Private Sector Assessment

for

Health, Nutrition and Population (HNP) in Bangladesh
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**ACRONYMS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAA</td>
<td>Analytical and Advisory Assistance</td>
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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ALRI/ARI</td>
<td>Acute (Lower) Respiratory Infection</td>
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<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>APP</td>
<td>Alternative Private Practitioner</td>
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<tr>
<td>BBS</td>
<td>Bangladesh Bureau of Statistics</td>
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<td>BCC</td>
<td>Behavior Change Communication</td>
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<td>BCG</td>
<td>Tuberculosis vaccine</td>
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<td>BINP</td>
<td>Bangladesh Integrated Nutrition Project</td>
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<td>BMA</td>
<td>Bangladesh Medical Association</td>
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<td>BMDC</td>
<td>Bangladesh Medical and Dental Council</td>
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<td>BMMS</td>
<td>Bangladesh Maternal Health Services and Mortality Survey</td>
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<tr>
<td>BNC</td>
<td>Bangladesh Nursing Council</td>
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<td>BPCDOA</td>
<td>Bangladesh Private Clinic and Diagnostic Owners’ Association</td>
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<tr>
<td>BPHC</td>
<td>Bangladesh Population and Health Consortium</td>
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<td>BPMPA</td>
<td>Bangladesh Private Medical Practitioners’ Association</td>
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<tr>
<td>BRAC</td>
<td>BRAC (formerly, Bangladesh Rural Advancement Committee)</td>
</tr>
<tr>
<td>CAH</td>
<td>Division of Child and Adolescent Health and Development</td>
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<tr>
<td>CAR</td>
<td>Contraceptive Acceptance Rate</td>
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<td>CBR</td>
<td>Crude Birth Rate</td>
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<td>CC</td>
<td>Community Clinic</td>
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<td>CDR</td>
<td>Crude Death Rate</td>
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<td>CES</td>
<td>Coverage Evaluation Survey</td>
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<td>CHC</td>
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<td>Canadian International Development Agency</td>
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<td>CIET</td>
<td>Community Information &amp; Epidemiological Technologies</td>
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<td>CPR</td>
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<td>DFID</td>
<td>Department for International Development (UK)</td>
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<td>Director-General (Health Services)</td>
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<td>Demographic and Health Survey</td>
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<td>DP</td>
<td>Development Partner</td>
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<td>DPT</td>
<td>Diphteria/Pertussis/Tetanus</td>
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<td>EC</td>
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<td>EIS</td>
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<td>ESP</td>
<td>Essential Services Package</td>
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<td>FP</td>
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<td>FY</td>
<td>Fiscal Year</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccination and Immunization</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<td>GOB</td>
<td>Government of Bangladesh</td>
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<td>HA</td>
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<td>Human Immunodeficiency Virus</td>
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<td>Health, Nutrition, Population</td>
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<td>Health and Population Sector Program</td>
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<td>HRD</td>
<td>Human Resource Development</td>
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<td>Human Resources Development Unit</td>
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<td>IDD</td>
<td>Iodine Deficiency Disorder</td>
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<td>IHE</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>i-PRSP</td>
<td>Interim Poverty Reduction Strategy Paper</td>
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<td>IST</td>
<td>In-Service Training</td>
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<td>IUD</td>
<td>Intra Uterine Device</td>
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<td>Live Births</td>
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<td>Line Director</td>
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<td>LE</td>
<td>Life Expectancy</td>
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<td>MB,BS</td>
<td>Bachelor of Medicine and Bachelor of Surgery</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MCWC</td>
<td>Maternal and Child Welfare Center</td>
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<td>MDG</td>
<td>Millennium Development Goal(s)</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio (No. of maternal deaths/1,000 live births)</td>
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<tr>
<td>MMRRate</td>
<td>Maternal Mortality Rate (No. of maternal deaths/1,000 women 15-49 years)</td>
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<td>MO</td>
<td>Medical Officer</td>
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<td>MOHFW</td>
<td>Ministry of Health &amp; Family Welfare</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>NAN</td>
<td>National Plan of Action for Nutrition</td>
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<td>NCB</td>
<td>National Commercial Banks</td>
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<td>NCES</td>
<td>National Coverage Evaluation Survey</td>
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<td>NGO</td>
<td>Non Governmental Organization</td>
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<td>NID</td>
<td>National Immunization Day (for polio vaccination)</td>
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<td>NNP</td>
<td>National Nutrition Program</td>
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<td>NTB</td>
<td>National TB Program</td>
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<tr>
<td>ORS</td>
<td>Oral Rehydration Solution</td>
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<td>ORT</td>
<td>Oral Rehydration Therapy</td>
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<td>PFC</td>
<td>Project/Program Finance Cell</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PIP</td>
<td>Program Implementation Plan</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>PM</td>
<td>Program Manager</td>
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<tr>
<td>PNC</td>
<td>Postnatal Care</td>
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<td>PPP</td>
<td>Public-Private Partnership</td>
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<td>PSA</td>
<td>Private Sector Assessment</td>
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<tr>
<td>PSB</td>
<td>Pharmaceutical Society of Bangladesh</td>
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<td>QA</td>
<td>Quality Assurance</td>
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<td>RHC</td>
<td>Reproductive Health Care</td>
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<td>RHF</td>
<td>Recommended Home Fluids</td>
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<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<td>SD</td>
<td>Standard Deviation</td>
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<td>SDB</td>
<td>Specialized Development Bank</td>
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<td>SDS</td>
<td>Service Delivery Survey</td>
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<td>Sida</td>
<td>Swedish International Development Cooperation Agency</td>
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<td>SMC</td>
<td>Social Marketing Company</td>
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<td>SOE</td>
<td>State-owned enterprises</td>
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<td>SSC</td>
<td>Secondary School Certificate</td>
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<td>STD</td>
<td>Sexually Transmitted Disease(s)</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>TFIPP</td>
<td>Thana Functional Improvement Pilot Project</td>
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<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>THC</td>
<td>Thana/Upazila Health Complex</td>
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<td>Tk</td>
<td>Taka</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>US$</td>
<td>US Dollar</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>VRS</td>
<td>Vital Registration System</td>
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Executive Summary

This report presents the findings of a Private Sector Assessment (PSA) for Health, Nutrition and Population (HNP) in Bangladesh conducted from November 2002 to May 2003, with technical and financial assistance from the World Bank and DFID. The objective of the study was to gain a better understanding of the private HNP sector in Bangladesh and to identify options to improve public policies towards to the private sector.

Main Findings

The Provision of HNP Services in the Private Sector

The following bullet points are worth making:

- Private service delivery sector is dominant
- Among the private providers, the major proportion is those with low levels of formal training (Alternative Private Practitioners), raising serious concerns about quality of care
- Low overall resource base (i.e., expenditure on health care in Bangladesh is very low)
- Lack of constant standards and distribution of care
- Lack of competition between public and private, some between private and private especially in ambulatory sector
- Structural monopoly in public sector and geographic monopolies in private hospital sector

The PSA analysis confirmed the findings from other studies that the private sector dominates the provision of basic care, nursing homes, laboratory and ambulatory diagnostic services in Bangladesh. The public sector, however, remains a critical provider of inpatient care. Private sector providers are a heterogeneous group, differing in their training, legal status, system of medicine used, type of organization and on whether or not they held a public sector employment as well. Alternative private practitioners (APPs) are by far the largest group of providers. These include partially qualified or unqualified allopathic practitioners, drug vendors, and practitioners of non-allopathic or mixed systems of medicine. Estimates on the number of APPs providers are unfortunately unreliable: the best estimate is that alternative private practitioners outnumber all qualified allopathic physicians by a ratio of 12:1.

In terms of human resources, the private sector predominates (in nearly every category of health professionals, a greater proportion of them work in the private sector). However, Bangladesh has one of the lowest nurse to population ratios in the world: 11 nurses per 100,000 population, compared to 132 in low income countries, and 750 in high income countries. The shortages are mainly in the rural areas, whereas in some urban areas in fact, there are many unemployed nurses. But even in urban areas, the actual availability of qualified nurses in health facilities is low; this is because, most facilities make do with unqualified and unregistered nurses, is a cause for concern in terms of quality. Thus the challenge is not only to increase number of nurses, but also to enhance the role and the quality of nursing in basic care. Although physicians are also in short supply, especially in rural areas, they outnumber nurses by a ratio of 1.7 to 1, compared with an average ratio of 0.6 to 1 in other low-income countries. The government invests
relatively heavily in the education of physicians compared to other providers. Current plans to expand the numbers of physicians will still fall short of the growing needs in the health sector.

Gender issues are very relevant when analyzing the human resources capacity in the private sector in Bangladesh. Other than traditional birth attendants and nurses, male private health providers far outnumber females: by about 4 to 1 among qualified doctors and by about 9 to 1 among APPs. This has a deleterious effect on women’s access to care. In addition to these problems in the numbers of staff and gender of provider, there are also serious problems in skills mix, quality of training and deployment of staff.

Findings from the survey of private providers conducted in this study point to important deficiencies in the technical quality of care delivered even by formally trained practitioners in both private and public sectors. For example only 10% of private providers in hospitals used medical protocols to treat tuberculosis patients (see chart below). In the absence of appropriate mechanisms and institutions to promote quality of care in a systematic manner it is impossible to monitor and assure quality of care; in such a scenario, the quality is unlikely to be high. These problems are even greater in the case of APPs, the largest and least measured group of providers in the country. Traditional providers’ knowledge was particularly poor on MCH issues, for example, the management of a newborn with pneumonia and the complications of delivery.

![Figure XS.1: Proportion of Private Hospitals Using Medical Protocols](chart)

The survey also suggested that workforce motivation and infrastructure are critical constraints to qualified private providers, whereas access to credit does not appear to be a problem.
Consumption of private HNP Services

The following bullet points capture the main demand-side issues:

- Overall low consumption of essential care
- Poor populations demand / consume basic ambulatory care services from private providers; private services are not merely for the rich and
- Gender disparities in access
- Financial barriers to access
- Information and others barriers

Overall health care consumption in Bangladesh in both public and private sectors is low compared with other countries and relative to need. The use of maternity services is particularly low: only 8% of deliveries occur in a health facility with skilled birth attendants. The private sector is used for the overwhelming majority of outpatient curative care, while the public sector is used for a larger proportion of hospital deliveries and preventive care. About 90% of medical care for children with acute respiratory infection (ARI) or diarrhea is obtained from the private sector; of 45 countries where this has been studied, Bangladesh has amongst the highest reliance on the private sector. This indicates the importance of the private sector in terms of access and signals the need for effective quality of care measures.

![Graph showing use of public and private providers for selected services by the richest and poorest quintiles](image)

**Fig. XS2. Use of Public and Private providers for selected Services by the richest and poorest quintiles**

The dependence on the private sector for curative care is also true for the poor in Bangladesh. The poorest 20 percent of Bangladesh children have a higher dependence on the private sector.
for the management of ARI and diarrhea than the richest quintile. Like in most other countries, poverty is a significant constraint to health care use in Bangladesh. The largest differences between the rich and the poor are for medically trained deliveries, antenatal care, treatment for ARI, and immunizations. In contrast, the use of modern contraceptives and oral rehydration therapy for diarrhea, two commodities where there has been extensive social marketing, do not show such disparities between the rich and the poor. This suggests that social marketing may help in reducing some of the inequities in the consumption of certain health-related commodities across income quintiles. Women and girls tend to receive less medical care than their male counterparts, with gender bias resulting from cultural norms that require women to obtain permission prior to seeking medical care, and needing to find someone to accompany them when they do. The situation is made worse by the lack of female health providers.

The exit interviews with clients and household interviews show that perceptions of provider’s experience and familiarity with the provider are important reasons for selecting private health providers. Satisfaction with services may also be important, though further studies are needed to examine what specific factors influence care-seeking behaviors in Bangladesh.

Analyses of household data show that in absolute terms the richest quintile spends out of pocket about six times as much as the poorest quintile on health care, presumably purchasing a higher quality of health service. The relative spending in the private sector is in contrast higher among the poor than among the rich. For the poorer populations, health care costs result in foregone medical treatment and/or the risk of worsened or continued poverty. The cost of drugs and transportation and distance to the provider are found to be some of the most important barriers to health care. The private providers are often closer to the clients and more conveniently located than public facilities. Financial barriers and lack of basic insurance coverage - public or private - appear to be major constraints to access to care for the poor.

Serious efforts need to be made to address the financial, physical and social barriers to access, especially for the women and the poorer population groups. Operations research is needed to see how consumers can influence quality of care – by being empowered to demand better quality.

Interaction between the public and private sector in HNP

The following bullet points are striking:

- Weak regulatory framework; ineffective enforcement
- Several pilot initiatives include government-NGO partnerships, but most are donor-financed and haven’t been scaled up
- MOHFW needs the fiscal space and greater and different kinds of capacity to enhance engagement with the private providers.
- Misperception of size and scope of private sector by government and lack of capacity to play any role other than service provision

An analysis of the interaction between the government and the private HNP sector shows that the range and magnitude of government engagement with private providers is not congruent with their importance. The bulk of interaction takes place in terms of regulation, and with regard to private clinics and hospitals. Less formal, less organized providers, such as non-allopathic practitioners, including traditional birth attendants, and drug vendors and retail pharmacists have
very little interaction with government. Thus whatever little public-private engagement has occurred in Bangladesh has mostly excluded the providers of greatest importance to the poor.

There are, however, positive experiences in the area public-private engagement, including a number of pilot initiatives to work with private, mostly non-profit, service providers. Notably, the very successful NGO-contracting experiences on nutrition and urban primary health care, and other forms of partnership in areas of family planning, TB control and immunization, bear important lessons for the rest of the HNP sector. In addition, involvement of, and collaboration with, some private sector actors has occurred sometimes in policy discussions and formulation, though this has not been a consistent feature. Recently the government has been considering the possibility of contracting NGOs to better manage several hundred public facilities at the union\(^1\) levels with a view to expanding the coverage and improving the quality of essential HNP services. Such an initiative is a very welcome step in the right direction and should be supported actively by the development partners, so that it quickly matures into a well-designed large-scale pilot with the potential for scaling up if found successful.

Secondly, the fulfillment of government’s stewardship responsibilities in the HNP sector could be enhanced. Health services regulation currently appears to be a fairly low priority issue. There is little collaboration with professional and providers organization, nor support for self regulation. Currently professional and provider organizations are primarily playing the role of trade unions. Neither consumer nor patients’ organizations have yet emerged to play an advocacy role, nor to engage in monitoring of service quality and outcomes. Instruments to engage private actors require government officials to perform tasks very distinct from their traditional activities. There is currently very little capacity to implement such instruments in the MOHFW or in local government bodies.

Thirdly, misperception and low capacity underlie weak public-private engagement. The policy-makers’ interviews reveals that there is limited understanding of the private sector size and role in provision of care, especially for MCH services in rural areas. Most policy makers – especially those at the national level - believe that private providers mainly cater to tertiary care needs of the rich in the capital and other urban areas; while in fact, it is the poor who are more dependent on the private providers, especially the APPs. Removal of such misperceptions, and building MOHFW capacity for large-scale engagement with the private sector are critical pre-requisites to a policy shift from the past approach of fixing the public sector to the new strategy of leveraging the private sector through public policies.

