected extensive loss due to natural calamities (floods, cyclones, epidemic etc). But unfortunately their basic needs of livelihoods including health care have remained largely unmet. Population explosion, frequent natural disasters, incompetence of political leadership, weakness in public administration and governance are held primarily responsible which lead to shortage of resources for investing in social sector viz. literacy, *health*, sanitation etc. Improper distribution of scarce resources and serious defects in management are also claimed to exist)[1]. Bangladesh with 142 millions of population is one of the world's most densely populated countries which spend on US$ 7 per capita for health. Surprisingly enough against this pale background, Bangladesh has a good infrastructure for delivering primary health care, and sadly enough that the full potential of this infrastructure has never been utilized due to lack of properly implementable health service policy and management. The independence of Bangladesh 1971 acted as a breakthrough for the development of public health in this part of land. The declaration of Alma-ata[2], up-gradation of health infrastructure (in 1982) in connection with the general administrative reforms, adoption of Health and Population Sector Programme (HPSP) with the help of World Bank (WB) was expected to significantly reshape the public health situation of the country.

The health network included establishment of medical and dental colleges, upazila health complex, postgraduate institute for higher studies, establishing autonomous bodies like Bangladesh Medical and Dental Council (BMDC), Bangladesh Nursing Council (BNC),

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Bangladesh State Medical Faculty (BSMF) to regulate standard and quality of medical, nursing and paramedical education. National Institute of Preventive and Social Medicine (NIPSOM) was established to serve as the national focal point for higher education in public health[3].

Bangladesh expressed its commitment with the world community to render minimum health care service for its people and formulated national strategies and plan of action for attaining Health For All (HFA)[4] by fixing up a number of major health issues related to national health status, service delivery, coverage and quality of life. Accordingly, Primary Health Care (PHC) received highest priority in the next national five year plan emphasized on four major areas (viz. improvement of health status, development of health care delivery system, improvement of quality of life and extension of coverage and accessibility in formulation of national HFA by the year 2000). This change focused on the reorganization of the health infrastructure as part of the general administrative reform programme. It was also noticeable in the formulation of national drug policy. But even now the targeted goal has not been achieved. There were some important studies on the health sector and health services in Bangladesh. Khan Ahmed, Andaleeb, Mendoza and sabir, Azad and Haque, Prince and other highlighted some significant issues in their works which mainly explored the existing structural and functional aspects, major health programmes, performance of different sectors, and inability of covering the total population under health care service systems. Awareness raising and education were also emphasized here. But none of the researches provided importance on pro-people policy, administration and responsive redesign of health in the changing realities and differences among the beneficiaries because of their status, geographical location and access to right. In the context of Bangladesh, it is an endeavor of the present study to make preliminary effort at understanding health sector.

On this backdrop this paper aims at identifying the real condition of existing public health, public health administration and public health practices, and recommending necessary measures for a poor friendly/pro-people health policy administration as well as a strong and sound health service system for Bangladesh.

Conceptual Framework

Health is metabolic efficiency contrasting to sickness as a metabolic inefficiency. Nobody is totally healthy or totally sick. Each of us is a unique combination of health and sickness. And each of us has a unique combination of abilities and disabilities, both emotional and physical[5].

- Health can be defined negatively, as the absence of illness, functionally, as the ability to cope with everyday activities, or

positively, as fitness and well-being. In any organism, health is a form of homeostasis. This is a state of balance, with inputs and outputs of energy and matter in equilibrium (allowing for growth). Health also implies good prospects for continued survival. In sentient creatures such as humans, health is a broader concept.

- Health is viewed holistically as an interacting system with mental, emotional and physical components. If refuse to "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1994).

Public health is community health. It has been said that: "Health care is vital to all of us some of the time, but public health is vital to all of us all of the time."[6]

On the other hand Public Health Administration is a part of public administration[7] having a motto to deliver services on one of the basic need as well as a human right of the people. It is a self-explanatory concept by its name. All aspects of administration are dealt with here like human resources management i.e. personnel management including recruitment, selection, training and development, promotion, discipline, transfer, wage & salary administration for remuneration, local government i.e. involvement of local bodies and local people for ensuring their primary healthcare facilities at grassroots revel, (rural and urban), financial management for the very requirements of financial base to deliver the services smoothly through budgetary process.

Public Health administration includes[8] health services relating to combinations of both curative and preventive medicine in centre and periphery, environmental sanitation, personal health, community health, control of communicable diseases, vital statistics, professional education and training as well as social welfare and social security, labour welfare, nutrition, recreation, family planning and other health related activities (like mass vaccination and checking of food adulteration.

