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Overcoming Poor Governance: A Study on Public Health System in Bangladesh

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Abstract

This analytical study conducted in 2009 highlights governance failures and problems in the public health sector that hinder the efficiency and effectiveness of service delivery. It is also intended in gaining a better understanding of how to overcome poor governance and service management in this sector. From the findings, it has been found that the present condition of governance in the field of public health in Bangladesh is not satisfactory. Many problems act as barriers to good health governance. The findings of the present study will assist the policy makers to initiate and to implement policy decisions and strategies that will ensure good health governance in the country.

Introduction

Health service is one of the fundamental rights of the people (Declaration of Alma-Ata 1978) and is one of the basic requirements for improvement in the quality of life (Ruhul *et al.* 1999). Public health refers to the broader and comprehensive view of health, as it means the promotion and protection of the health of the general public. Public health services are those that are provided to the general public by the government to help them live a healthy life (Osman 2009). For the poor, the availability and quality of public health services is of great importance. Where public services are inadequate, the poor will resort to private services but with a considerable negative impact on the family's disposable income. When

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government resources for health are constrained, good management of health services is particularly important to sustain health care access for the poor, at least to a minimum package of primary care and referral services (World Bank 2007). In public health care, good governance implies that health care systems function effectively and with some level of efficiency (Lewis 2009). Good governance in health systems promotes effective delivery of health services and raises the level of health outputs (e.g. number of treated patients) and can contribute to improved outcomes (e.g. health status) (Lewis and Pettersson 2009).

Bangladesh has a health system which is dominated by the public sector. 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 (GOB 2002). However, the state is not able to deliver door to door health service as yet (Islam and Ullah 2009). 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 (Uddin and Ahmed 2008). Finally, in August 2000 the national health policy has been declared by the Government of Bangladesh with aim of ensuring better health services to all the people in the country. But policy achievement in the health sector is very poor (Ara 2008). Due to poor governance, the quality of health care remains very poor and people are not getting the minimal health services from the public health system (Ferdous 2007; Hossain 2004), although the Bangladesh Government and its development partners have also acknowledged their concerns about the quality of health care services (Andaleeb *et al.* 2007). In this background, the objectives of this study are: (i) to identify the existing problems and governance failures have caused to severe demand-supply shortfall, (ii) to identify the factors responsible for poor governance in this sector, and (iii) to put a pragmatic model towards improving the governance of the sector.

Materials and Methods

This analytical study is prepared based on secondary data. Various research articles, working papers, reports, websites, and related books are used in order to gather data. Both qualitative and quantitative approaches are used for preparing this research paper. Some sections are supplemented by personal experience and views.

Results and Discussion

Current status of public health system

The largest part of country's health infrastructure and health service system has been established by Government's management and control (Haque 2009). The Government of Bangladesh, since independence, has been investing substantially in the institution building and strengthening of health and family services in the country. Bangladesh accepted the goal and reiterated firm political and social commitment to achieve 'Health for All' by the year 2000 based on the Primary Health Care Strategy declared in Alma-Ata in 1978 (GOB 1998). The organizational structure of the public health care system in Bangladesh is highly centralized. At the central level, the Ministry of Health and Family Welfare (MOHFW) is the highest government authority headed by a Cabinet Minister, responsible for to implement, manage, coordinate and regulate national health and family planning related all activities, programs and policies. The Secretary is the administrative head of the ministry who is assisted by huge number of cadre and non-cadre civil servants (Ara 2008). There are two implementation wings under the MOHFW: (i) Directorate General of Health Services (DGHS) and (ii) Directorate General of Family planning (DGFP). The DGHS and DGFP are responsible for implementing all health programs and family planning programs respectively (Haque 2009). The Government has given efforts to develop a network of health care systems from grassroots level to national level to cater to the masses. There are mainly three levels of public health facilities which are: primary health care facilities located up to upazila level; secondary health care facilities at district level; tertiary health care facilities including Medical College Hospitals (MCH); and super specialized care (specialized institutions) (GOB 2009). Health services delivery and care facilities providing by public health sector at various levels in Bangladesh are presented in Table 1.

Table 1: Public health system in Bangladesh

1. Infrastructure of public health			
Level(s)	Organization(s)		Service provided
	Name	Number	
National level	Medical College Hospitals	15	Tertiary healthcare/ Super-specialized care
	Specialized Hospitals	21	
District level	District Hospitals	61	Secondary healthcare

Up to Upazila level	Upazila Health Complexes	431	Primary healthcare
	Union Health and Family Welfare Centers	3,622	
	Community Clinics	11,883	
2. Human resources in public health			
Post(s)		Number	
Physicians		14,644	
Nurses		14,971	
Medical Assistants		More than 1,900	
Health Technologists		Around 5,000	

Source: GOB 2009.