**Key issues**

The following bullet points summarize the key issues:

- Public sector is not strategically using the scarce resources that are available in the private sector

\(^{1}\) A union is the lowest administrative division with fixed public facilities for the provision of health care and consists of around 20 villages, with around 20,000 population on average. 8-10 unions generally make a sub-district (Upazila or Thana), which has a population of around 200,000 on average and 6-8 sub-districts make a district. There are about 4,700 unions, 470 Upazilas and 64 districts in Bangladesh.
• The low level of public expenditure on health care and the fact that all public spending goes to public providers leaves little head room for contracting with private providers
• Low level care provided by APP and persistent shortages of formally trained staff
• Uneven quality and problems with access
• Poor need better capacity to make informed decisions about the quality of care provided by private practitioners
• The poor are more likely to forego medical treatment due to financial constraints
• Other barriers prevent appropriate health seeking behavior
• Lack of competition between public and private leads to inefficient use of resource
• Structural monopoly in public sector leads to low quality, low productivity and inefficient use of scarce public resources and geographic monopolies in private hospital sector allows these providers to charge unreasonable rents (above market rates)
• Poor coordination between public and private sector, lack of complementarities, and contributes to gaps in coverage

Despite the great achievements of Bangladesh in improving HNP outcomes in the last twenty years, the country is facing significant constraints to achieve further improvement in the health of its population, particularly women and children. The key issues emerging from our analysis include the following:

a) In spite of the obvious importance of the private sector, health policy in Bangladesh thus far has focused on the public sector and, in particular, on administration of public facilities. There has been insufficient attention paid to the potential of using the private sector more systematically in the pursuit of societal goals in health.

b) The public sector is not strategically using the resources that are available in the private sector. The low level of public expenditure on health care and the fact that almost all public spending on health goes to public provision leaves little “head room” for trying innovations such as contracting with private providers, or community financing schemes on a large enough scale to be meaningful. The structural monopoly in the public sector leads to low quality, low productivity and inefficient use of scarce public resources and geographic monopolies in private hospital sector allows these providers to charge unreasonable rents (above-market rates). The seemingly diverse private sector suffers from various market failures resulting in the lack of free and fair competition; facilitating such a “level playing field” would be an important role for the government

c) The low quality of care provided by APP and the persistent shortages and gender imbalance among formally trained staff compound the challenge of ensuring the vulnerable populations’ access to essential services of acceptable quality. The poor also need better capacity to make informed decisions about the quality of care provided by private practitioners.

Policy Implications

The central policy implication from these conclusions is to revisit the role of government in HNP, given the realities of resource and capacity constraints in the public sector, the already dominant place held by private actors in the financing and delivery of HNP services and the serious concerns about quality, access, accountability and governance with regard to both private
and public services. A policy shift from an approach of fixing the public sector problems to one of greater engagement with the private sector appears to be warranted. In particular the following areas would appear to deserve priority in government actions.

*Under-consumption of services by the poor and women*

The fact that most patients have a preference for private providers strongly suggests that the observed under-consumption of certain essential health services, especially by poor households and by women, cannot be remedied without increasing the access of under-served populations to private providers. The problem is particularly important for maternal health services, e.g., assisted delivery by a skilled attendant. The more traditional government approach of expanding the supply of services provided by government employees out of public facilities is not working for large segments of the population. The gender distribution of the providers is an important determinant on the decision to seek care, particularly for women.

*Service quality and outcomes*

Private health services - mostly clinical services - appear to be of good quality in the eyes of consumers. This judgment is likely based on those characteristics of private services that can be easily assessed by patients, such as ease of access, degree of courtesy/respect, and being able to procure both advice and medicines in one place. Much more problematic for consumers is the ability to assess correctly the technical quality of private treatment received or to relate such treatment to outcomes of illness episodes, either good or bad. To make up for this important deficiency, and ensure that in most cases consumers derive good value from their purchases of privately provided services, deliberate and well-conceived collective action will be required. Issues of quality need to be looked at separately for the formal and informal sectors as public policy interventions would be different for these two groups of providers. The multitude of provider types in the private sector warrants a mix of different policy options.

*The knowledge base*

While various public interventions could be conceived based on what is now known about the private health sector in Bangladesh, the large knowledge gaps that exist would magnify the uncertainty always associated with new policies and courses of public action. The knowledge base about private health services needs to be widened to dispel misconceptions, and enable the progressive refinement of policies and programs. However, the authors wish to emphasize the need to begin pilot-testing some practical policy options, without waiting for, and simultaneously with, further studies that may be undertaken.

*Policy Options*

The following policy options were discussed during stakeholder consultations in early May 2003 with government officials, private sector actors, civil society, the academia, and development partners. While there was broad agreement on the need to increase the engagement with the private sector and on the value of the options presented here, it was felt that further debate, consultations, pilot tests and studies are needed before policy decisions are taken. The options listed below are initial ideas for consideration.

- Develop a clear public policy towards the private sector that that harness the valuable resources that are available in this sector
• The government needs to create “head room” in its public expenditure envelope so that some public resources will become available for influencing the behavior of private providers through contracting with private providers and subsidizing care for the poor.

• Bring APPs into service provider system by working with them in strengthening skills and increase the number of formally trained staff through training and encourage liberalization of the medical labor market.

• Increase quality benchmarking, performance based competitive pressures and incentives to attract private practitioners to work in low coverage areas in addition to traditional regulatory and quality assurance techniques.

• Make information about the quality and price of private providers readily available to consumer, especially for the poor.

• Introduce targeted subsidies and community level insurance for the poor and social insurance mechanisms for civil servants and formal sector workers.

• Use strategic financial incentives (i.e., fees for doing vaccinations etc) and social marketing techniques to overcome other barriers to appropriate health seeking behavior.

• Increase competition between public and private sector through competitive and selective contracting and performance benchmarking.

• Introduce internal markets (make public providers compete for public funding on a performance basis) and new public sector management techniques (ie contracting out, contracting in, management contracts etc).

• Redefine the role of the MOH and strengthen its core stewardship capacity in areas such as strategic planning, monitoring and evaluation, coordination, regulation, quality control and enforcement.

More specifically, these options are suggested, to address the three major policy implications identified in the report. These options need to be pilot-tested and evaluated first, before being scaled up nationally, but such pilots should be large enough to yield meaningful lessons.

To address under-consumption of services by the poor and women:

- **Explore insurance / risk-pooling and prepayment mechanisms:** Since people are paying for private sector HNP services from their pocket already, well-designed community insurance schemes could be feasible, if coverage of appropriate benefit package with acceptable quality could be assured. Such schemes would not only pool risks and resources for curative services for minor illnesses, but also provide for catastrophic coverage (if public subsidy for such coverage is considered appropriate) and could include incentives for seeking preventive services by building differential co-payments or deductibles. Insurance schemes could be of different types in terms of the benefits package, kinds of beneficiary pool, and other aspects, ranging from micro-insurance schemes at the community level to the social insurance programs covering large populations employed in the organized sector.
Pilot contracting private providers with government funding: the government has already had some experience in contracting out some of its services to non-profit organizations, but most of these models have been through donor-financed projects and have yet to be scaled up. Serious consideration needs to be given to the option of larger scale contracting of HNP service provision to the private providers, financed by public funds. Contracting arrangements could be performance-based; i.e., contract fees are linked to agreed outputs and health outcomes.

Expand social marketing: Bangladesh has a positive record of social marketing in contraceptives and oral rehydration therapy. Social marketing has been shown to reduce inequalities in access to such commodities. This experience could be expanded to other essential health-promoting commodities, such as bednets and soap, whose increased consumption would be beneficial to health outcomes.

Expand direct information campaigns: Such campaigns should address under-served households to enhance their appreciation of the importance of the health services they are not seeking – and the risk linked to the care obtained from unqualified practitioners. Most public information campaigns have so far focused on household behaviors directly impacting on health; more attention needs to be paid to changing health-care seeking behaviors.

Explore demand-side subsidies: Public resources may be used to provide health coupons or such similar instruments to poorer population groups, giving them the necessary purchasing power to consume essential services from the private sector; this approach puts the choice of providers in the hands of the consumers, and empowers them. The success of demand-side subsidies depends on the availability of appropriate services of acceptable quality; hence, this option needs to be used in conjunction with other policy measures geared towards quality improvement, e.g., accreditation.

To improve service quality and outcomes in the private sector

These options could be divided into two distinct sets of approaches: (a) those targeted at the formal sector, i.e., the qualified allopathic providers and facilities and (b) those targeted at the informal sector (APPs). Some options may apply to both groups.

Institute specific initiatives to improve quality of services provided by alternative private practitioners: Encourage the development of APP representative organizations, both local and national, through formal involvement in consultation and policy dialogue. Expand existing initiatives (contracting, training, information dissemination) to include APPs where viable; of particular relevance are the informal providers of maternal and child health services, including the traditional birth attendants.

Conduct direct information campaigns to households to increase the consumption of services. It can also influence the demand for increased quality of services, resulting in pressure on private providers to improve their practices.

Promote the formation of consumer organizations in health: This would supplement and reinforce the ability of individual consumers to demand better quality services and to
represent their concerns and even negotiate more competitive prices. Consumer organization can also play a role in the monitoring of quality of care in the private sector.

- **Subsidize training of private providers**: This option is particularly useful for APPs, whose qualifications and skills are variable and inadequate in most cases. Recognizing the ineffective enforcement of the laws that ban their illegal practice, an alternative or complementary public policy might be to equip them with acceptable levels of knowledge and skills, both to improve their effectiveness and reduce the potential harm they cause to the public.

- **Upgrade the regulatory framework**: This should include the revision of outdated regulations and identification of appropriate mechanisms and resources for enforcement of existing, appropriate regulations. Considering the existing, limited capacity to monitor and enforce regulations, this may be a long-term goal. Self-regulation, is also an complementary professional/provider associations need to be identified and their capacity to play the role of a self-regulatory body needs to be strengthened.

- **Explore accreditation**: Private providers and facilities could be accredited, with a reliable system of regular monitoring and maintenance of standards, so that the consumers can have a basis on which to judge the quality of services. This option should be linked to direct information campaigns to households.

- **Explore franchising**: This involves brand name development of health services, to give the consumers of health care a way to choose providers with an assured standard of services. Franchising could also give the providers a sense of belonging and pride.

*To improve the knowledge base for policy-making*

It is clear that the PSA has not covered the whole ground on the subject and further studies and analytical work are needed. To enrich our understanding of the dynamics of the private sector, further work should include a more in-depth analysis of: (a) factor markets (pharmaceuticals, medical equipment, consumables, etc); (b) labor market dynamics; (c) capital markets; and (c) potential for insurance markets). A broadening of knowledge base is also necessary on other related subject areas. **It must be stressed however, these suggestions for further studies are not to be misconstrued as a reason to delay policy actions for which considerable evidential basis already exists.** A distinction must be made between operations research to pilot-test the policy options and the other research activities aiming to generate new knowledge.

While the specific areas of research would need to be determined through future consultations among stakeholders in Bangladesh, some suggestions are listed here:

- Conduct a more comprehensive, nationally representative survey of private sector providers including all types of alternative providers, particularly traditional birth attendants, and should include a comparative analysis of strengths and weaknesses of private providers, including NGOs.

- Carry out econometric analysis of the private health care market, including an analysis of the supply-demand curves, price-elasticities, unit-costs and such other aspects that could enlighten the policy-makers more about the economic drivers of supply of, and demand for, private services.
• Conduct a further analysis of HNP-related commodities (pharmaceuticals, vaccines, baby food formula, hygiene products, bed nets, etc.), to study both supply and demand side factors relevant to these markets and look at ways of building public-private partnerships in these areas.

• Conduct a labor market assessment, including the market dynamics of supply and demand in relation to human resources, and the incentive mechanisms influencing providers in the private sector.

• Financing studies: building on the ongoing study on alternative financing options, pilot tests of demand-side financing, community insurance schemes, and other ways of generating additional resources that could free up some of the public sector funds for greater engagement with the private sector.

• Conduct a full-fledged study of governance issues as they apply to private as well as public sector, including the issue of dual practice.

• Based on a thorough analysis of the various markets relevant to HNP services, develop a strategy for creating a more competitive environment among the private providers and also between the public and private providers, using public policy as a facilitating tool.

The context and process of this Private Sector Assessment

This work was done within the rubric of a broader Analytical and Advisory Assistance (AAA), which adopted a participatory approach resulting in greater ownership by various stakeholders; the Government official who chaired the stakeholder consultation on the draft of this report declared that it was jointly prepared with the active participation of, and fully owned by, the Government. Four other studies within the AAA umbrella are designed to, together with the PSA, form the basis of future HNP Policy Options for Bangladesh: a health labor market assessment (CIDA), an alternative health financing options study (WHO), a governance study (the Netherlands), and a study on decentralization (Sida and EC). The concept note of the AAA acknowledged that the substantial volume of evidence from past studies has had very little impact on policy; hence the AAA adopted a dual-track approach of analytical work combined with consultation, better dissemination of already available evidence and consensus-building through a national policy dialogue.

The PSA aimed to analyze the private health sector in Bangladesh with regard to its structure and functions - including configuration of services, volume, quality and price. The main supply and demand factors, strengths and weaknesses in provision of services, and modalities of interaction between the public and the private sector were explored. While the PSA analyzes private sector participation in the overall HNP sector, it uses maternal and child health (MCH) as an area of special interest to illustrate general principles and to draw lessons for the broader HNP sector. MCH was chosen in view of its great importance to Bangladesh, and because MCH outcomes constitute a significant part of the Millennium Development Goals (MDG). In order to achieve better MCH outcomes, and thus the MDG, the public policy must address the providers who are providing the bulk of the MCH services to the poorest populations, most of whom are in the private sector. Hence the rationale for this report’s focus on the private sector.
Due to time constraints, the PSA focused on service provision, particularly the various types of providers in the private sector, quality of care and its determinants, consumption of and access to services by vulnerable groups, the resulting equity implications, and the interaction between the public and private sectors. Follow-on work should include a comprehensive treatment of (a) the commodities markets (pharmaceuticals, medical equipment, hygiene products, infant feeding formulations and other health-related commodities); and (b) labor, capital and insurance markets – and their econometric analyses. Notwithstanding such need for further studies, there is enough evidence to act already; a review of the macro-economic context indicates that the time is now ripe for a more pro-active engagement with the private sector.

The PSA was based on information from five key sources: a) a literature review and original analysis of existing household data; b) a survey of private providers and consumers of HNP services; c) interviews of policy-makers, managers and key private sector actors; d) case studies of existing public-private partnerships in Bangladesh e) a review of pertinent health regulation. Several Bangladeshi institutions, World Bank staff and international and national consultants were engaged in the study.

The Way Forward

This section provides some pointers on how the policy options might be realized into action. The authors do not wish to be prescriptive about the solutions for the issues emerging from their study. Rather, public policy should evolve through a participatory process in Bangladesh, with the active and broad-based involvement of all stakeholders. Therefore, the policy options presented here - both the “what” and the “how” - are merely a starting point for national debate.

As the Government is preparing its new Health, Nutrition and Population Sector Program (HNPSP), the findings of this study and the other related studies under the AAA work could serve as a useful vehicle for policy dialogue, taking a fresh perspective on sector reforms needed to achieve HNP outcomes as part of the MDG.

In order to advance such national policy debate and enable the government of Bangladesh to better harness the potential of the private sector for the achievement of health outcomes, the following are possible next steps:

- Set up a Public-Private Task Force in the MOHFW to provide a focal point for evolving processes and activities towards a fruitful relationship between public and private actors. This task force would promote, institutionalize, and coordinate public-private interactions. This would be a temporary measure until durable processes, systems, financing mechanisms, and regulations relating to public/private partnership in the health sector are well-established and absorbed by the relevant agencies.

- Create the necessary fiscal space or “head room” in the public resource envelope, so as to ensure the availability of the substantial additional resources needed to finance increased engagement with the private sector and the required pilots on a large enough scale to make them replicable (over and above the current health sector budget, most of which is already committed to public sector provision). One way of doing this would be through demand-side financing initiatives, micro-insurance schemes or other community financing mechanisms.
• **Capacity development** in the MOHFW to enhance its engagement with the private health sector. Such capacity requires the development of new types of skills, in areas that have not traditionally been among the functions of MOHFW. The capacity of other relevant actors, such as civil society, development partners, and private sector actors should also be considered. This would include substantial education for public sector staff on the size and distribution of private HNP sector in Bangladesh, and ways of building partnerships with private actors; similarly, training and confidence-building activities targeted at the private sector would also be critical.

• **Participatory policy-making and more inclusive planning and programming**: The findings of this and other related studies, should be actively and widely disseminated, as the for national policy debates, involving stakeholders at all levels so that a broad-based set of policy options is developed. Private sector actors should be included in such process and a full consideration given to private sector capacity in service and facility planning. Participatory policy debate should take advantage of the i-PRSP, which already includes some of the ideas outlined in this report.

• **Pilot activities to test the selected policy options**. Once specific policy options are selected through consensus, they need to be tested through operations research to determine their feasibility and measure their impact in the Bangladeshi context. The design of such pilots should build on previous experience, and evidence already available about public-private partnerships, demand-side financing, micro-insurance schemes, contracting with results-based financing and other such ideas.