Like other public agencies, the public health administration also requires organization structure, personnel and their development, planning and management.[9]It equally need planning, organizing, staffing, directing, coordinating, reporting, budgeting, line and staff position of health personnel, scalar process, functional organizations, administration and management operational functions.[10]

Background of public health administration in Bangladesh

The history of public health in Bangladesh (as part of the sub-continent) dates back to the colonial rule of British Indian era, meant the protection and promotion of health of the military personnel and their civilians. The

administrative machinery was meant to govern as a police state and public health was a transferred sufject.[11] The real development in public health administration began in 1859 when the rule were taken over... by the British crown[12] Afterwards, significant progress has been made pertaining to decisions and acts as well as building of institutions. In the Pakistan movement, there was a complete breakdown of public health administration, but it was decentralized with maximum authority given to the provincial governments, the government of East Pakistan, through a five year plan, initiated actions for the improvement of the health administration. That was a scheme with a view to providing integrated and comprehensive health care to the rural population. But East Pakistan (then independent Bangladesh) did not receive equitable share of central allocation and support for the development of its health manpower and health services[13], and it was not well planned and did not keep pace with the increased need of a new welfare state. This gross disparity in the development of health services administration also like other spheres developed a sense of deprivation among the countrymen which resulted into the birth of Bangladesh as an independent sovereign state. Just after independence, a good number of initiatives have been taken in the field of public health with right earnest. It's against this background that the present organizational set-up of health services in Bangladesh emerged.

The health services system in Bangladesh comprises three components-public, private and NGO cum voluntary sector.[14] The organization structure of health services in Bangladesh follows the general administrative pattern of the country. The present structure and functioning of the health services is oriented toward delivery of primary health care (PHC) to vast rural population through a network of health facilities and operational field staff to serve the minimum needs to be sound of the people.[15] Aspects of public health administration can be categorized into three-fold points- organization structure, manpower and development, and health planning used development. The efforts of public health administration are directed towards raising the level of health by planning, organizing, staffing, directing, coordinating, budgeting and responding (all these principles of administration) [16]

Organization and Management of Public Sector health Services in Bangladesh

The organization structure of healthcare delivery system is based on a paternalistic (bureaucratic/top-down) model rather than populist (bottom up) one. Here is a top-down policy decisions regarding manpower planning and development, development of the system itself, extension of facilities and allocation of resources and finance. Basically, policy is

formulated at the central level and is carried out the decisions at various levels from national to grass-roots level.

Table 1: Levels of public healthcare administration[17]

Level(s)	Jurisdiction(s)		Organization(s)	Service provided
National	National/Capital (Central)		MoHFW, Health Directorate	Super- specialized care
Regional	Div/Dist	Coordinating	Divisional level	referred tertiary healthcare
	Dist		District	Secondary Healthcare
Local	Upazila Rural Thana		Upazila	Primary healthcare
Grassroots level	Union, Ward Villages		Union	

National level

At the top (national) level, the highest administrative (supervisory) authority lies in the Ministry of Health and Family Welfare (MoHFW) headed by the minister and assisted by a secretary, an administrative section, one joint secretary for health and family planning division. They are also assisted by deputy secretaries and assistant secretaries. The directorate general of health service (DGHS) operates under the ministry for health service only (in central level). The DGHS is assisted by one assistant director general (ADG), 8 directors and a number of deputy directors, assistant directors and other supporting staff.

The ministry is responsible for formulation of policy, decision-making, legislation and coordination with other ministries and bilateral and international health agencies and DG is entrusted with planning, implementation, monitoring and reviewing of programme and projects. At the national level, national specialized institutions provide a wide range of services well known as super specialized[18] healthcare like cancer, diabetes, cardiac surgery, orthopedic, neurosurgery etc.

National level policy and programme includes strengthening infrastructure; national drug policy; national policy for administration of medical student and new incumbents; Medical College Hospital (MCH) and family planning; Expanded Programme on Immunization (EPI); control of diarrhoeal diseases and disaster management; nutrition programme; micro-bacterial disease control, production and supply of drugs, vaccines, sera, fluids and reagents; supply of safe drinking water and sanitary latrines; Arsenic control and mitigation programme; Sexually Transmitted Diseases (STDs) and HIV/AIDS; health care quality assurance; health education; and multi-sectoral approach for socioeconomic development.[19]

Regional level

At the divisional level, divisional director is responsible for supervision, monitoring and coordination of health activities in all districts under the

division. S/he is assisted by the assistant directors- one for administration and the other for Centre for disease Control (CDC) and by other staff.[20] There are medical college hospitals in each division, providing specialized and laboratory facilities for the treatment of complicated diseases. It also takes up the cases referred to by the local and district level hospitals. There is limited administrative authority at this level.

The Civil Surgeon (CS), at the district level, as the team leader and health authority, is responsible for all health activities- institutional and domiciliary excepting medical colleges and hospitals attached. He is assisted by one deputy civil surgeon and on medical officer and other technical and general staff. These hospitals are serving as the referral for lower level health complexes (upazila) for further treatment with bed facilities varying from 50 to 250. Some districts have medical college hospitals. Here, services provided are of specialist, laboratory and diagnostic.