From the Table 1 it is clear that primary health care in Bangladesh is provided through three main types of institutions. The Upazila Health Complex (UHC) is designed to bring the primary health care service to the doorstep of the rural people; secondly, the Union Health and Family Welfare Centers (UNFWC) provide family planning outpatient service at the union level; and thirdly, Community Clinics (CC) serve as referral points for primary health care (Biswas *et al*. 2006). There are 431 Upazila Health Complexes (UHC), 3,622 Union Health and Family Welfare Centers (UHFWC), and 11,000 Community Clinics (CC) for primary health care in the country. On the other hand 61 District Hospitals (DH) are mainly responsible for secondary health care while 15 Medical College Hospitals (MCH), and 21 Specialized Hospitals provide tertiary services. The big public hospitals in the cities, and particularly in the capital Dhaka, are the apex of the public health system and serve as teaching hospitals where the next generations of doctors are trained. It is very clear that there is an acute shortage of doctors, nurses, medical assistants, and health technologists in the public health sector in Bangladesh.

Governance failures and problems in the public health sector

This is despite the fact that in terms of health infrastructure, Bangladesh is better placed than many other countries. Thus, such a dismal health scenario is due mainly to the inefficient governance of the sector implying inappropriate policies, rules, regulations, legislation and their state of enforcement; non-responsive managements, weak accountability and lack of transparency in the sector (Barkat 1998). In health care systems, poor governance accounts for much of the inefficiency in service provision, and in some cases results in no service at all. Lack of

standards, information, incentives, and accountability can not only lead to poor provider performance but also to corruption, 'the use of public office for private gain' (Lewis and Pettersson 2009). The quality of medical care of the major providers, namely government hospitals at the district and metropolitan cities, upazila and union level government health care complexes/centers and other specialized government hospitals is very poor (Chowdhury 2007). These are not able to provide standard services. Irregularity of attendance by the doctors, nurses and hospital attendants, the cursory treatment by traditional doctors & under qualified practitioners are the common scenario in public health system (Ferdous 2007).

Table 2: Existing service available in UHCs

Opinion	**Response (in %)**	
	Yes	**No**
Receives proper treatment	38	58
Receives required medicine	12	88
Have allegation about Medicare service	43	57
Services are disposed within stipulated time	63	37
Harasser by middlemen	60	40
Received necessary medicine as well as treatment	30	70
Service are delayed	50	50
Deprived on account of complex procedures	40	60

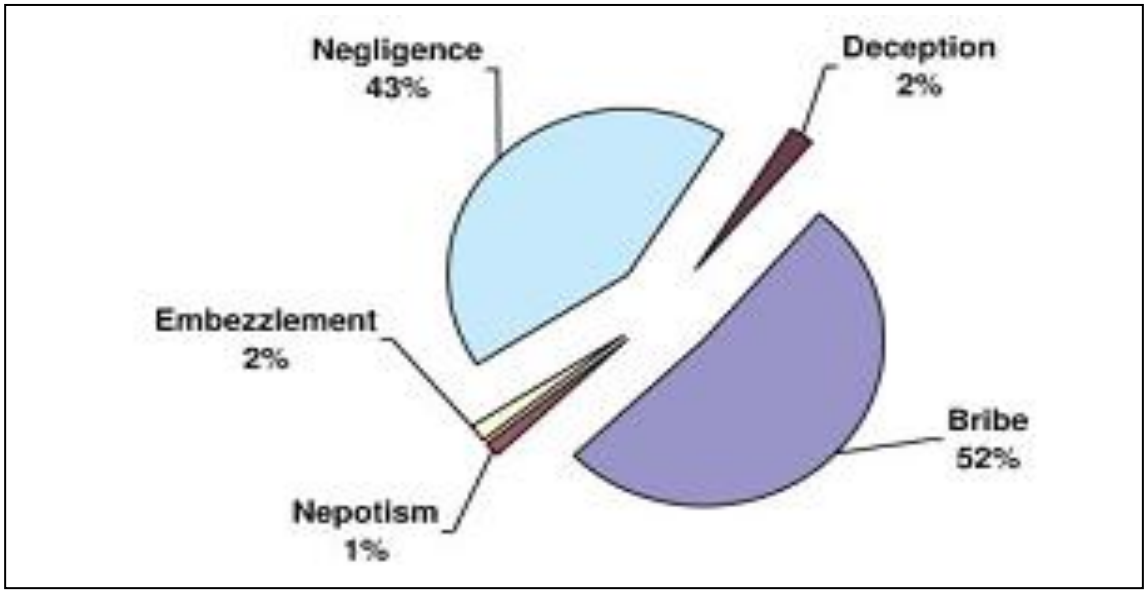
Source: Alam and Karim 2005.