A **preliminary timeline** for the next steps is suggested as follows (this needs to be agreed with the Government):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Completion of other related studies (financing, governance, etc.)</td>
<td>August 2003</td>
</tr>
<tr>
<td>Dissemination of existing evidence, multi-pronged communication exercise, consultations across the country</td>
<td>July to December 2003</td>
</tr>
<tr>
<td>Development of broad-based HNP Policy Options</td>
<td>December 2003</td>
</tr>
<tr>
<td>Initiation of Pilot Interventions (e.g., micro-insurance, results-based contracting with private sectors, demand-side subsidies)</td>
<td>January 2004</td>
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</table>
Chapter 1. Introduction

1.1 Background

The Health, Nutrition and Population (HNP) sector in Bangladesh is at a crossroads: business as usual or new pathways to betterment of the health, nutrition and fertility outcomes for the citizens, especially the poor and vulnerable segments of the population. The Government of Bangladesh (GOB) and the Development Partners (DPs) are considering the achievements and challenges of the ongoing Health and Population Sector Program (HPSP) and preparing for the next Health, Nutrition and Population Sector Program (HNPS). GOB has also recently completed an Interim Poverty Reduction Strategy Paper (i-PRSP), based on which the World Bank and the International Monetary Fund are considering a Poverty Reduction Support Credit. A clear opportunity presents itself, at this juncture, to the policy-makers in Bangladesh to re-examine the country’s approaches to HNP.

After three decades of independence which saw significant achievements in morbidity, mortality and fertility reductions, Bangladesh is poised for new public policies to address lingering issues of inefficiencies, inequities and poor quality of and access to HNP services. Addressing these issues is essential to the continued and further improvements in HNP outcomes.

Thus far, GOB and DPs have been focusing largely on the establishment, maintenance and improvement of facilities and services in the public sector. However, simultaneously there has been a growth of mostly unregulated health services in the private sector. Moreover, the private sources (mainly out-of-pocket) contribute more than two-thirds of the overall health expenditures and private providers cater to over three-fourths of the acute episodes of illness. Considering the serious resource constraints in the public sector along with the dominance of the private financing and provision of HNP services, a continued near-exclusive focus on the public sector services would be inadequate. It would seem obvious that addressing the sector’s problems in the future requires the institution of appropriate public policies to enhance the effectiveness of the private sector’s contribution to public health goals.

The HNP policy debate has thus far been limited mainly to issues such as unification of the Health and Family Planning wings of the Ministry of Health and Family Welfare (MOHFW), decentralization of financial and managerial functions within the public sector, enhancing hospital autonomy in the public sector and the maturation of the “sector-wide” approach. Though these issues are important, they have sidelined other critical issues e.g., governance, accountability and incentive mechanisms in the private as well as public sectors, stewardship role of government and alternative pro-poor financing and service delivery mechanisms. Limiting public policy discussions to fixing the problems of the public sector is no longer appropriate. A

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2 The private sector is defined to include all actors outside of the government. This broad definition encompasses both the commercial sector and the not-for-profit sector, non-governmental organizations (NGOs), care providers with or without formal qualifications, practicing allopathy, homeopathy, ayurveda, or other systems of medicine, facilities of various sizes, hospitals, clinics, pharmacists and drug vendors, and suppliers of health-sector related goods and services.
fundamental review of the role of the state in HNP is warranted and should be at the heart of any real reform of the sector.

In 2001 the DPs, led by the Bank and the Department for International Development (DFID), supported a study called “Health Futures in Bangladesh”. But this study and other existing rich body of knowledge appear not to have been put to much use, so far, in informing policy. In 2002, the Bank, together with GOB and other DPs, launched an initiative called “HNP Sector Policy Options”, to build on the Health Futures Study and add value to the knowledge base on which the preparation of the future sector program could be built. This was done within the rubric of the Bank’s Analytical and Advisory Assistance (AAA), and sought broad-based participation and ownership by various stakeholders. Annex 1 outlines the process and context of the AAA task, indicating how the PSA fits within it.

Apart from the fact that public policy can no longer afford to ignore the private sector which is already a dominant player in HNP, the reason for the focus on private sector is that valuable benefits accrue by engaging the private sector to deliver health-related goods and services. In addition to the possibility of increased efficiencies, improved quality of services and enhanced choice to the client – all of which are potential benefits of competition – the government can also better focus its limited resources and capacity on stewardship functions, i.e., regulation, monitoring, public information, financing, and purchasing. This is not to say that government should completely get out of the delivery function; but a better understanding of the market for HNP services would help determine which select areas of HNP provision might be appropriate for government’s direct provision and which others, for private sector provision.

In order to take full advantage of the potential – and address the challenges – of working with the private sector, governments need to gain a better understanding of private actors. Who are the private sector actors? What goods and services do they provide? What are the different kinds of incentives influencing the behavior of the private sector? In which areas is the private sector well placed to complement public sector efforts? What are the most effective strategies for engaging the private sector? Although some evidence is emerging regarding these questions, there is a clear need for further information and knowledge.

1.2 Objectives

The objective of the proposed study is to gain a better understanding of the private health care markets in Bangladesh and to identify areas for increased collaboration between the government and the private sector.

In this context, an attempt is made to study the private health care markets in Bangladesh in terms of their structure and functions (including configuration of services, quality and price), the main demand and supply factors, strengths and weaknesses in private modalities of financing and provision, a comparison of private and public sector services for selected interventions of public health importance. Once again, it would be important to note the broad and inclusive definition of private sector used here, as stated in footnote 1 on page 1.

1.3 Scope

While the PSA analyzes private sector participation in the overall HNP sector, it uses maternal and child health (MCH) as an area of special focus to illustrate general principles and/or draw
lessons for the broader HNP sector. MCH was chosen for this emphasis in view of its great importance to Bangladesh, and because MCH outcomes constitute a significant part of the Millennium Development Goals (MDG).

Conscious choices had to be made to limit the focus of the PSA, as the private HNP sector is too complex to be covered in full detail under one study. For instance, the supply side factors (Chapter 4) do not include a comprehensive treatment of pharmaceuticals, medical equipment, hygiene products, infant feed formulations or other such health-related commodities, all of which constitute important private sector inputs impacting on health.

1.4 Methodology and Sources of Information Contributing to the PSA

The following table shows the five distinct sources of information that have contributed to the material being presented in this report.

Table 1.1 – The Sources of Information Contributing to the PSA for HNP

<table>
<thead>
<tr>
<th>A. Literature review (including analysis of household income and expenditures)</th>
<th>B. Survey of private providers and consumers of HNP services</th>
<th>C. Interviews of policy-makers, managers and key actors</th>
<th>D. Case studies of public-private partnership models in Bangladesh</th>
<th>E. Health regulation review</th>
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PRIVATE SECTOR ASSESSMENT FOR HNP IN BANGLADESH

Each of the above activities was carried out by separate consultants, contracted by the World Bank. Item B was jointly financed by the Bank and DFID (through their ongoing support to the Institute of Health Economics, managed by Maxwell Stamp) – using common methodology and instruments. While A is based on existing body of information, B and C bring fresh evidence based on new data collected for this study; D and E reflect new analyses of existing information. Full reports of the four sub-studies / reviews (described under 1.4.2 to 1.4.5) are available separately as background documents; only selected information from these are reflected in appropriate chapters of this report. Here we provide just a brief description of these five sub-tasks which have contributed to the PSA.

1.4.1 Literature Review

This includes a review of relevant papers, publications and documents that contain both international and Bangladeshi evidence on the private HNP sector and on public-private partnerships. The literature review was conducted at the initial stage of the PSA. It informed the design of the other studies and their instruments for data collection. Annex 2 contains the findings of the review of international evidence, focusing on the role of the private sector in maternal and child health; the Bangladeshi evidence is reflected in the main text of the report. The literature review included a secondary analysis of the Bangladesh Household Income Expenditure Survey 2000, the results of which are provided in Chapter 5.
1.4.2 Survey of Private Providers and Consumers

This survey jointly financed by the World Bank and DFID, was carried out for the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MOHFW), by the Institute of Health Economics (IHE) and the National Institute for Population Research and Training (NIHORT). The survey results are primarily reflected in Chapters 4, 5 and 6 and a summary is included in Annex 3.

The survey had three major objectives:

- To get a description of the private sector from a provider and a consumer perspective based on information from a limited number of sites.
- To provide a basis for formulation of hypotheses for a larger study of the private health sector in Bangladesh.
- To pilot test protocols to be used later in such a study.

The study was not intended to be a comprehensive study of the private providers and beneficiaries representing all of Bangladesh. Rather it was intended to provide initial impressions from a non-representative sample, as a means of building the platform for a larger and more robust study. The sampling was purposive, multi-stage starting from the administrative divisions of the country. The study collected information from a limited sample of private providers: private hospital managers; private allopathic practitioners in hospitals/clinics – a mix of qualified and non-qualified; private pharmacists and retail drug vendors – a mix of registered and unregistered; private non-allopathic practitioners – a mix of qualified and non-qualified. The sampling, while purposive, included a representation of urban and rural localities, for-profit and not-for-profit providers, and providers close to and those not so close to a public facility. Also, the sample covered all the six administrative divisions of the country.

The survey included:

- 356 household interviews to identify demand-side factors that determine health-seeking behaviors, especially those which related to the choice of a private provider versus a public health facility, the type of provider used for the various health conditions or health services, perceptions about the quality, price and other relevant considerations.

- Interviews with 32 hospitals or clinic managers, 42 clinicians, 72 pharmacists or drug vendors, 26 traditional practitioners, 36 homeopaths, 356 households and 762 consumers. Through these interviews, data was collected on size and general scope of services at the facility, facilities and activities for child and maternal health services, characteristics of patients seen and their illnesses, knowledge on management of priority childhood illnesses, sources of revenues, fee structure including exemption or credit mechanisms, drug sales (in retail outlets), quality assurance mechanisms in place, mechanisms for gaining and maintaining customers, constraints on operating services, experience from and attitudes towards interaction with the public sector, including any specific experience from regulation, contracting out etc.

- Exit interviews with consumers of services provided by all of the above categories, to collect data on: basic characteristics of customers, reason for visit and diagnosis if known, reasons
for choice of provider including identification of service factors that are most appreciated, treatment given, events from onset of illness to current visit including visits to other providers, expenses related to illness with specific information on current visit, experience from visit and attitudes towards provider, and assessment of provider in relation to other providers, including public.

1.4.3 Interviews of Policy-makers, Managers and Private Sector Actors

The purpose of these interviews was to obtain qualitative information on the public sector perspective about the private sector, and the vice versa. The data derived from these interviews have been reflected mainly in Chapters 4, 5 and 6 of the report. A summary is included in Annex 4. The interviews included public sector decision-makers, their advisors, managers at various levels of the health system and the implementers of the public policies. A small group of key actors from the private sector (including NGOs) was also included. More specifically, these interviews were designed to obtain the following information:

- The main health sector objectives of the government
- The main activities of the private sector and how those activities currently contribute to the health sector objectives of the government
- The perceived strengths and weaknesses of the private sector
- The proposed future role for the private sector in health and how this role would contribute to the achievement of the health sector objectives
- The government’s policy, formal and informal, towards the private sector
- How policy concerning the role of the private sector is made, and which actors are involved
- Experience of past and current public-private partnerships
- Constraints to expansion of public-private partnerships

1.4.4 Case Studies of Public–Private Partnership in Bangladesh

An analysis was done of case studies of innovations in public-private partnerships (PPP), as one part of a private sector assessment that examines options for engagement with the private sector. In addition to contributing to the PSA, the information from these studies was intended to improve the public dialogue on the future of Bangladesh’s health system. The information from the case studies is primarily reflected in Chapter 6, which deals with the interaction between the public and private sectors, and in Annex 5, where a summary is included.

Most PPP initiatives in Bangladesh have been partnerships between the government and non-profit organizations and have included activities of TB control, nutrition, family planning, immunization, and urban primary health care.

1.4.5 Review of Health Regulation

The health regulation review contributed substantially to chapter 6 of this report on Government-Private Sector Interaction. The review covered both the legal and formal regulatory mechanisms.
and informal, professional self-regulatory systems, if any. A summary of this review is found in Annex 6.

Health legislation covers a broad range of subjects like the regulation of health care providers, environmental pollution, food safety, pharmaceuticals quality, occupational health and industrial hygiene. But the main focus of this review was on the regulation of the quality of privately provided health care services and goods, including health care practitioners, NGO facilities, pharmaceutical manufacturers, private pharmacies and diagnostic facilities. The review described the intended arrangements and how things actually work (and perceptions/misperceptions).

1.5 Reviews, Consultations, and Dissemination

Based on the information derived from the above sources, the core authors have put together this report, which has benefited from one round of consultations with in-country stakeholders, including government officials, key private sector actors, academia and DPs. The report would be finalized after internal review by the World Bank, after which there would be a series of dissemination workshops to stimulate a national policy debate on the issues and options presented and develop a broad-based consensus on the issues presented and appropriate policy to be tested. Such a process would also use the results of the other related studies within the AAA framework.

2.1 Introduction

This chapter provides a brief overview of government policies in several key areas in the post-independence period and their likely effects on economic growth and poverty alleviation—with poverty alleviation defined as including progress in human development in addition to higher and better distributed household consumption expenditure. The purpose of the chapter is simply to put the subject of this report in a broader context. All of the policies described below would have contributed to shaping the private segment of the health sector, together with other sectors of the economy. The chapter first addresses the observed trends in economic growth and poverty alleviation before moving on to policies.

2.2 Trends in Economic Growth and Poverty Alleviation

Economic growth has been good after independence, with an average annual rate of growth in real per capita GDP of 2.5% in the 1972-99 period, and about 3% in the 1990s. This growth performance was based on an expansion in the rate of investment supported by progressively greater openness to international trade. Economic growth has been reflected in a significant reduction in consumption poverty over time. For example, in the 1990s, the proportion of the population estimated to be poor declined from 59% in 1991-92 to 50% in 2000, and that of the very poor declined from 43% to 34% over the same period. However, the pace of poverty reduction in rural areas slowed down between 1995-96 and 2000, with poverty in urban areas actually rising during this period (World Bank and Asian Development Bank, 2002).

There has also been good progress in some of the key human development indicators, starting from a low base. The infant mortality rate (IMR) has declined from 153 per thousand in the mid-1970s to 66 in 2000, and the total fertility rate declined from 6.5 to 3.0 children per woman in the same period.

In education, enrollments at the primary level doubled from 8 to 17.7 million between 1980 and 2001, with an increase in the net enrollment rate from 65% to 84%. The primary school completion rate also increased substantially. Enrollment in secondary education has been growing rapidly as well, increasing from 3 million students in 1990 to over 10 million at the end of the 1990s. The increase in female secondary school enrollments has been particularly rapid, assisted by a successful program of government stipends targeted to women. However, there are concerns about the quality of education, for which no systematic attempts at measurement have been mounted so far. There are also large disparities across socio-economic groups in both health and education.

The successes in human development are only partly attributable to government policies and programs. Households themselves, NGOs, and private for-profit service providers have made a large contribution. In education, an estimated 80% of total primary enrollment is in private schools, and NGOs have been particularly active in this respect. In health, the private health care providers’ share of all outpatient contacts has been estimated at over 80% (Hay, Unpublished. 2002). Moreover, in the case of health indicators such as infant mortality there are many other factors at play in addition to the provision of health services (public or private). These factors would include for example the availability of safe water and sanitation facilities or...
the nature of basic hygiene practices within the household, and here too the private sector and households would have influenced the outcomes.

2.3 Trends in Government Policies

2.3.1 Broad Directions

After independence there was a short period of experimentation with a socialist-style, controlled economy, with an emphasis on state ownership of means of production and the imposition of price and other controls intended to influence outcomes in various factor and product markets. Many private companies were nationalized. Since the mid-1970s, though, the trend has been towards deregulation, liberalization and a focus on private-led growth (Ahmed, 2002). Nevertheless, there is an important structural reform agenda still pending. To a large extent this agenda relates to the further redefining of the roles of government, which would contribute implicitly to shaping the role of the private sector in future years.