At the heart of the system Upazila Health Complex (UHC) plays a pivotal role in public health delivery system providing services diversified and complex in nature including preventive, curative (inpatient, out-patient, diagnostic) and promotive.[21] It acts like referral services to union health centre. In the same time, belongs to the hierarchical structure of the secondary and tertiary levels. It also extends services of management, training, technical support and coordination to the grassroots level health services agencies and persons. The upazila health and family planning officer plays role as the team leader having assistance from medical officers/specialists, dental surgeon, sanitary inspector (food & sanitation), health inspectors, nurses, laboratory technicians and other are supporting staff. This unit is entrusted with providing primary healthcare services. Simultaneously, it provides some specialized care like in medicine, surgery, dentistry and gynecology.

Union level,[22] as the lower level/grassroots and sustainable administrative unit provides services including healthcare to people. This is the smallest and most peripheral healthcare service unit having sub-centre which provides out-patient services for injuries, wounds and ailments and with no diagnostic, surgical or bed facilities. This unit is under the leadership of one medical officer as in-charge and is assisted by one medical assistant, one pharmacist, one family welfare assistant and one ULSS. The Union Service Centre (USC) is staffed by one medical officer, one pharmacist and one MLSS.

Ward is the lowest unit of public health administration system where health workers provide doorstep services to the people. This includes domiciliary services and field visits.

At the village level, there are community clinics; satellite clinics as most peripheral level health services facilities with a view to provide

minimum care. From time to time, this services are delivered (say once a month). The patients are motivated to go and take services there like EPI, Oral Re-hydration Therapy (ORT) services, awareness raising about health, sanitation nutrition communicable diseases etc. The staffing patter of the clinic is one health assistant, one family welfare visitor, Asst health inspector.[23]

Health Services in Private and NGO Sectors

Private sectors are increasingly taking part in health sector of the country which is easily visible in clinics and diagnostic centre grown each and everywhere. It is not much to talk that private sectors are playing leading role in health care although for the poor patients, government hospitals are still the major providers. A fairly large number of NGO are playing potential role namely BRAC, Gono Sasthya Kendro, VHSS, Family Planning association of Bangladesh. In addition to that the international donor agencies, viz. WHO, UNICEF, UNDP, UNFPA, ADB and WB, some other organizations take part in bi-lateral programmes, viz. USAID, SIDA, DANIDA, JAICA, NORAD etc, other international organizations also deserve mention, viz. save the Children's Fund (UK, US, Australia), Terre Des Hommes, CARE, Pathfinder, HEED, OXFAM etc.[24]

Table 2: Health care service facilities at a glance[25]

Organization & No. of Beds			**Service Providers**	
	Public	**Private**	Registered doctors (MBBS, BDS)	32498
Dispensary	1362	-	Dentists	1567
Hospital	670	712	Registered nurse	18135
Beds	33368	12239	Registered midwife	15794
-	-	-	Registered female health inspector	102726

The available health care service facilities are not adequate enough compare to the size of population of Bangladesh.

In 1998-1999, The Centre for Policy Dialogue (CPD) conducted a study on the patients going abroad and found about 85% of them claimed that the physicians did not concentrate on them as much as they need.[26]

Personnel administration in practices of public health

The public health personnel administration includes various functions of personnel in the health sector of the country such as the recruitment and selection procedure of health officials, their training, advancement through promotion, their motivation through wage, salary and incentives, control through disciplinary actions like demotions, transfer, punishment etc., in management activities of the personnel engaged in public health sector. The main focus of our discussion, we would like to, confines in the recruitment and selection procedure of the public health personnel.

The manpower planning and development policy basically follows the policy of central government regarding personnel management in health

cadre and likewise the decisions are carried out at various levels from national to peripheral ones.

At first, we see the system of recruitment of BCS (Health) and BCS (Family Planning) carde officials who have to serve as the Class-I Public health cadre and gazette officials as well, in the very initial stage, health ministry by analyzing its wings, demand for appointments of doctors to the ministry of establishment (MoE) and then as its advisory body, requests the Bangladesh Public Service Commission (BPSC) to select qualified candidates through a competitive examination and recommend for final selection.[27]

In the newly introduced system, there is a slide change in the examination process by BPSC. Every candidate has to go under a process of a preliminary examination through multiple choice questions (MCQ) of 100 marks; qualified ones have to sit for 900 marks written and 100 marks viva voce. Here lies the difference with general carde service that professional cadre like health has to take 200 marks (2 papers) written examination on related discipline.[28]

For an instance, we are presenting two tables explaining the manpower of health (doctors & nurses) of DMCH here:

Table: Personnel of doctors[29]

No	Designation	Number of Doctors		Total
		Female	Male	
1	Professor	10	29	39
2	Associate Professor	08	27	35
3	Reg. doctor	06	29	35
4	Asst. register	10	52	62
5	Honourary medical officer	80	100	180
6	medical officer	35	53	88
7	Internee doctor	50	105	155
	Total	**100**	**395**	**594**

Table: Personnel of nurses[30]

No	Designation	Number of nurses		Total
		Female	Male	
1	Staff nurse	581	72	653
2	Male student nurse	-----	65	65
3	Female student nurse	608	-----	608
	Total			

Recommendations and Concluding Remarks

Article 18 (1) of the constitution of the People's Republic of Bangladesh recognized public health as a fundamental right and as primary duty of the state to ensure it[31]. It also provided to raise the level of nutrition and improving public health and in doing so to adopt effective measures. Since independence the government has undertaken a fairly number of programmes for efficient delivery of health care services as a right. A

chunk of the mass people remained out of proper health care facilities. Health for all, (a commitment with world community) could not be achieved so far. This reality rationalizes the needs to examine the aspect for adopting suitable policies and plans for health care development of the citizens.

The early efforts of health administration were directed to alleviate the sufferings of the people due to sickness mostly catering to the needs of urban elite class which was subsequently extended to small towns.[32] But most of the people of the whole country are living in rural areas. This aspect should be addressed in the health policy of nation for their overall development.

The government health care services are growing dissatisfaction among the people because of unnecessary growing of cost without improvement of quality or expansion of facilities in consistent with ever growing need of the population. On the other hand, private clinics and hospitals are rather more commercial than humanitarian. They provide services only for well offs of the society with a high cost which is often unaffordable for the poor mass.[33] So, the sense of social justice has now been related to the health care services, as it is a basic right of the countrymen which should be reflected in public health administration and policy.

The whole country is constituted with a variety of people from different geographical location such as people living in hilly areas, in the remote islands like Swandip, Hatia and other places out of sound transportation and communication network. They deserve to have policies of proper health care facilities which they suit. Our study emphasizes the significance of necessary policy changes of this aspect by removing the limitations of the existing policy measures identical for all of the citizens by the authority.

The systematic infrastructure of the public health care services network of the country could neither earn full satisfaction of the common masses nor could completely handle the problems in this regard. There are several opinions from various quarters. The providers usually claim limited allocation of resources to be responsible while policy makers and recipients of services claim lack of transparency, accountability, morality and mismanagement.[34] Others claim extremely centralized bureaucracy and/or incompetent political leadership as hindrances in the way of eradication of such problems. This study likes to suggest the elimination of the causes behind the poor and ineffective mode of delivery system of public health care services. The government and relevant authorities should keep this matter in consideration while formation of policy.

The government provides health care services comprehensively and can operate it from a macro level which is interrupted due to inadequate infrastructure, equipments/inputs, lack of funds, suitable service delivery mechanisms, and trained staff. But in case of private sector and NGOs it is a micro level, sectoral programme working on specific issues. For an overall success in both levels, the government should encourage NGOs and private sectors to promote their supplementary and complementary roles in the implementation of the national programme and to innovate cost-effective and nationally replicable models.[35] Some suggest for fully privatization of the health sector for improving overall management ensuring better health care for the people. This is another outcome of our study to find out the proper relationship of public, private NGO sector in attaining more benefit for national development as a whole and can help in avoiding duplication in health care service programms.

As healthcare warrants consideration of humanitarian approach, private sector should be properly guided to play that social responsibility. The regulatory practices of government over private and NGO sectors in providing health care services should be checked with proper care and concern.

Policy advocates suggest that government should adopt[36] decentralization of administration, mobilization of more local resources, more accountability, practice of ethics & morality in providing services, incorporating beneficiaries in the decision-making process, and training of the personnel relating to the particular sector. The possibility and prospects of practices of these phenomena in the health care service sector in Bangladesh should be reaped efficiently by the authority. The government should be more conscious about these phenomena in the health care service sector of the country for citizen's betterment and thereby satisfaction.

In the prevailing condition health sector where arsenic, adulteration of food, bird flu, HIV/AIDS are coming with its alarming form and making the situation risky and vulnerable, there is rationale to be careful for making public health administration people oriented, time-responsive and meaningful. The total system of public health sector requires redressing to response to the changing situation.

Considering the above mentioned points, We conclude also by making strong recommendation for conducting such kind of in-depth study an empirical one on public health and administration with a view to have a pro-people/poor-friendly public health policy and responsive and sensible administration for Bangladesh which will reflect community leadership, shared decision-making, linkages with other organizations, positive organizational climate for peoples satisfaction and participation. The government along with private sector and NGOs should concentrate their attention in this regard

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