Table 2 shows the service available in Upazila Health Complex. 58% respondents opined that they did not receive proper treatment while 42% opined that they received proper treatment. On the other hand 88% respondents expressed their dissatisfaction on the fact that did not receive required medicine, which indicates that supply of necessary medicine in Upazila Health Complex is not sufficient. Although 57% respondents have no allegation against Medicare services but 60% respondents have allegation about harassment by middlemen. It is observed that only 40% respondents were deprived of the service due to complex procedures.

Corruption in the health sector is a critical problem in developing and transitional economies where government resources are already scarce (Vian 2002). A household survey on corruption in Bangladesh found that the health sector was the second most corrupt sector after the police. The

survey found that 80 percent of all patients who sought inpatient treatment in public hospitals were admitted by illegitimate methods; 56 percent paid money; 22 percent used personal influence; and 18 percent sought help from hospital staff (Transparency International 2002). Another survey was conducted in June to July 2007 to investigate direct experiences of health service users across 52 districts (out of 64) within the six divisions of Bangladesh. The survey data showed that 41.8 percent of service users had encountered corruption in health under various guises: bribery, negligence of duties, nepotism, embezzlement or deception where bribery and negligence are the highest forms of corruption experienced by health service users. These will take the form of: doctors charging for writing prescriptions; referring patients to their private clinics and having to pay extra fees for pathological tests in government health facilities (Knox 2009).

Figure 1: Forms of corruption in public health



Source: Knox 2009.

Absenteeism of health care providers is one of the major challenges of good health governance in Bangladesh. The study conducted by the World Bank (2007) found absenteeism to be a common feature in the Upazila health complexes. Overall, the absenteeism rate is approximately 16 percent of the workforce. Absenteeism was more common among senior staff than junior staff and was particularly high amongst doctor. Absenteeism rates were observed to be especially high among the senior level Upazila managers. In contrast, third and fourth class employees generally had lower rates of absenteeism than the higher level employees.

Table 3: Absenteeism in public health

1. Percentage of attendance status by employee designation			
Designation	Number of Employees Observed		
	Expected as per Record/List	Found Present	Percentage of Absenteeism
Upazila Health and Family Planning Officer	15	14	7
Resident Medical Officer	13	10	23
Upazila Family Planning Officer	13	7	46
Medical Officer Maternal and Child Health	15	10	33
Medical Officer	43	32	26
3rd and 4th class employee	297	259	13
2. Causes of absenteeism in public health			
Causes	Percent		
Irresponsibility and negligence of duty	16		
Not working in a preferred work place	13		
Being out of town / outside the duty station	19		
Personal business	29		
Administrative weakness	26		
Private practice	29		
Total	100		

Source: World Bank 2007 (Estimated based on Health Sector Risk Area Validation Survey 2004).

The qualified doctors are more inclined to moonlight in private clinics where government employed doctors maintain a dual obligation with their responsibilities (Barkat 1998). Doctors are often criticized for neglecting their duties through absenteeism and private practice during office hours. The doctors during their duty period give prescription in their own pad and receive money in lieu of it. The private practice during duty period is highly objectionable and tantamount to bribery (Alam and Karim 2005). Hence, patients get less care in the government hospitals. Generally, the most vulnerable groups use the government hospital facilities. As a result of private practice of government doctors, this group is deprived of proper care from the government hospitals (GOB 1998). The data on absenteeism by doctors is summarized in Table 4.

Table 4: Private practice by doctors during office hours-direct observations

Direct observations	%
Doctors present in the hospital complex during office tour	20
Doctors attentive to their patients	47
Patients reported that doctor received money (additional fees) from them	60
Doctors involved in private practice at hospital complex	60
Doctors leaving hospital during office hours	53
Doctors that leave hospital as per hospital rules	33
Doctors encouraging patients to visit their private offices	67
Doctor that have private practice outside the hospital complex	53
Sample: 15 Upazilas.	

Source: World Bank 2007 (Estimated based on Health Sector Risk Area Validation Survey 2004).