2.3.2 Macroeconomic Management

In general macroeconomic management was satisfactory after the late 1970s, but deteriorated in the late 1990s leading to a rising consolidated fiscal deficit (from 4.4% of GDP in Fiscal Year 1998 to 6.5% in Fiscal Year 2000) and very low foreign exchange reserves. The fiscal deficit has been reduced since then through the introduction of a series of revenue and expenditure measures, and reserves have also grown though they remain below a comfortable level. Tax effort has been weak, with fiscal revenues presently amounting to only about 9% of GDP. The low tax effort makes it very difficult for the government to increase spending on health and education, among other priority sectors. Management of the exchange rate has been generally good, and for the past ten years there has been a unified and moderately flexible exchange rate regime. Future introduction of social health insurance would need to be fully integrated into the overall macroeconomic framework.

2.3.3 Trade Policy

As noted above, the openness of the economy to foreign trade has increased over time. In the 1990s especially there was good progress in reducing tariffs and non-tariff restrictions. However, there is still a substantial unfinished trade reform agenda and protection remains high by world standards. The Government has recently announced its intent to push forward with trade reforms, with a goal of moving over the next three years to a three-tier tariff structure with a maximum tariff rate of 30%.

2.3.4 Financial Sector Policies

Government-owned banks, comprising national commercial banks (NCBs) and specialized development banks (SDBs), have dominated the banking sector. They have a very high proportion of non-performing loans, a problem that has shown little improvement over time. They also have very large interest spreads (which they need in order to survive), which have tended to raise spreads for private banks as well, negatively affecting private investment. The effectiveness of private banks has been affected by insider lending, and their loan recovery rates are also too low by international standards. The weak and inefficient financial system limits access to credit, raises real interest rates, and acts as a serious drag on economic growth.
World Bank study estimated that if financial sector inefficiencies had been removed 20 years ago, real GDP per capita would have been 15-37% higher by 1995 (World Bank, 2000a).

Future development of community financing and supplementary health insurance will require strengthening of the enabling and regulatory environment in the insurance industry, including clear rules about capital resources, risk exposure, and re-insurance.

2.3.5 **State-Owned Enterprises (SOEs)**

In addition to banks, the government still owns a large number of enterprises in manufacturing and infrastructure. Most of these SOEs have had poor financial performance, and as a consequence have relied heavily on drawing budgetary resources to survive. These resources could be put to better uses in other areas that should command a higher priority, such as health and education (for the period 1991-2002, SOE losses amounted to about 25% of the combined budget for education and health). Moreover, the inefficient services provided by SOEs operating in energy, telecommunications, railways, ports and other public utilities have increased the cost of doing business in the country and thus have negatively affected economic growth. Consumer access to utility services has also suffered because of limited reach of utilities, especially in rural areas (e.g., only 19% of rural households had access to electricity in 2000). The government has developed a program of closures and privatization, initially focusing on manufacturing SOEs, and in July 2002 it actually closed a jute mill employing 25,000 workers. The lessons learnt from SOEs could be applied to reform of hospitals.

2.3.6 **Governance**

It has been estimated that poor governance costs the country between 2 and 3 percentage points annually in lost economic growth (World Bank, 2000b). A recent survey indicates that private sector senior managers spend as much as 25% of their time dealing with government agencies on regulatory and administrative issues. Lack of clear legislation, inconsistent application and enforcement of regulations, absence of effective mechanisms for holding public officials accountable, ineffective appeal mechanisms and an inadequate legal and judicial system have all been detrimental to the business environment and economic growth. Governance problems such as absenteeism also greatly reduce the effectiveness of government services in health and education, among other sectors.

2.3.7 **Private Sector Development**

Formal private sector activity in Bangladesh has been limited to a few sectors (World Bank, 2001). Outside of agriculture, export-oriented garment and knitwear manufacturing is the largest area of formal private sector activity, accounting for about 70% of total exports. Power and natural gas are also important areas of private investment. Much of the rest of the private sector activity is in the informal sector, including small-scale manufacturing and trading.

The government has emphasized the private sector’s role, especially in export-oriented industries, as the engine for sustained growth and employment generation. Structural and trade reforms in the 1990s had a positive impact on private sector development, especially in the export and manufacturing sectors, and in attracting foreign direct investment in the 1990s. Private investment as a percentage of GDP increased from 9.8 % in 1990 to 15.5% in 1999. Net foreign direct investment increased from US$14 million in 1990 to US$192 million in 1999,
mainly in power generation and natural gas production. However, poor governance, heavy taxation, inadequate infrastructure, and social and political instability result in very high costs of doing business. Access to finance is limited, due to the weak commercial banking system and underdeveloped capital markets.
Chapter 3. Health Situation Analysis

The health priorities in Bangladesh as identified by this review are to reduce child and maternal mortality by targeting the key causes of this mortality. Further, resources and attention must be devoted to emerging communicable diseases such as HIV/AIDS and tuberculosis. Lastly, the epidemiological transition from communicable to non-communicable diseases as major contributors to the burden of disease will have implications for resource allocations in the coming decade.

In all activities special attention must be given to reaching the poor and vulnerable where mortality and disease burden are higher. Prevention of avoidable mortality and morbidity among these groups should be a priority. The very limited public resources for HNP should be prioritized to finance essential services, based on societal choices, cost-effectiveness and potential impact of interventions. The government’s priority in curative care may be to ensure access for the poorest groups and to promote and support quality of services in both private and public sectors.

3.1 Health Situation and Disease Patterns in Bangladesh

3.1.1 Mortality Reductions

Bangladesh has seen a remarkable improvement in health indicators over the last 30 years. The infant mortality rate (IMR) stood at 153 deaths per 1000 live births in the mid-1970s (Ministry of Finance, GOB, 2002) while the latest data suggest an IMR of 62 (Streatfield et al., 2001). In a similar way under-five mortality has declined by two thirds in thirty years and now stands at 83, according to the Demographic and Health Survey (DHS) 1999/2000. Life expectancy at birth is now estimated at 61 years.

The main causes of death in children under five years of age are given in Table 3.1.

Table 3.1 – Main Causes of Death in Children under Five Years of Age, Bangladesh (2000)

<table>
<thead>
<tr>
<th>Cause of death in children less than five years of age</th>
<th>Percentage of all deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARI + possible ARI</td>
<td>27 %</td>
</tr>
<tr>
<td>Perinatal causes</td>
<td>24 %</td>
</tr>
<tr>
<td>Diarrhea incl. Dysentery</td>
<td>16 %</td>
</tr>
<tr>
<td>Injury (including drowning)</td>
<td>8 %</td>
</tr>
<tr>
<td>Neonatal tetanus</td>
<td>8 %</td>
</tr>
<tr>
<td>Severe malnutrition</td>
<td>7 %</td>
</tr>
<tr>
<td>Measles (+ measles followed by ARI or diarrhea)</td>
<td>1 % (3%)</td>
</tr>
<tr>
<td>Other causes</td>
<td>17 %</td>
</tr>
</tbody>
</table>

Source: Baqui et al., 2001

From the table it can be concluded that almost half of the deaths in children under five are due to ARI and diarrhea. It is estimated that two thirds of the deaths in children have malnutrition as an underlying cause.
The data conceals significant socioeconomic disparities. For instance, infant mortality is 70% higher for the poorest quintile than for the richest group (Ministry of Finance, GOB, 2002). According to the 1996/97 DHS, children in the poorest quintile households suffered 83% higher mortality than children in the richest households.

With regard to gender differences, the data from the DHS survey 1999/2000 show that females have lower neonatal mortality (i.e., in the first month of life), but higher post-neonatal mortality (in the following 11 months of the first year). Differences are not statistically significant, however (Streatfield et al, 2001).

Neonatal mortality currently accounts for about two thirds of infant deaths (42/1,000 live births), and almost half of under 5 deaths (42 out of 94 /1,000 live births). Among neonates more than half the deaths in this first month of life actually occur in the first week, many on the first day of life (Streatfield et al, 2001). This points very clearly to the vital importance of safe delivery and post-natal care to improve child survival.

The maternal mortality rate (MMR) is still high by all standards. It was recently estimated to 320 deaths per 100,000 live births with a verbal autopsy identification of maternal deaths in the Bangladesh Maternal Health Services and Mortality Survey (BMMS) 2001 (NIPORT, 2002). This would represent a decline by 36% from 1986-1991 to 1998-2000. The data from the BMMS also show a significant variation from 320 (retrospective questions on deaths in households, i.e., verbal autopsy method) to 400 (“direct sisterhood method”\(^3\)) in the estimate of the MMR, depending on which method is used. Further analysis of the survey data is being carried out to assess if the household data suffer from underreporting of maternal deaths. The decline in MMR from 1986 to 2000 with data using the sisterhood method is shown in Table 3.2 (NIPORT, 2002).

### Table 3.2 – Direct Estimates of the Maternal Mortality Ratio from Different Surveys using the Direct Sisterhood Method

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mortality Ratio (per 100,000 live births)</td>
<td>514</td>
<td>485</td>
<td>449</td>
<td>400</td>
</tr>
</tbody>
</table>

Source: NIPORT, 2002

From Table 3.3, it can be seen that around 350,000 children under five die each year in Bangladesh. The number of women dying in relation to pregnancy and delivery is around 17,000 each year. This means that roughly 45 young Bangladeshi women and nearly 1,000 under-five children die every day; almost all of these deaths in women and children could be prevented if appropriate care services could be provided.

\(^3\) The Direct Sisterhood Method is used in DHS. In this method, respondents are asked to provide detailed information about their sisters, including the numbers reaching adulthood, the number who have died, the age at death, the year in which the death occurred and the years since the death. It does not provide a current estimate of maternal mortality but larger sample sizes permit the calculation of a ratio for a more recent period of time.
Table 3.3 – Estimated Total Births, Maternal Deaths, Infant and Child Deaths in 2000

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total in 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>140,368,000</td>
</tr>
<tr>
<td>Births</td>
<td>4,284,000</td>
</tr>
<tr>
<td>Maternal deaths</td>
<td>17,136</td>
</tr>
<tr>
<td>Infant deaths</td>
<td>261,324</td>
</tr>
<tr>
<td>Deaths in children younger than 5 years</td>
<td>355,572</td>
</tr>
</tbody>
</table>

Source: WHO (2003a)

3.1.2 Communicable Diseases

Tuberculosis (TB) is a disease that is given significant attention in Bangladesh. In addition to the regular work that is being carried out within the government structure, the MOHFW is collaborating with NGOs on TB control within the framework of the National TB Program (NTB). The number of smear positive pulmonary TB cases has been increasing since the program was initiated. That may be a result of the rapid expansion of the program, leading to complete case detection. It may also reflect a genuine change in the incidence of the disease.

The current prevalence of TB positive cases is estimated at 280,000. The annual incidence is estimated at around half that number (Streatfield et al, 2001). Given the long duration of TB, the disease is one of the leading causes of the national burden of disease. The number of deaths due to the disease was estimated at 70,261 in 2000-2001.

HIV/AIDS is an emerging threat in Bangladesh, despite a low prevalence rate (< 1%) even among high-risk groups such as sex workers, migrant workers and Sexually Transmitted Disease (STD) patients (Streatfield et al, 2001). However, it has been pointed out that the rate of syphilis is high in these groups (from 6% to 34%). This is in contrast to the pattern seen in many other countries where HIV/AIDS tends to be much higher when STD prevalence is so high. Recently an increase in the prevalence of HIV among intravenous drug users, suggesting a possible beginning of an epidemic. Even though there may be differences in the epidemiology of HIV in Bangladesh, there is every reason to take all possible action to prevent the spread of the disease and a potentially serious epidemic. Bangladesh may be in the fortunate situation where the HIV epidemic can still be stopped.

3.1.3 Epidemiological Transition

An epidemiological transition is taking place in Bangladesh as communicable diseases are more successfully prevented or cured. Of the non-communicable diseases, cancer and cardiovascular diseases are the leading causes of morbidity and mortality. Projections show that as early as 2010, non-communicable diseases will increase their share as cause of mortality to 59% from 40% in 1990. Communicable diseases are expected to decrease their contribution to mortality in the same time period from 51% to 30% while injuries will increase their share from 9% to 11%.

When morbidity and disability are taken into consideration, non-communicable diseases are expected to account for 60% of the disease burden in 2010, while communicable diseases and peri-natal conditions would together account for around 20% (Ministry of Health and Family Welfare, GOB, 2002). However, set-backs in the control of communicable diseases may occur if full vigilance is not maintained. HIV/AIDS is a potential threat in this context. Malaria and
dengue may also show unexpected increases in incidence. Furthermore, if the socio-economic situation should deteriorate, diseases related to poverty and malnutrition, like diarrhea and pneumonia, may increase. The increasing urbanization is likely to affect the morbidity and mortality pattern in the coming years.

### 3.1.4 Nutritional Status

Though nutritional status has improved over the years, still an estimated 35% of children are moderately and 13% severely underweight. The data show a wide economic differential in malnutrition, with children in the poorest households being twice as likely to be moderately malnourished, and four times as likely to be severely malnourished as children in the richest homes. Malnutrition has declined in all economic quintiles, but has declined faster among the richest quintile. This means that in spite of the overall improvements for all groups, inequities have become larger (Streatfield et al, 2001).

### 3.1.5 Population Growth

There has been widespread concern over the family planning situation. At the current growth rate the population of the country will double in 47 years. The government sees a major challenge in this. Lately, there has been a lively discussion over whether the average number of children born to a woman during her reproductive lifetime, i.e. the total fertility rate for women aged 15-49, has gone down or not. The DHS survey in 1993/94 showed a figure of 3.4 and the DHS in 1996/97 3.3. The DHS estimate from 1999/2000 was still 3.3 indicating no change in fertility over a period of 7 years. The most recent estimate of 2.9 comes from the Health and Demographic Survey (HDS) conducted in 2000 by the Bangladesh Bureau of Statistics (BBS). Data are inconclusive on whether or not fertility has leveled off or is going down (Streatfield et al, 2001). The latest figures suggest that 54% of women of reproductive age use contraceptives. Studies indicate that the people rely mainly on natural and temporary methods for birth control, even though contraceptive prevalence rates are gradually going up.

### 3.2 Millennium Development Goals (MDGs)

The Government of Bangladesh is a signatory to the MDGs; accordingly, the indicators under MDGs that relate to health assume particular significance. They are given in Table 3.4.

The goal for IMR set for 2015 is 22 deaths and for the under-five mortality rate the target is set at 31 deaths per 1000 live births. These are more ambitious goals than those under MDG globally, because they are based on the value at year 2000 as the benchmark (instead of the 1990 values used by MDG globally). In other words, they seek to achieve the same percentage reductions as envisaged under MDG in 15 years instead of 25. Hence they will require significant efforts if they are to be attained. Investments in antenatal services, delivery services, health education, preventive services, like immunization, and essential curative services like oral rehydration and treatment of pneumonia and malaria, are crucial in reducing mortality among infants and children. To reduce the infant mortality rate the peri-natal mortality should be given highest attention through support to antenatal care and delivery services. For children older than one year, the proper treatment of childhood illnesses is particularly important. However, to prevent some of the essential childhood illnesses all children need to be fully immunized by the age of one.
Table 3.4 – Major HNP Goals under an Accelerated Social Development Strategy with 2000 as the Benchmark Year

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1990</th>
<th>2000 (Benchmark data)</th>
<th>Annual progress over 1990-00 (%)</th>
<th>Proposed target 2015</th>
<th>Proposed annual progress 2000-15 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality rate</td>
<td>94</td>
<td>66</td>
<td>-3.0</td>
<td>22</td>
<td>-4.4</td>
</tr>
<tr>
<td>Under-five mortality rate</td>
<td>108</td>
<td>94</td>
<td>-1.3</td>
<td>31</td>
<td>-4.5</td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td>480</td>
<td>320</td>
<td>-3.3</td>
<td>240</td>
<td>-3.6</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>56</td>
<td>61</td>
<td>0.9</td>
<td>73</td>
<td>1.3</td>
</tr>
<tr>
<td>Population growth rate</td>
<td>2.1</td>
<td>1.6</td>
<td>-</td>
<td>1.3</td>
<td>-</td>
</tr>
<tr>
<td>% children underweight</td>
<td>67</td>
<td>51</td>
<td>-2.4</td>
<td>26</td>
<td>-3.3</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Family Welfare, GOB, 2002

Even though the decline in MMR during the last 10 years is impressive, high priority must be given to further reducing the maternal mortality in order to reach the proposed target for 2015 of 240 deaths per 100,000 live births. This will in particular require arrangements so that deliveries can be carried out under safe circumstances with close access to Emergency Obstetric Care (EmOC). The most recent data show that 91% of births occur at home. 75% of births are assisted by a dai, a traditional birth attendant who is usually not trained (NIPORT, 2002). The survey also showed that only 5% of all delivering mothers in the sample surveyed got antenatal care, assisted delivery and appropriate post-delivery care, a minimum service package that should eventually reach all pregnant women. There are also clear inequities in access to and consumption of services. Only 30% of households in the lowest wealth quintile receive antenatal care as compared to almost 80% in the highest. The NIPORT study reported a high 60% complication rate in deliveries. This shows the urgent need to provide access to EmOC for all in Bangladesh.