A common tendency is observed in terms of utilization – a stark imbalance in service utilization at public health facilities. There is low utilization of most facilities at the primary level (Upazila and below) and over utilization of facilities at the secondary and tertiary levels *(http://www.whoban.org/health_system_bangladesh.html)*. A huge quantity of supplied medicine and equipment is left unutilized and unconsumed. The fourth class employees of the hospitals are selling drugs of hospital stores to outside pharmacies. Moreover, physicians are getting bribe from the private medicine suppliers (Ara 2008).

Perhaps the most critical challenge faced by the health system in Bangladesh is in the arena of human resources for health (HRH). The health system in Bangladesh not only suffers from a critical shortage of appropriately trained HRH, but also from a serious mal-distribution of health workforce (Joarder 2009). Bangladesh currently has a shortfall of 60,000 physicians and 280,000 nursing staffs (BHW 2007). The manpower distribution is also more urban oriented. Generally, physicians prefer to locate their practice in the urban areas where they get better income opportunities, better living facilities and other socio-cultural services. A good number of posts are lying vacant at Upazila and below levels. The government is not able to provide even a graduate doctor in all the union level health facilities but there is an over concentration of health personnel in the urban area (Rahman 2006). Almost 84 percent of the country's trained modern health workforce is concentrated in urban areas. With more than 65 percent of the country's population, rural areas

have only about 16 percent of the HRH. With only about thirty-five percent of the country's population, urban Bangladesh has 84 percent of its physicians and more than 75 percent of its nurses (BHW 2007). There are also high regional disparities in the distribution of physicians, nurses and dentists in the country. The highest number of physicians is concentrated in Dhaka division (10.8 per 10,000 population) followed by Chittagong division (4.8 per 10,000 population). The availability of qualified health care provision is lowest in Barisal, followed by Sylhet and Rajshahi (Table 5).

Table 5: Distribution of manpower per 10,000 population by area and division

	Physician	**Nurse**	**Dentist**	**All**	**Nurse per Physician ratio**
Rural	1.10	0.80	0.08	2.10	0.70
Urban	18.20	5.80	0.80	24.90	0.30
Barisal	1.70	0.90	0.30	3.08	0.50
Chittagong	4.80	3.60	0.30	8.80	0.70
Dhaka	10.80	2.80	0.50	14.20	0.20
Khulna	1.30	1.90	0.05	3.30	1.40
Rajshahi	2.10	1.10	0.00	3.20	0.50
Sylhet	2.20	0.40	0.00	3.20	0.10
National	5.40	2.10	0.30	7.70	0.40

Source: BHW 2007.

Without funding public health care services grind to a halt. The flow of public funds and the ability to manage funds at the provider level thus become the first level of concern for performance of the health care system (Lewis and Pettersson 2009). However, the Government allocates only 5 percent of the budget to the health sector, while it allocates 13 percent for defence. The Government's allocation and technical support (medical equipments) are not sufficient in the rural health complex (Islam and Ullah 2009). Moreover, the financial management of public health completely depends on MOHFW and DGHS as the budget procurement, supply, and maintenance of resources are controlled centrally (Shahjahan and Murshed 2008). The allocated funds for health sector also are not utilized and managed properly. In many places, bureaucratic problems, corruption and mismanagement lead to inadequate public funds at the point of service and the informal charging of patients. The allocated funds are disbursed very slowly and often at a reduced level. The slow

disbursement of funds causes delayed completion and ineffective utilization of funds (Ara 2008). As a result, public health care services of the country could neither earn full satisfaction of the common people nor could completely handle the problems in this regard (Uddin and Ahmed 2008).

Decentralized governance and local level participation can contribute to improving the health care system, through better monitoring and supervision of the functioning of the health system at the local level (Ahmad 2003). Unfortunately, the Human Resources Management (HRM) of public health is controlled by a bureaucratic process through rigid rules and regulations that hinders the efficiency and effectiveness of employees. The recruitment, training, reward, and punishment for employees are controlled centrally. Thus the people working in public health lack motivation to deal with large volume of patients. This in turn affects the quality of care in public health (Shahjahan and Murshed 2008). The people's participation is also far from being satisfactory (Islam and Ullah 2009). The centralized structure of the public health system tends to trap voice at the local level, which discourages citizen participation and leaves senior managers disconnected from public attitudes, choices and experiences of health care (Thomas *et al*. 2003).