For all conditions, priority must be given to reaching poor and vulnerable families in the community, especially in rural areas where services are inadequate. As documented in many studies, premature mortality, including maternal mortality, and malnutrition is more common among the poor and vulnerable. Reaching these groups with services will therefore pay off particularly well in terms of reaching the MDGs.

Population growth is targeted for further reduction, which is a strong reason to maintain the priority given to family planning services in the country. Any backlash in population growth would have serious implications on the health situation as well as on the socioeconomic condition of the people.

The target set for malnutrition may be one of the hardest to reach. More than half of children in Bangladesh are said to suffer from some degree of malnutrition today. Reducing that proportion to only a quarter will require not only effective nutrition support programs with the health and
welfare sector but also a significant improvement of the living standard of the broad masses, in particular the poor.

The graphs in Figure 3.1 illustrate the progress towards some of the MDGs. Evidently, the goals are realistic given the progress made from 1990 to date, but at the same time it should be kept in mind that it becomes more difficult to make further improvements. Continued attention to key interventions is therefore required.

**Figure 3.1 – Indicators for Millennium Development Goals (MDGs), Progress during 1990-2000 and Projections to Reach the MDGs by 2015**

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**Malnutrition Prevalence, weight for age (% of children under 5)**

- **1990**: 70
- **2000**: 60
- **2015**: 50

---

**Infant Mortality Rate (per 1,000 live births)**

- **1990**: 100
- **2000**: 80
- **2015**: 60

---

**Under-5 Mortality Rate (deaths per 1,000)**

- **1990**: 150
- **2000**: 100
- **2015**: 50

---

**Maternal Mortality Ratio (per 1,000 live births)**

- **1990**: 6
- **2000**: 4
- **2015**: 2

---

**Births attended by skilled personnel (%)**

- **1990**: 20
- **2000**: 80
- **2015**: 100

---

**Actual Progress**

- - - Proposed target under accelerated social development strategy

Source: Ministry of Health and Family Welfare, GOB, 2002
3.3 Government Programs to Address Key Health Challenges

The overall improvements in living conditions leading to a decline in malnutrition, provision of safe water, better sanitation and education, especially among women, and birth spacing are among the main factors behind the decline in mortality and improvement in health indicators. However, preventive and curative health services targeting children through interventions like immunization, provision of oral rehydration and proper treatment of acute respiratory infections have no doubt also contributed significantly to health improvements. The government is making significant efforts to further improve the health situation by implementing various preventive and curative interventions with the support from the development partners. Some of the key interventions are described in the following section.

3.3.1 Essential Services Package

The Essential Services Package (ESP) implemented under the Health and Population Sector Project (HPSP) includes reproductive health care, child health care, communicable disease control, and limited curative care (World Bank, 1998).

The reproductive health care (RHC) component of the ESP consists of safe motherhood, family planning services, prevention and control of reproductive and sexually transmitted infections and infertility, adolescent care, and neonatal care. The safe motherhood component of RHC encompasses Essential Obstetric Care (EOC), including antenatal care, tetanus toxoid immunization, detection and management of pregnancy complication, screenings of high-risk pregnancies, attendance at delivery by trained staff, obstetric first aid, referral, and provision of services for complicated delivery and post-natal care.

The child health care (CHC) component of the ESP comprises basic preventive and curative care for infants and children, including control of acute respiratory infections (ARI), diarrheal disease, vaccine-preventable diseases, and malnutrition, including micro-nutrient deficiencies.

The cost of the ESP was estimated at 171 taka per capita (US$ 3.3) in 2001 (Ensor, 2001). A public expenditure review estimated that the spending on ESP by component was 33% for child health, 18% for maternal health, 4% for reproductive health, and 30% for family planning (Ministry of Health and Family Welfare, GOB, 2001). The costs in real terms of key essential interventions are given in Table 3.5.

Table 3.5 – Costs of some key essential interventions in health care

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Cost (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six month DOTS treatment for TB</td>
<td>10.00</td>
</tr>
<tr>
<td>Five days of antibiotic treatment of ARI</td>
<td>0.27</td>
</tr>
<tr>
<td>Giving one dose of measles vaccine</td>
<td>0.26</td>
</tr>
<tr>
<td>Oral rehydration of a case of diarrhea</td>
<td>0.33</td>
</tr>
<tr>
<td>Treatment of a sexually transmitted infection</td>
<td>11.00</td>
</tr>
<tr>
<td>One course of first-line treatment of malaria</td>
<td>0.12</td>
</tr>
<tr>
<td>An insecticide-treated net for prevention of malaria</td>
<td>3.00</td>
</tr>
<tr>
<td>One disposable home delivery kit for mother and baby</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Family Welfare, GOB, 2002

17
The implementation of the ESP has met considerable access problems. Data from the DHS survey showed that 27% of caretakers used one or more ESP services when their child fell ill. This was a lower number than earlier surveys in 1996-1997 which showed 33% use rate.

A study by Ensor et al (2002) showed that the ESP is helping to target resources to priority services, but that there are major barriers to access for vulnerable groups. To improve ESP performance it was suggested that access to key services should be emphasized, that efficiency of service provision should be improved and that financial control should be modified so that allocations could be more responsive to priorities set (Ensor et al, 2002).

### 3.3.2 Child Health Programs

Two other health programs of great relevance to child health are the Integrated Management of Childhood Illness (IMCI) and the Expanded Program on Immunization (EPI).

The Government of Bangladesh adopted the IMCI strategy in 1999 as a new way forward to reduce childhood mortality and morbidity. IMCI combines curative and preventive interventions to address the major conditions contributing to morbidity and mortality in childhood, including diarrhea, ARI, malaria, measles and malnutrition. It includes actions at three levels, namely to improve health workers’ skills, strengthen the health system, and improve family and community practices for child health and development.

The IMCI is currently implemented in three pilot upazilas. Initial efforts focused on training of health workers in first-level health facilities. The range of interventions in the three pilot areas will be expanded in 2003. The IMCI working group is planning to expand IMCI in 10 new upazilas in 2003 and to extend the range of interventions in the three pilot upazilas. In addition, NSDP is planning to use IMCI as the main strategy to improve quality of care in 55 clinics supported as part of the project, and to train depot holders in the provision of community-based care for major childhood conditions (including ARI) (WHO, 2003b).

### 3.3.3 Expanded Program on Immunization (EPI)

The morbidity and mortality from five of the six diseases covered by the national immunization program (diphtheria, tetanus, whooping cough, polio, measles) have decreased considerably over the last decade. The proportion of children reached by the immunization Program has however gone down since 1993 when it reached its peak. The National Coverage Evaluation Survey (CES) for the year 2000 showed that 53% of targeted children were fully immunized (WHO and John Snow Inc., 2002). This leaves 1-1.5 million children unprotected each year. Hence, the pool of non-immunized children and adolescents is gradually growing. High drop-out rates of 30-40% from the program are a persisting problem. The access to EPI services is measured by the coverage of DPT 1, which was 95% in 2000. The main challenge in EPI is to make caretakers bring their children back for a full immunization course (UNICEF, 1999).

The government must give high priority to increasing immunization coverage. Immunization has been extended to the communities through EPI outreach centers. There is a need to reinforce the health workers carrying out these activities. Special efforts to eliminate polio are being

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4 The sixth disease is tuberculosis for which the vaccine in the program only provides some protection.
supported by the donor community. National Immunization Days (NID) with polio vaccines are conducted successfully each year.

### 3.3.4 Maternal Health

A number of project activities have been initiated to reduce maternal mortality. The government has adopted a National Strategy for Maternal Health (Ministry of Health and Family Welfare, GOB, 2001b) after an extensive consultative process with stakeholders.

The principles of the strategy are to

- focus on emergency obstetric care for reducing maternal mortality
- provide essential obstetric care/basic maternity care for promotion of “good practices”, early detection and appropriate referral of complications
- promote women’s access to resources
- improve quality of services

Some of the targets for 2010 set by the strategy are to increase the met need of Emergency Obstetric Care (EmOC) from 27% to 70%, increase uptake of antenatal care to 60%, increase skilled attendance rate at deliveries from 13% to 50% and perinatal care to 30% from a baseline of 2%. In addition, a number of other targets are set, such as to increase weight gain during pregnancy, incidence of low birth weight, prevalence of anemia etc.

The National Strategy for Maternal Health states that a “clear policy will be determined on what should be the roles and means of involving NGOs in ESP service delivery, especially, maternal health programming. This is particularly important in the urban context” (Ministry of Health and Family Welfare, GOB, 2001).

Some of the main constraints on maternal health programs are lack of skilled personnel, weak management capabilities and limited resources. It has been suggested that higher priority should be given to more training and utilization of midwives at peripheral level.

### 3.3.5 National Tuberculosis Program

The National Tuberculosis Program (NTB) is making progress and the cure or treatment completion rate of those found sputum positive was 84% in 2000. All thanas are now covered by the NTB. The case detection rate is still on the lower side though, estimated at 29% in 2000. The target for case detection was set at 70% for the year 2000. That target has now been moved back to 2005 (Streatfield et al, 2001). Clearly, TB control will remain a high priority in the coming years. The fact that NGOs like Damien Foundation and BRAC are involved in the program make it particularly interesting from the perspective of public-private partnerships.

### 3.3.6 National Nutrition Program

The GOB adopted the National Plan of Action for Nutrition (NAN) in 1997. The NAN has adopted an inter-sectoral strategy and is supporting activities across all sectors relevant to nutrition. The strategy is to involve managers at all levels in the society (district, thana and
ward) in the policy making and implementation of nutrition activities, and to develop a workable and effective coordination mechanism between sectors in a cost effective manner.

The most significant manifestation of the government’s commitment to tackling malnutrition to-date has been the implementation of the Bangladesh Integrated Nutrition Project (BINP), as a large pilot to be scaled up nationally if successful. The project covered 60 sub-districts in the country with community-based nutrition interventions, and succeeded in changing household behaviors related to feeding and eating practices as well as other related health behaviors. Using growth monitoring and promotion as the central strategy, this project sought to reduce malnutrition among children under five and among women. While an independent end-line evaluation is currently under way, data from project records suggested the successful achievement of project objectives. The project used food supplements to targeted children and women as a demonstration tool in an attempt to bring about behavior change. The project also tried to build national capacity to deal with malnutrition and had an inter-sectoral component as well. One of the key reasons for the success of BINP has been the strong and effective partnership between GOB and NGOs, which was a first in the early 1990s.

BINP has been succeeded by the National Nutrition Project (NNP), which aims to cover 140 sub-districts. But this latter project has been suffering from serious implementation delays due to early disagreements between the Government and the financing development partners. Those issues have recently been resolved and implementation has just begun. It is critical that the momentum of BINP not be lost, if continued improvements in nutrition are to be achieved.

Some other activities carried out within the health sector to improve the nutritional status are distribution of vitamin A-capsules to all children under six years of age, control of iodine deficiency (IDD) through iodization of salt and health education, and breast feeding promotion.

3.3.7 Family Planning Activities

Despite the remarkable declines in the birth rate and consequently the population growth rate, Bangladesh remains the most densely populated country in the world (excepting city-states) and hence population control is still a serious concern. Family planning activities have been successfully implemented over the years. Contraceptives have been distributed through the family planning workers who have reached out in the community. Health education on the benefits of a small family size and the health implications of birth and pregnancy control has been carried out through personal contact, media and other communication channels. As a result the general awareness of the people has been raised.

At the current growth rates, it is expected that the population would more than double in about 50 years, adding more than 100 million persons to this country. Out of such population growth, 82% is estimated to come from the population momentum, the natural growth that is due to the fact that Bangladesh’s population is very young. The main way of reducing this natural growth is to encourage people to postpone the age of marriage and adopt a small family norm. This requires continued emphasis on BCC as well as the availability and widespread use of contraceptives.
Chapter 4. The Provision of HNP Services in the Private Sector

By far the main suppliers of clinical care to Bangladeshis are the alternative private practitioners (APPs), who include partially qualified or unqualified allopathic and non-allopathic practitioners, and village pharmacists. The best estimate is that APPs outnumber all qualified allopathic physicians by about 12:1.

Bangladesh has one of the lowest nurse to population ratios in the world. The challenge is not only to increase their numbers, but to enhance the role and quality of nursing care. The widespread use of unqualified workers as “nurses” is a serious cause for concern. Although physicians are also in short supply, they outnumber nurses by 1.7 to 1, compared to an average ratio of 0.6 to 1 among low-income countries. The government invests relatively heavily in the education of physicians compared to other providers. Current plans to expand the numbers of physicians ought first to address the existing problems in the production and retention of physicians. New findings in this study show a significant “brain drain” of doctors migrating to high-income countries.

Other than traditional birth attendants and nurses, male health providers far outnumber females: by 4 to 1 among qualified doctors and by 9 to 1 among APPs, which results in significant gender disparities in access.

New findings indicate that there are important deficiencies in the technical quality of care, especially though not only by APPs. Institutions and mechanisms to promote quality in the health sector are lacking, in the public as well as private sectors. This is an indication of a high likelihood of poor quality. There is little experience in Bangladesh in strategies to influence where or how private providers practice medicine, critical factors for improving access, quality, pricing, and accountability of health services. Not surprisingly, the largest and least measured group of providers, the APPs, is also the least influenced by current public policies.

The government could make the biggest gains in ensuring the provision of health services by vigorously and systematically tackling quality issues, and by beginning large experiments to learn how to monitor and influence the most significant group of health providers, the APPs.

4.1 Introduction

This chapter deals with the issues related to supply side factors of private health services, specifically examining the health labor market and private health infrastructure. We begin by examining the different types of private sector actors, distinguishing between the supply of qualified physicians, nurses, other paramedical workers, as well as the informal market comprising traditional practitioners and other village doctors. In the last section of the chapter, we outline what is known about the types of private health facilities, particularly the different types of inpatient and outpatient facilities, pharmacies, and laboratory services. In the chapter

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5 Greater details on the labor market of HNP sector in Bangladesh can be found in the background study on the health labor market, which was financed by CIDA and is a part of the overall AAA work. This chapter’s treatment of the labor market discusses key aspects about the supply of services.
that follows, we explore the demand perspective of private health services, examining what private health services people use, and the reasons why they use them.

This chapter deals briefly with the supply of health goods, notably the private producers and distributors of important health commodities such as contraceptives, bed-nets, oral rehydration fluids, and infant formula and feeding supplements. However, we do not examine other private key input markets such as manufacturers and distributors of pharmaceuticals, medical equipment, construction of buildings, or those markets providing non-clinical services such as maintenance, hospital kitchen and laundry services, or technical assistance.

4.2 The Actors

Health providers can be distinguished by the system of medicine they practice, and whether or not they are qualified to practice in that system of medicine. Because of the wide variety in classifications of providers that have been used in Bangladesh, we are forced to make some simplified if arbitrary labels for the providers, making more refined distinctions where possible. In this report, we divide the health providers between those qualified allopathic providers who receive formal education and are formally recognized through qualifications that allow them to be registered with a public agency (e.g. doctors, nurses, and trained paramedicals who practice “western” or “scientific” medicine), and providers who do not have formalized training and recognized qualifications in allopathic medicine, whom can be disaggregated into alternative private practitioners and traditional midwives (dais). The alternative private practitioners (APPs) include practitioners of traditional or non-allopathic systems of medicine (who may or may not have received schooling in these systems of medicine), and non-qualified allopathic providers. It is observed that increasingly, many APPs actually practice an eclectic mix of medical systems, with many self-declared traditional providers actually prescribing allopathic medicines (Sarder and Chen, 1981; Claquin, 1981; Bhuiya, 1992; ORQ-Marg Quest Ltd., 2000ab). The main sub-categories of alternative private providers include:

Allopathic providers

- Non-qualified allopathic providers, who in some studies are called village doctors. These providers have not received formal education to practice allopathic medicine, although some have received some semi-formal training, including the palli chikitshaks trained through a short-lived government sponsored program that ended in 1982

- Pharmacists who supply allopathic or other medicines, but who do not have formal qualifications to diagnose illness or prescribe medicines. In some studies, these providers are included in the same category as village doctors.

Traditional Providers

- Kabiraj who practice an ayurvedic system medicine, based on ancient Hindi systems of medicine and commonly involving diet, herbs, and exercise. Some of these providers have been formally trained in ayurvedic colleges.

- Totka who combine ayurvedic, unani (a traditional Muslim system of medicine), and shamanistic systems, but who tend to not follow a unifying system for explaining illness
or health. They may use allopathic medicines as well, though many will use herbs in the diagnosis or treatment.

- Spiritual healers, who follow various traditional belief systems involving supernatural causation or cure for disease, who often rely on chants or sacred readings in their treatment.

- Homeopaths, who follow the homeopathic system of medicine, which originated in Germany, and involves treatment through minute quantities of the presumed cause of disease. In some cases, homeopathic providers in Bangladesh have been formally trained and recognized in homeopathy.

The distinction between the public and private sector providers is not always clear. The public sector employs only qualified allopathic doctors (i.e. doctors with a minimum of an MBBS degree), qualified nurses, qualified pharmacists, and some cadres of qualified paramedicals (e.g. medical assistants and laboratory technicians). A considerable proportion of allopathic doctors and other formal sector providers also work entirely in the private sector (see below). Many of the public sector doctors also practice privately, either by working at private clinics and hospitals after public hours (dual job-holding), or by charging private fees while practicing at public facilities. In this chapter, we consider this type of practitioner as first a public sector health worker, even if their participation in the private sector dominates their time and income. Providers from the informal sector can also be considered to be operating entirely in the private sector, although the government has had a number of programs to involve dais in family welfare programs, and for that reason may consider them and other health workers part of a public health workforce.

Private providers are clearly a heterogeneous group, differing in their training, legal status, nature of service, mix of public and private practice, and type of organization (Table 4.1). The consequence of this is that some types of providers are less visible for study or regulation, making it difficult to ascertain the true size or nature of the private sector. This is particularly the case for those that are not formally trained and are practicing illegally.

**Table 4.1 – Visibility of Private Health Providers According to Selected Characteristics**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>More Visible</th>
<th>Less Visible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal status and training</td>
<td>Formally trained and operating legally (e.g. doctors, nurses, pharmacists)</td>
<td>Informal – untrained and illegal (e.g. shopkeepers, itinerant vendors)</td>
</tr>
<tr>
<td>Organization</td>
<td>Incorporated for-profit or non-profit organization</td>
<td>Unincorporated solo practitioners</td>
</tr>
<tr>
<td>Size of facilities</td>
<td>Large hospitals, networks of clinics</td>
<td>Solo practitioners</td>
</tr>
<tr>
<td>Nature of service</td>
<td>Comprehensive clinical care</td>
<td>Single product or service (e.g. drugs)</td>
</tr>
<tr>
<td>Public-private mix</td>
<td>Full time public practice or legal dual practice</td>
<td>Illegal dual practice</td>
</tr>
</tbody>
</table>

Source: Adapted from Smith et al, 2001
Despite the difficulties in obtaining precise estimates on the number of health providers, it is clear that the private sector outweighs the public sector, and that APPs in particular constitute the bulk of health providers in Bangladesh. As illustrated in Table 4.2, it has been estimated that 50% of doctors, 42% of nurses, 65% of paramedicals, and 100% of APPs are in the private sector. The APPs outnumbers qualified doctors by 12 to 1. It is not clear whether those who claim to be traditional practitioners actually outnumber the unqualified allopathic providers, as the ranges on the estimates are quite wide, and many of the traditional practitioners also practice allopathy. In subsequent sections, we'll examine the issues concerning the different types of health providers in more detail.

International comparisons on health personnel are difficult to make, because of the differences in the definitions of health workers, and the poor quality of data in most countries. Yet even with these limitations, some conclusions can be drawn about Bangladesh. Compared to other countries, the number of qualified physicians and nurses in Bangladesh are quite low (Table 4.3). One striking finding is that Bangladesh has very low physician and nurse to population ratios, even in comparison to other low-income countries and most other countries in the region. The other striking finding is that the physician to nursing ratio in Bangladesh is very high; among all low-income countries, only Pakistan has a higher ratio. Out of 183 countries with data on physician numbers, Bangladesh ranks 41st from the bottom for physicians per population. Yet when comparing the number of nurses per population, only Nepal, Liberia, and Central African Republic have fewer nurses than Bangladesh. The implications are that more than nearly any other country in the world, Bangladesh needs to consider how to increase the number of practicing nurses while also coming up with creative strategies to deal with the physician shortage.
### Table 4.2 – Estimated Numbers of Health Providers in Bangladesh

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Midrange Estimate of Number in 2001</th>
<th>Midrange Providers per 100,000 Population</th>
<th>Percent Private Sector</th>
<th>Low Estimate Providers per 100,000 Population</th>
<th>High Estimate Providers per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formal Allopathic Sector</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors&lt;sup&gt;6&lt;/sup&gt;</td>
<td>23,000</td>
<td>19</td>
<td>50%</td>
<td>11 (HRDU, 1997)</td>
<td>23 (HRDU, 2003)</td>
</tr>
<tr>
<td>Nurses&lt;sup&gt;6&lt;/sup&gt;</td>
<td>13,000</td>
<td>11</td>
<td>42%</td>
<td>11 (CSIP, 1995)</td>
<td>15 (PRU, 2002)</td>
</tr>
<tr>
<td>Paramedicals</td>
<td>81,000</td>
<td>66</td>
<td>65%</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Informal Sector</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternative private practitioners</td>
<td>284,000</td>
<td>231</td>
<td>100%</td>
<td>77 (Ali, 2001)</td>
<td>473 (Sarder &amp; Chen, 1981)</td>
</tr>
<tr>
<td>Allopathic providers</td>
<td>110,000</td>
<td>90</td>
<td>100%</td>
<td>38 (Claquin, 1981)</td>
<td>145 (ORQ-Marg Quest, 2000)</td>
</tr>
<tr>
<td>Traditional providers</td>
<td>173,000</td>
<td>141</td>
<td>100%</td>
<td>50 (Claquin, 1981)</td>
<td>239 (Ali, 2001)</td>
</tr>
<tr>
<td>Dais (Traditional Birth Attendants)</td>
<td>119,000</td>
<td>96</td>
<td>100%</td>
<td>14 (Claquin, 1981)</td>
<td>549 (Sarder &amp; Chen, 1981)</td>
</tr>
</tbody>
</table>


### Table 4.3 – International Comparisons of Physician and Nursing to Population Ratios (Around 1998)

<table>
<thead>
<tr>
<th>Country</th>
<th>Physicians per 100,000 population</th>
<th>Nurses per 100,000 population</th>
<th>Physician/Nurse Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>19</td>
<td>11</td>
<td>1.8</td>
</tr>
<tr>
<td>India</td>
<td>106</td>
<td>94</td>
<td>1.1</td>
</tr>
<tr>
<td>Nepal</td>
<td>4</td>
<td>5</td>
<td>0.8</td>
</tr>
<tr>
<td>Pakistan</td>
<td>57</td>
<td>34</td>
<td>1.7</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>37</td>
<td>103</td>
<td>0.4</td>
</tr>
<tr>
<td>Global Average</td>
<td>146</td>
<td>334</td>
<td>0.4</td>
</tr>
<tr>
<td>Global Median</td>
<td>114</td>
<td>233</td>
<td>0.5</td>
</tr>
<tr>
<td>Low Income Countries</td>
<td>73</td>
<td>132</td>
<td>0.6</td>
</tr>
<tr>
<td>Middle Income Countries</td>
<td>142</td>
<td>278</td>
<td>0.5</td>
</tr>
<tr>
<td>High Income Countries</td>
<td>286</td>
<td>750</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Source: WHO, 2003c and author’s calculations

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<sup>6</sup> Doctors and nurses are here considered as public sector providers if they are employed by the public sector, even if they also practice privately. This leads to an under-estimate of the proportion of these categories in the private sector. The more appropriate approach would be to count dual practitioners under both the public and the private sectors. While that would be double-counting those providers, it would lead to a more accurate reflection of the respective share of the market held by the public and private sectors.
In addition to examining the types of providers, we also look at the types of places where they work. The types of health facilities we examine include hospitals, which we define as health facilities that have inpatient (or “indoor”) facilities to treat patients overnight. Clinics, or “doctors chambers”, are defined as facilities where only outpatient (“outdoor”) treatment is provided, whether it is offered in a separate building, or in the home of the provider. Pharmacies are considered as facilities where pharmaceuticals are dispensed. In many cases, it may be difficult to distinguish clinics from pharmacies, though a distinction can be made between those pharmacies that are officially registered with government, and those that are not. Laboratories are defined as health facilities that provide diagnostic services only, such as pathology, biochemistry, hematology, microbiology or radiology services.

4.3 Physicians

There is no precise count of the number of physicians who are actively practicing in Bangladesh today. As of March 2003, the Bangladesh Medical and Dental Council (BMDC) reported a cumulative total of 34,541 physicians registered. As shown in Figure 4.1, the number of graduates was fairly steady over the 1990s, and has increased slightly in the 2000s, while the proportion of female doctors has increased from 9% in 1975 to 38% in 2002. A survey of their membership registered through 2000, however, returned only 9,988 responses (BMDC, 2003). In contrast, the Human Resources Development Unit relates that the BMDC reports that up until 2002, Bangladesh has 28,537 doctors (HRDU, 2003). In 1998 an HEU report made reference to a 1997 HRD project, based upon a 1993 census, reporting there to be approximately 13,200 practicing physicians with an additional 2,800 abroad and 2,000 unemployed. The same paper also referred to a Bureau of Statistics report on the Survey of Professional and Miscellaneous Services Personnel, which reported that there should have been 22,356 doctors in 1993-1994 based upon the same 1993 census.

Figure 4.1 – Bangladesh Medical and Dental Council Registrations by Year and Sex

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7 In the Medical Establishments Survey 1997-98 (BBS, 1998), hospitals are defined as facilities that have both indoor and outdoor facilities, while clinics and nursing homes are defined as facilities that have only indoor treatment. In our analysis, we treat them both as hospitals.
Registered doctors work in both the public and private sectors, but estimates of those working only in the public sector are difficult to come by. In the BMDC survey, 27% of respondents reported they were only in the public sector (BMDC, 2003). However, 39% reported mixed public employment with private practice. Another study reported that 69% of practicing physicians were in the public sector, but the percentage of those who also had a private component was not given (HRDU, 2003). The estimated percent of those working exclusively in the private sector varies from 22% (BBS, 1998) to 31% (Health Economics Unit, 1998b) to 34% (BMDC, 2003) to 50%.

“Brain drain” is another serious problem for Bangladesh, with many physicians leaving the country to work elsewhere (See Box 4.1).
Box 4.1 – The Brain Drain in the Health Sector in Bangladesh

The loss of trained medical personnel from developing to developed countries, known as “brain drain”, is a long-standing problem (Chanda, 2002; Pang et al, 2002). Brain drain is driven by both push and pull factors. Among the pull factors are the attraction of the potential for higher income and professional advancement, access to the latest in technology, and better working, living and educational opportunities for the physician and his or her family. It is estimated that 56% of all emigrating physicians move from less developed to more developed countries, with the major destinations being Australia, the United Kingdom, the USA, and countries of the Eastern Mediterranean (Chanda, 2002). Push factors include poor pay and working environments, fear of violence, political oppression, and discrimination (Pang et al, 2002).

While less developed countries have some control over “push” factors, they have virtually no control over the pull factors which cause the loss of physicians in whom their society has made a significant investment. In a background study examining graduating MBBS classes from three Bangladesh medical colleges, it was found that more than 20% of the 1975 graduating class had emigrated, compared nearly 28% of the 1985 cohort, with an annual loss of nearly 1.5% of doctors graduating between 1975 and 1995. The USA, Saudi Arabia, and the UK are the most common countries of emigration. Further details about the physicians and their characteristics may be found in the Labor Market Assessment (Peters et al, 2003).

The total cost of losing a doctor can’t be easily measured. However, the costs of medical education can be reasonably determined. There are currently 13 medical colleges in the public sector (five of which are new and financed through the development budget), and 20 non-governmental medical colleges (HRDU, 2003). Estimates for the cost of medical education for an MBBS degree varies between established public schools, newly opened public schools and private schools. Based upon a weighted average of 5 established public medical colleges, it is estimated that Tk 250,000 (US$5,000) is spent over the average of 5.8 years it takes to produce an MBBS graduate (Health Economics Unit, 1998a). A comparable figure for a 5 year program at Dinajpur Medical College, a new public school, (including costs of establishing the school and annual recurring costs) is Tk 491,000 (US$10,000). Private schools are the most expensive with total costs estimated to be between Tk 800,000 and 1,000,000 (US$16,000-20,000) (HRDU, 2003). This cost will likely increase in light of the plan to implement a new curriculum.

4.3.1 Income/Incentives/Disincentives for Physicians

Estimates of income vary by type of practice and level of experience. In a survey of private health service establishments, average monthly income varied from Tk 7,500 to Tk 150,000 (US$ 150 to US$ 3,000) with the majority of the practitioners earning incomes at the lower end. However, 95% of those sampled also had some public component to their income (BBS, 1998). In a separate study of public employees who also had a component of private practice, 79% reported a monthly government salary between Tk 5,000-10,000 (US$ 100-200), 16% had salaries up to Tk 15,000 per month, and 5% earned Tk 5,000 or less. As for their private salary component, 19% earned less than their government salary, 21% earned an amount similar to their
government salary, and 56% earned more. The overall average total income was Tk 27,500 (US$ 550) per month. In the absence of third party payments and reliable income tax information, these numbers are likely to be underestimates even though efforts were made to verify them (Gruen et al., 2002). It is estimated that only 12% of doctors are listed by the National Board of Revenue, which is the agency responsible for tax collection (UNB, 2002).

As noted above, many physicians earn their income from dual public and private practice. This combination allows them to maximize the benefits they receive from each type of practice. By and large, the same types of services are offered in both settings although facilities and attention to individual patients tend to be better in the private sector. Physicians report that a government position increases their reputation, although younger doctors express this more. Doctors at the PHC level even said they would abandon private practice if their government salaries were higher. The appeal of public practice also lies in the job security, a public pension and, for some, the opportunity to teach medical students and be of service to the poor (Gruen et al., 2002).

Disincentives for private practice in the rural areas include lower purchasing power, competition with other doctors in urban areas and with alternative private providers, and a weak infrastructure. Another area of concern is harassment from “local mafia-like structures (mastaans)” (Gruen et al., 2002). Security is a concern of physicians in both the public and private sector, particularly for those serving in rural areas. Another difficulty with recruiting and retaining doctors for rural areas is that most physicians are highly educated and come from urban backgrounds. They are reluctant to give up that life and certainly don’t want their children to be deprived of the opportunities available in cities (Chaudhury and Hammer, 2002). In this study of absenteeism, determinants of physicians likely to attend their rural postings include living in the same local as the clinic, access of roads, and electrification. Two factors which physicians report they would like to see improved are increased opportunities for continuing medical education and increased regulation of the private sector by the government (Gruen et al., 2002).

In an extensive survey done for the MOHFW on incentive schemes for public sector doctors and other health workers, the most frequently mentioned source of dissatisfaction was “lack of promotion”, followed by “low salaries”. The lack of consequences for poor performance and non-recognition of good work was problematic. Complaints of inadequate residential and clinical facilities, lack of access to quality health care for the physicians and their families, physical and social insecurity, and concerns about management were also voiced (Figure 4.4) (SRGB, 2002).