Transition from 'poor governance' to 'good governance': Looking for a pragmatic model

Improving governance poses an important challenge to governments in transition and developing countries, but there are good examples of things that can be done based on actual experiences (Lewis 2006). This is not to say that Bangladesh's health delivery system has failed (Haider 2007). Being a developing country Bangladesh has been experiencing a slow and steady improvement in her health status (Akhter and Wohab 2006). Based on the findings, the study puts forward a pragmatic model (See *Figure 2* in Annex) designed by Barkat (1998) in order to transform the governance of public health from a 'poor' (vicious cycle) to a 'good' (virtuous cycle) system. In this model, major causes of governance failures and problems are summarized in the first cycle and those can largely be overcome with the adoption of second cycle.

Conclusion

Good governance remains at bay in Bangladesh. Poor governance, even mal-governance, is often surfacing with heavy tolls on people's expectations (Rouf 2007). Many studies and reports have captured the

problems that poor people face in accessing affordable, appropriate and quality health care due to poor governance in the country (Thomas *et al.* 2003). An efficient management system should establish based on function, responsibility and accountability at the individual and organization levels so that the providers are motivated to serve the needs of the clients. The government has to take initiative for ensuring the essentials of good governance in health sector without any delay.

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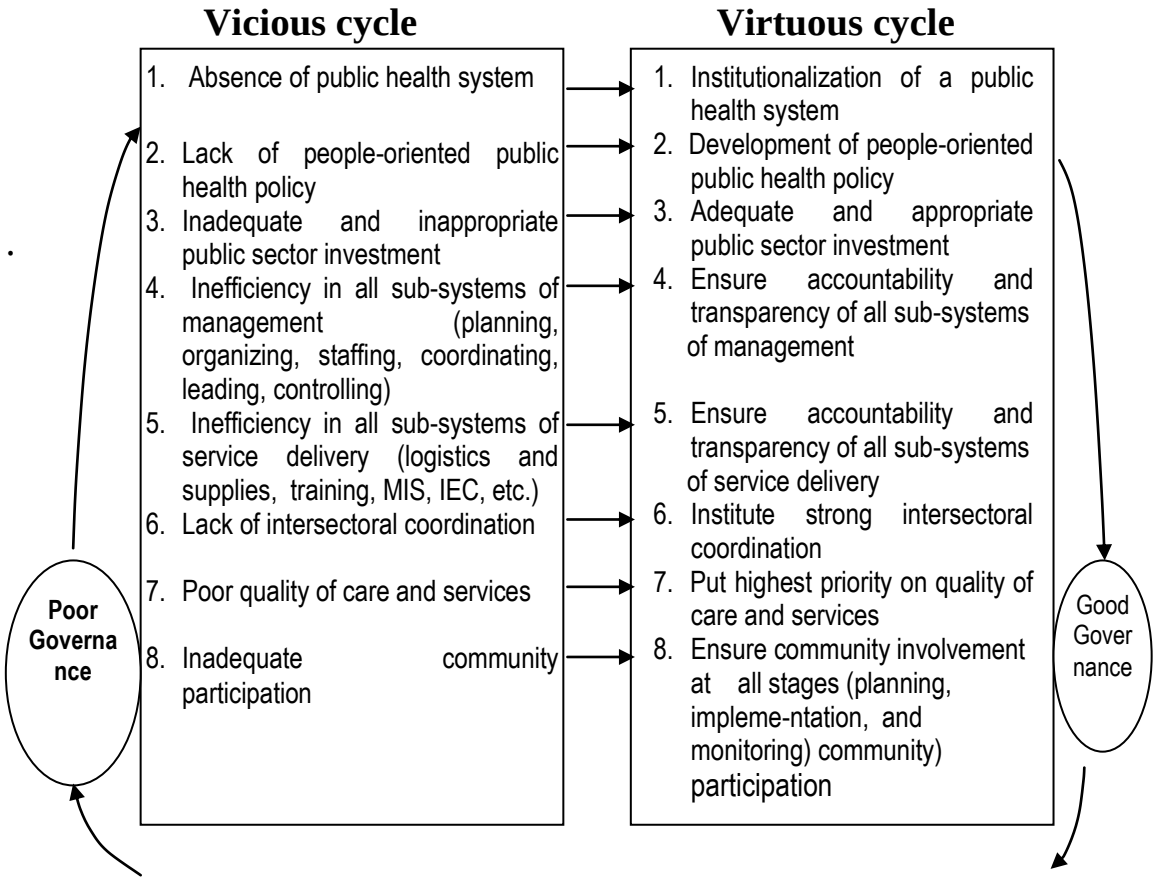
Annex

Figure 2: Transition from 'poor governance' to 'good governance' in public health system in Bangladesh



Source: Barkat 1998.