4.3.2 Quality of Care Provided by Physicians

One of the most important aspects of the performance of doctors is the quality of the care they provide. However, apart from the BMDC registration requirements, there is little assessment or reporting on the quality of physician care in Bangladesh, whether practicing in the public or private sectors. In a background study on private practitioners, it was found that about 90% of private hospitals maintained patient records, nearly 60% used standard treatment protocols (HEU/IHE/NIPORT, 2003) (Figure 4.2). Nearly all facilities claimed to use safe disposable syringes. 98% of private physicians appropriately recommended ORS for treatment of acute diarrhea, but only two-thirds correctly identified the need to do a sputum test to assess a suspected case of tuberculosis, and only 61% would correctly do an examination for a woman with post-partum bleeding. Though limited in scope, these findings show that there is significant
room to improve the technical quality of care among private practitioners. In Chapter 5, we will also examine perceptions of quality of care from the patient’s perspective.

**Figure 4.2 – Percentage of Private Hospitals using Medical Protocols to Treat Patients**

![Percentage of Private Hospitals using Medical Protocols to Treat Patients](image)

Source: HEU/IHE/NIPORT, 2003 and authors’ calculations

### 4.4 Nurses

Even though the estimates on the number of nurses working in Bangladesh are not consistent, by any standard, the number of qualified nurses is very low. As of February 2003, the Bangladesh Nursing Council reported a total of 19,066 nurses (93% female) in their registry. Distribution by year of registration and sex is shown in Figure 4.3. However, it is not clear how many nurses are actually employed in Bangladesh. A 1997 study reported 13% unemployment with another 20% of nurses working overseas (Health Economics Unit, 1998a). Another estimate is that approximately 2,000 nurses are estimated to be working in the Middle East (10%) and 7,000 (37%) are unemployed (BNC, 2003). Based on a national census of professional services personnel, there were just over 12,000 nurses working in 1993-94, a ratio of nearly 11 nurses per 100,000 population (CSIP 1995). As noted above, this is one of the lowest proportion of nurses to population anywhere in the world, as well as one of the higher doctor:nurse ratios (1.7:1). One contributing factor is that in Bangladesh, 95% of nurses work in hospitals and clinics in urban settings. Unlike other countries, nurses are not trained or employed as public health clinicians for rural settings.
Nursing “brain drain”, like its doctor counterpart, has been recognized by a number of developed countries that are creating guidelines to limit damage to developing countries (Buchan, 2000). However, data on immigration of nurses from Bangladesh to other countries is not available, and a survey of Bangladesh nursing graduates did not produce meaningful results on the magnitude of the problem. Given the longstanding global shortage of nurses, it is likely that many nurses that are qualified to work in other countries would emigrate there if employment opportunities remain poor in Bangladesh. However, physical and human resources at nursing training facilities are in poor condition, and the vast majority of students and teachers are not able to adequately use the English language, which is the language of instruction and a requirement for work in many other countries (Peters et al, 2003).

The nursing market in Bangladesh is further undermined by a lack of standards and regulation. To obtain work in private clinics, qualified nurses must compete with unregistered individuals who act as nurses, even though they may have minimal private training to give injections and provide unskilled care to patients. The average monthly salary of registered nurses is Tk 8,700-10,000 (US$ 200-230) in the public sector, though unqualified nurses may work much lower wages in private clinics (Begum, 1998). Low salaries and lack of promotion appear as some of the major concerns of public sector nurses, who share many of the same concerns about incentives as physicians (Figure 4.4).

The challenges of enhancing the role of nursing, improving the quality of nursing education, and better regulating the nursing market are at least as important as increasing the number of nurses in Bangladesh. In order to deal with a growing population and maintain the ratio with physicians, it is estimated that by 2020 an additional 20,567 nurses would need to be trained. If one wanted to improve the doctor:nurse ratio to 1:1, an additional 45,649 nurses would be required (HRDU, 2003). Before accounting for losses due to retirement, emigration, and leave, this would require more than doubling the current output of nurses.
Figure 4.4 – Causes of Dissatisfaction Among Doctors and Nurses in the Public Sector

<table>
<thead>
<tr>
<th>Cause of Dissatisfaction</th>
<th>Doctors</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Salary</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>No Promotion</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>Lack of Manpower</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Evaluation of Service</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Working Facility</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Residential Problems</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Intrusion of Outside</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: SGRB, 2002

4.5 Trained Paramedicals

There are many types of paramedical professionals practicing in Bangladesh, though there is little reliable information on their numbers or types of practices. Most of the paramedical schools require a grade 10 or secondary school certificate (SSC) to enter their three-year training programs. As can be seen from Table 4.4, the public sector employs some types of specialized paramedical personnel trained specifically for public health functions, such as the Health or Family Planning Inspectors. On the other hand, the private sector has the dominant number of laboratory technicians (94%), medical assistants (89%), and pharmacists (69%); though in each case, it is doubtful that the private sector practitioners actually have the full educational qualifications as those employed in the public sector. The vast numbers of private sector personnel in these categories suggest that there is a considerable private market for the types of services they can provide. In the case of the medical assistants and pharmacists, they are likely also acting as physician providers, i.e. making diagnosis and prescribing treatment to patients.

Very little attention has been paid to paramedical professionals in Bangladesh, and coincidentally there is very little research or information on their practice. Basic questions concerning how paramedical professionals are trained or supervised, how they practice their professions, what their concerns are, or what contributions they are making to the health system have not been seriously addressed. Given the lower cost of training, and greater ability to select paramedical professionals from rural populations, the main strategic issue for Bangladesh is to consider whether paramedicals could take up more of the responsibilities in the health care system. This question is particularly relevant in considering options in remote areas where it is difficult to get MBBS doctors and registered nurses to be stationed in either public or private sectors.
Table 4.4 – Estimates of Health Workers in Bangladesh Other than Physicians and Nurses

<table>
<thead>
<tr>
<th>Provider</th>
<th>Public Sector 2002</th>
<th>Private Sector 1996-97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Assistant</td>
<td>5,598</td>
<td>45,603(^8)</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>7,622</td>
<td>1,789</td>
</tr>
<tr>
<td>Licensed pharmacists (without university or technology degree)</td>
<td>0</td>
<td>15,477</td>
</tr>
<tr>
<td>Laboratory Technicians</td>
<td>1,840</td>
<td>29,085</td>
</tr>
<tr>
<td>Radiographers</td>
<td>1,054</td>
<td>?</td>
</tr>
<tr>
<td>Health Inspectors</td>
<td>1,401</td>
<td>0</td>
</tr>
<tr>
<td>Family Planning Inspectors</td>
<td>4,110</td>
<td>0</td>
</tr>
<tr>
<td>Dentists (&amp; Dental Surgeons)</td>
<td>1,740</td>
<td>1,247</td>
</tr>
<tr>
<td>Other trained paramedical(^9)</td>
<td>3,574</td>
<td>?</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28,941</strong></td>
<td><strong>47,598</strong></td>
</tr>
</tbody>
</table>

Sources: Public sector From HRD Data Sheet 2002 (HRDU, 2003). Figures do not include other para-professionals, including Family Welfare Assistants (22,350), Health Assistants (21,016), Assistant Health Inspectors (4,202), and Family Welfare Visitors (5,248). Private sector Most categories are from BBS (1998), except for pharmacists (ORQ, 2000), which are likely under-estimates. The estimates do not include another 45,820 health related workers estimated to be working in the private health sector, and is intended to exclude those working as village doctors (BBS, 1998).

There are also a large number of auxiliary health workers who have shorter periods of training and lower entry requirements than the paramedical workers considered above. Many of these workers have been specifically trained for the public health workforce, including some 50,000 Family Welfare Assistants, Health Assistants, and Family Welfare Visitors, and an estimated 25,000 traditional birth attendants who have been involved in public sector programs (PRU, 2002). NGOs and government have also trained various types of community health volunteers, such as BRAC’s *Shasthyo Shebika* (Khan *et al.*, 1998). While the drop-out rate of community volunteers can be quite high, the success seems to be dependent on careful selection of volunteers, involvement of communities, supportive supervision, and good training (Islam *et al.*, 2002; Khan *et al.*, 1998; Arnhold, 1979). In the case of tuberculosis treatment, BRAC’s use of illiterate community volunteers turned out to be 50% more cost-effective than the comparison government program (Islam *et al.*, 2002). Around the world, the recurrent lesson has been that it is easier to initiate these programs than to appropriately select and maintain support for community health volunteers (Walt, 1988). Further opportunities for using community volunteers in Bangladesh should be considered only when it is clear that proper attention can be paid to the conditions that make community volunteers successful beyond an initial period, and where adequate monitoring can be sustained.

### 4.6 Alternative Private Practitioners

It has long been recognized that health providers in the informal private sector provide the majority of health care to the Bangladeshi people, particularly in rural areas (Claquin, 1981; Sarder and Chen, 1981). These providers are very well embedded into the culture and society of

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\(^8\) Probably includes many health providers who do not have a three-year Medical Assistant training

\(^9\) Other trained paramedicals includes Physiotherapists, Family Planning Officers and related professionals
Bangladeshi villages (Bhuiya, 1992; Feldman, 1983; Ashraf et al, 1982; Leslie, 1976). Alternative private practitioners (APPs) are also becoming more organized, forming their own professional associations in local areas. In Brahmanpara, nearly half of the village doctors had some kind of registration with a legal or professional body (ORQ-Marg Quest Ltd, 2000b). Despite the dominance of these types of providers, relatively little is known about the actual number of the different types of alternative private providers, the types of practices they have, or how their behavior can be influenced. Other than a brief period when government sponsored the *palli chikitshak* training program in the early 1980s, policymakers have largely ignored the informal sector.

### 4.6.1 Types of Qualifications and Practices

Formal training in traditional systems of medicine now exists in Bangladesh, with government recognizing nine unani colleges and six ayurvedic colleges with each having a four-year diploma course (BBS, 2002ab). Despite the presence of recognized colleges in alternative systems of medicine, the vast majority of APPs practicing in Bangladesh have not received formal education in their system of medicine. However, a substantial proportion of APPs have received some semi-formal health training. For example, 61% in the Brahmanpara study had some kind of certificate of training (ORG-Marg Quest Ltd, 2000b). Most traditional providers have had training through apprenticeship (Feldman, 1983; Sarder and Chen, 1981). Many of the traditional providers learn their trade from an *ustad* (expert teacher), usually through a short apprenticeship (Ashraf et al, 1982). In the Brahmanpara study (OMQ-Marg Quest Ltd, 2000b), where the village doctors appear to be largely allopathic providers, more than two-thirds were first generation providers. The general education levels among the allopathic providers tend to be higher in the allopathic providers compared to the traditional practitioners, with the majority of allopathic providers having completed junior secondary school, and many having completed high school (ORQ-Marg Quest Ltd, 2000ab; Bhuiya, 1992; Sarder and Chen 1981). The gender distribution of private providers, which may have important consequences for access to health care, is described in Box 4.2.

### Box 4.2 – Gender Distribution of Private Providers

With the exception of the traditional midwives, who are female, the alternative private providers are dominated by males, particularly the allopathic practitioners. In 1976-77, a nationwide survey found that 99% of alternative providers were male (excluding traditional midwives). In a census taken in Matlab thana in 1978; similar proportions of unqualified allopathic and homeopathic providers were male, whereas the *kabiraj* and *totkas* were more evenly distributed (Sarder and Chen, 1981). In the Brahmanpara study conducted in 2000, 98% of village doctors were male (ORG-Marg Quest Ltd, 2000b), a figure consistent with other small area studies (Cash et al, 2001; Bhuiya, 1992; Feldman, 1983). The obvious implication of such a male dominance of providers in a traditional rural society is that it is more difficult for women to access health care even through the alternative private providers. This issue is discussed further in Chapter 5 where the demand for and use of health services is considered.

One of the limitations of current information on village doctors is the inability to identify the degree of local variation in the provider markets. For example, Ashraf and colleagues (1982) noted that conditions were changing, and that the majority of curative care at the time of the study was provided by unqualified allopathic practitioners and drugshops, and that ayurvedic and
unani systems of medicine had largely disappeared. Winch (unpublished data, 2003) reports that there are large differences in the types of providers available in two study areas in Sylhet and Mirzapur. In the Sylhet study area, most of the providers use traditional systems of medicine, whereas in Mirzapur, allopathic medicine is more common. In Chapter 5, we will also see how people use different types of providers for different illnesses.

Most of what is known about the practice patterns of APPs comes from small area studies, making it difficult to generalize results to the entire country. APPs are known to provide services for a wide range of health conditions, though almost exclusively on an outpatient basis. Village doctors nearly always sell medicines (94% of village doctors in Brahmanpara; 95% of allopaths in Matlab), and the majority provides dressings. Kabiraj and totka providers are less likely to sell medicines, and many of the spiritual healers provide a much narrower range of services for a more limited set of conditions. Some providers, such as bonesetters, provide a very specific set of services. Similarly, most traditional birth attendants tend to provide services only for childbirth.

Most APPs provide services close to their population base. The allopaths and homeopaths tend to have a small building for their business in a local market or in the village (ORG-Marg Quest Ltd, 2000b; Bhuiya, 1992), as do those who are pharmacists (ORG-Marg Quest, 2000a). Traditional healers tended to operate from their homes, and are more likely to make home visits (Bhuiya 1992). Allopaths are more likely to work on a full-time basis than other providers (ORG-Marg Quest Ltd, 2000b; Sarder and Chen, 1983). In Claquin’s (1981) study, only 35% of APPs worked on a fulltime basis, seeing an average of 17 to 52 patients per week. In Brahmanpara, the village doctors nearly all worked fulltime, and averaged 18 patients a day (ORQ 2000). In contrast to these providers, traditional midwives averaged only two patients a week (Claquin, 1981).

4.6.2 Incentive and Disincentives of APPs

There are a few reports on the incomes and fees charged by alternative private practitioners, though both appear to be generally modest. Claquin (1981) reported that APPs charged between two to four Taka for consultation fees on average, which was equivalent to $0.12 to $0.25 at the time of the survey. However, fees for medicines could easily average 10 times this amount, with unqualified allopaths charging more than ayurvedics followed by homeopaths and spiritual healers. This level of nominal consultation fee and dependence on selling drugs was also found in Brahmanpara (ORG-Marg Quest Ltd, 2000b). In Brahmanpara, village doctors claimed to earn about Tk. 1,600 (US$ 32) per month from prescribing medicine to their patients, and another Tk. 2,200 (US$ 44) per month through other pharmacy sales.

There is little other information on the motivations of APPs, nor about their aspirations or practice constraints. The Brahmanpara study reported a near unanimous interest among village doctors in working in partnership with the public sector, though specific proposals were not assessed (ORG-Marg Quest Ltd, 2000b). Although there have been a number of projects that have attempted to work with APPs through training them, these are not well documented, and little is known about what strategies are effective in either improving their skills, preventing them from practicing illegally, or reducing the potential harm caused by poor quality services.
4.6.3 Quality of Services Provided by Alternative Private Practitioners

Poor quality of services is one of the major concerns regarding informal sector providers. In a detailed anthropological study on village practitioners in three villages, Ashraf and colleagues (1983) emphasized that a large variety of drugs are being prescribed, usually inappropriately. Because of a fatalistic attitude of the villagers, the health practitioners are rarely blamed or held accountable for poor practice. Bhuiya (1992) pointed out that understanding of the causes of diarrhea was quite limited among providers, and that only 60% of the providers used oral rehydration solution (ORS) for treatment, despite working in an area where ORS had been actively promoted for decades. He also pointed out that the allopathic practitioners were more likely to provide appropriate care for diarrhea than the indigenous practitioners. In a similar vein, Ali and colleagues (2001) found that access to allopathic practitioners (both qualified and unqualified) was related to lower childhood deaths due to pneumonia, whereas access to indigenous practitioners was related to higher mortality.

In the background study that surveyed different types of private health providers, various types of health providers were asked about how they would handle specific medical conditions (Figure 4.5) (HEU/IHE/NIPORT, 2003). With one exception, the correct medical care would include an affirmative answer to each of the responses shown in the figure (a newborn with pneumonia should be treated with antibiotics at a hospital, may not require a referral from a doctor who practices at a hospital). The results indicate a very low level of quality of care by the APPs in absolute levels, and in comparison to private hospital doctors. Among the APPs, the allopathic drug vendors performed slightly better than the homeopaths and traditional providers for childhood diarrhea and newborn pneumonia, but similarly badly for the appropriate investigations for suspected TB or management of a women with post-partum bleeding.
Figure 4.5 – Percent of Different Types of Providers Offering Appropriate Medical Care for Specific Medical Conditions

Source: HEU/IHE/NIPORT, 2003 and authors’ calculations

4.7 Health Facilities

Information on the numbers and types of private health facilities in Bangladesh is quite weak. In the public sector, there are precise counts on the locations and types of health infrastructure, though little is reported on how functional they are (i.e. staffed, equipped, and seeing a full complement of patients). Because most private practitioners operate out of small clinics or their homes, these types of doctor’s chambers are hard to enumerate, monitor, or regulate.

The last census of private health facilities was undertaken in 1997-98 (BBS, 1998). It focused only on facilities that had inpatient beds or provided laboratory services (Table 4.5). The data suggest that government inpatient facilities comprise about half (51%) of the total inpatient facilities, but a much larger majority of the hospital beds (72%). Just examining the number of registered private facilities would also seriously underestimate the number of private facilities: about 70% of the private inpatient clinics that were enumerated had been registered with the government. The majority of the other facilities had no type of registration, though some had obtained various types of licenses from local authorities. In another analysis of private clinics and hospitals in Bangladesh, the Health Economics Unit (1998a) found that only 27% of the 252
clinics sampled had been registered, with the largest growth in non-registered clinics occurring in the six years prior to the survey. Since the National Board of Revenue and the medical associations do not keep records on the location or number of private medical clinics, the true number of outpatient clinics, even from qualified allopathic doctors is not known, and is likely to be close to the number of health practitioners.

Table 4.5 – Estimated Number of Government and Private Health Facilities in 1997-98

<table>
<thead>
<tr>
<th></th>
<th>Government</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Registered</td>
<td>Unregistered</td>
</tr>
<tr>
<td>Hospitals</td>
<td>645</td>
<td>126</td>
</tr>
<tr>
<td>Hospital beds</td>
<td>29,106</td>
<td>--</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>0</td>
<td>314</td>
</tr>
<tr>
<td>Nursing Home beds</td>
<td>0</td>
<td>--</td>
</tr>
<tr>
<td>Total Inpatient facilities</td>
<td>645</td>
<td>440</td>
</tr>
<tr>
<td>Laboratories</td>
<td>NA</td>
<td>582</td>
</tr>
</tbody>
</table>

Source: BBS, 1998. The Health Economics Unit extrapolated from their sample to estimate that there were 584 private hospitals nationally (HEU, 1998a), compared to 613 reported here. NA – not available – laboratories in the public sector are nearly always part of public hospitals.

The largest gap concerning private health facilities is the absence of estimates on private outpatient clinics (or doctor’s chambers). As discussed above, APP tend to work out of a building, often their own home or place in the market. In many cases, it may be difficult to distinguish their places of practice from a pharmacy. But many public sector physicians and private MBBS doctors also have outpatient clinics, about which very little is known.

Given the limited information on even the number of health facilities in Bangladesh, particularly for outpatient clinics, it is obvious that there will be even less information available about their quality, efficiency, or pricing. As is discussed in Chapter 6, the current regulatory system of health facilities regulates only inputs (e.g. physical facilities, number of staff, availability of drugs), but does not address how the quality of clinical care is provided, or what kind of outcomes they produce. The lack of quality assurance systems in health care in Bangladesh has resulted in very little data available about the quality of care provided at health facilities, or the efficiency of their operations.

The HEU study (1998a) on 252 private medical hospitals provides a rare insight into their operation. Bed occupancy rates averaged only 56%, ranging from 12.5% to 97.5%. The average length of stay was 5 days, compared to about 7.2 days in the comparison government owned hospital. However, information on the case-mix of patients is not known, so the value of comparison is limited. The study did find that average return to capital was 38%, suggesting to the authors that private hospitals were making profits much larger than would be available in other sectors. This situation might occur because of relatively high barriers to enter the market, or may provide an explanation as to why there is a rapid expansion of private hospital facilities.

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10 Includes facilities that have obtained licenses from local authorities, comprising 8% of the total

11 Nursing homes have inpatient services but no outpatient services
The HEU study concluded that because facilities with a bed size of 11-20 beds had the lowest average costs, this was resulting in a large number of private facilities of this size.

To examine market barriers in a background survey on private providers, a background study of private hospital and clinic managers reported on some of their main business constraints (HEU/IHE/NIPORT, 2003). As shown in Figure 4.6, their main concerns are with motivating and recruiting qualified staff, problems with infrastructure, ability to purchase supplies, and uncertainty over government policies and regulations. Problems with electricity supply were universally reported as the main infrastructure problem. In contrast, issues related to obtaining credit, or with having a low demand are far less a concern to them. It may be that barriers to entry related to obtaining high quality personnel and supplies, and the difficulty of managing infrastructure problems, may allow the private hospitals to make substantial profits through high charges, and still keep a relatively high number of beds unoccupied. Caution is needed in interpreting these findings, as the survey was conducted on working facilities. If it were possible to study hospitals that were not able to start or had failed, the list of barriers might be quite different.

Figure 4.6 – Private Hospital Managers’ Opinions on the Business Environment

Turning to the laboratory facilities, it is clear from the number of people working as laboratory technicians in the private sector (over 29,000 in 1996-97) that the number of registered laboratories under-estimates the number of facilities providing laboratory services by a large factor. Given that the average laboratory employs nearly two laboratory technicians (and 5.6 staff on average), there would be about 16,000 laboratories in Bangladesh, compared to the 1,042 identified in the survey (BBS, 1998).
Two reasons that could explain the expected growth in laboratory services is that they are in high demand and they are very profitable. As new technologies become more available and more affordable, it is likely that these services are going to be demanded both by the public and by doctors. Data from the private health service establishment survey found that on average, laboratories performed about 28 tests per day, and had an annual operating profit (total income – total expenditure) of Tk. 404,000 (US$ 8,600) (BBS, 1998). The market is currently allowing for high profit margins on nearly all types of tests. The operating profits on nineteen laboratory tests examined in the same study was 175%, ranging from a low of 45% for plain x-rays of the abdomen, to 400% for mammography. Overall, the largest profits were being derived from blood sugar tests and hemoglobin examinations, and the least on x-ray procedures.

The large profits available from laboratories suggests that the market is in a rapid growth stage, with demand far outstripping supply, or that there may be barriers to entering the market that prevent competition from driving down prices. It is possible that equipment costs and technical ability to operate the machines are creating the conditions where laboratories can charge high prices.

Given the large profits involved in laboratory services, the issue of quality assurance becomes all the more important. In contrast to provider and hospital medical services, the quality of laboratory services is relatively more measurable, using standard sample selection techniques and reference laboratory standards. Quality assurance procedures should be easier to establish to assess the quality of laboratory test results. However, systems to monitor the quality of laboratory services do not exist in Bangladesh for all but a few laboratories that do so on their own, and largely for research purposes. The result is that the reliability and validity of most laboratory test results are unknown, despite the large amounts of money going into this market.

4.8 Other Private HNP Input Markets

Whereas a detailed assessment of the other input markets in health is beyond the scope of this study, it is important to recognize the scale and influence of these components of the private health sector. For example, in the pharmaceuticals market, there were 767 drug manufacturing units licensed in Bangladesh in 1997, another 1,353 drug wholesaling firms, and 33,975 retail trading firms (BBS, 2002a). Locally produced drugs were valued at US$ 312 million in 1997, accounting for 1.0% of GDP. Non-clinical contraceptive sales also rely on the private sector; about 40% of non-clinical family planning methods were distributed through private pharmacies in 1989 (BBS, 2002a). A more comprehensive study of the pharmaceutical sector would also need to consider the serious problem of spurious drugs, which have been known to cause grave danger to the health of Bangladeshi population, including women and children.

A significant proportion of health related commodities are supplied through private companies and organizations using social marketing techniques. Social marketing accounted for a total of 3.5 million couple-years of protection in 2001, which is 12.5% of the target market of 80% of all women of reproductive age (DKT International, 2003).

The Social Marketing Company (SMC) is the dominant player in social marketing in Bangladesh and distributes health related products to 200,000 retail outlets. SMC distributes 170 million condoms (70% of estimated use in Bangladesh) and 37 million cycles of oral pills (30% of estimated use) annually. In addition to reproductive health products, it distributes 105 million sachets of oral rehydration solution (ORS), which accounts for about 60% of estimated use
ORS was first marketed in Bangladesh in 1986, and has been an important part of health initiatives to reduce child mortality from diarrhea. The ORS market in Bangladesh has grown substantially through consumer education and advertising, and now encompasses 15 brands. SMC purchases its main brand, ORS saline, from a local manufacturer. It will soon produce ORS in its own production facility. In addition to providing ORS, SMC also provides training to APPs on diarrhea management with regional training teams consisting of one doctor and two assistants. SMC is considering to market zinc as a supplementary dose to persons with diarrhea, in collaboration with ICDDR,B. It also believes that there is social marketing potential of safe delivery kits (SMC, 2003).

Currently SMC is subsidized by the government, which provides the commodities free of charge for distribution and charges the consumer a very nominal price. Another way of looking at this is that SMC is distributing public goods free to the government. SMC is 40% self-financed and hopes to be fully self-sustaining by 2010.

Bednets, another important health commodity, is imported and sold in the private sector. However, the market for bednets is currently not very large. Soap is currently too expensive for the poor population, who mainly uses ash for handwashing (SMC, 2003).

More detailed studies are required to understand the private markets for goods and commodities relevant to HNP, e.g., bednets, infant food formulas, hygiene products, pharmaceuticals, vaccines, medical equipment.

4.9 Conclusions

There are clearly large information gaps concerning the supply of private health services in Bangladesh. Certainly more information that would help to describe the private sector would be useful, if only to better characterize the size and behavior of private providers. This gap could be closed through a well-designed labor market study.

Enough is already known about the health sector to conclude that the biggest portion of health providers is also the most neglected by public policy-makers. There are many reasons why public policy-makers may not want to deal with the informal market of health providers, and providing information may not be enough to convince policy-makers to address it. Yet there is an important information gap to be filled by conducting studies that would suggest ways to learn how to influence APPs and other private providers to better contribute towards the policy goals of improving health access, quality, affordability, and accountability. A labor market survey that focused on incentives and disincentives of different providers would be helpful. Studies that provided benchmark data on the quality of care and pricing would also be important.

The biggest gains in experience and information would be made through experimentation with strategies designed to take advantage of the private sector, especially the APPs. Such strategies that ought to be tested include contracting, franchising, social marketing, regulating and standard setting, training, providing subsidies, informing, and forming collaborations with the private sector (see Annex 2, Global Evidence on Modalities to Engage the Private Sector to Improve Maternal and Child Health Outcomes).

For policy-makers, there are a number of key recurring themes that run through this analysis of the private sector. One of these themes is the challenge to improve the quality of care. There is
no single best way to address this in Bangladesh, but what is known from experience elsewhere is that high level leadership and commitment is needed. Also critical is active participation from key stakeholders, including provider groups, government agencies, community and consumer representatives, and often some independent monitoring agencies. In the short term, some of the key steps may include pulling together leaders, testing quality improvement tools, and assessing performance and developing standards and benchmarks for different types of providers. In the medium to long term, credible institutions will be needed to promote professional self-regulation, consumer protection, targeted regulation, and use of payment mechanisms and information disclosure techniques to continually improve health services performance.

Another urgent issue is to correct the imbalances in the production of health personnel. There are too few nurses and doctors, and an over-abundance of unqualified providers, over whom the government has little influence. There are also too few female health care providers. Ambitious plans are proposed to increase the number of physicians, but given the resource constraints, alternative sources for the production of qualified medical care need to be considered. Simply trying to produce more doctors and nurses without substantial new resources to improve the quality of education is not likely to achieve the desired results of having a high quality health workforce. Given the brain drain of health professionals that dearly cost the public purse, a number of strategies could be pursued to try to retain health professionals, and reduce the losses. One relatively simple measure to reduce losses is to demand reimbursement or a bond covering the costs of medical expenses from physicians who obtain visas to work overseas. Without bringing in additional funds, it may be difficult to address some of the concerns of physicians. But it is also clear that physicians and nurses would desire more attention to career development and continuing education and support, opening the door to innovations in these areas. Developing more nurses and paramedicals that could take on more of the primary care diagnostic and therapeutic responsibilities that physicians assume is likely to be a more cost-effective strategy than focusing on training more physicians. This could supplement admission strategies that target rural communities. Of course, engaging with the existing APPs also has potential to reduce the needs for new health personnel.

Finally, the question of private practice among public practitioners is a persistent and pervasive issue that the public credibility of the health system. Partial approaches to this issue, such as formalizing private fees in government hospitals, or allowing private practice after hours, is likely to exacerbate the problem if nothing else is changed. To help the government in taking steps further work is needed to test the feasibility of different options to improve the governance of public hospitals, change labor relations, develop contracting of private physicians, and strengthening monitoring and reporting of hospitals.
Chapter 5. Consumption of Private Sector HNP Services

Overall health service consumption in Bangladesh is low in comparison to other countries and to levels of need. The use of maternity services is particularly low: e.g. only 8% of deliveries occur in a health facility.

The private sector is used for the overwhelming majority of outpatient curative care, while the public sector is used for a larger proportion of hospital deliveries and preventive care. The dependence on the private sector for curative care is greater for the poor in Bangladesh; the poorest quintile of Bangladeshi children have a higher dependence on the private sector for treatment of acute respiratory infection (ARI) and diarrhea than the richest quintile.

Poverty is a significant constraint to health care access and use. The largest differences between the rich and the poor are for medically trained deliveries, antenatal care, treatment for ARI, and immunizations. Women and girls tend to receive less medical care than males, with gender bias resulting from cultural factors and the relative lack of female health providers.

New analyses show that nearly all private health spending is at private facilities (88%). In real terms, the richest quintile spends about six times as much as the poorest quintile on health care, presumably purchasing a higher quality of health service.

High health care prices result in people missing needed medical treatment, and an increased risk of poverty. The cost of drugs and transport, and distance to the provider are some of the most important barriers to health care. The private providers are often closer and more conveniently located than public facilities. New studies show that perceptions of provider’s experience and familiarity with the provider are also important reasons for selecting private providers. Further studies are needed to better define the determinants of care seeking behaviors.

More attention is needed to overcome the social, financial, and physical barriers to care. There are indications that social marketing can help to reduce some of the disparities in use of services between the rich and poor. Further experimentation is needed to see how consumers can influence the quality of care, how health decisions in the home can be improved, and how the financial impact of health care costs can be reduced.

5.1 Introduction

This chapter addresses the issues related to the consumption of health services, particularly the utilization of health services and private payment for health care. The chapter begins by an analysis of consumption levels for various types of health services, and the differences between public and private sector consumption. We then turn to the question of barriers to access, and why people choose to use certain health providers. These include problems of financing, physical access, satisfaction with care, and social barriers.

In most of this chapter, we examine the actual use of different health services (utilization). Where possible, we also examine measures of need and demand for healthcare, and the respective measures of unmet needs and demands. Need is distinguished from utilization in that need is measured against a standard of what care should be consumed, such as the need for all
children to be immunized or for all mothers to have a safe delivery (e.g. attended by a trained birth attendant or at a health care facility). Measures of need for curative health care are more difficult to define, since the severity of illness and ability of health services to respond to illnesses are more subjective than normative. Measurements of demand are different from needs in that they reflect what care people actually desire to use, whether or not it is needed. The difference between the desired care and the care actually used is a measure of unmet demand, and the difference between utilization and defined needs is unmet need. Public health policy is often directed towards meeting health care needs, but in most cases of curative care, need is not measurable. Another problem is that needed care is often not demanded, as may be the case for safe deliveries in Bangladesh. Therefore, another important strand of public health policy is to raise appropriate demand, and to reduce unmet demands. In either case, whether addressing healthcare needs or demands, the private sector currently plays a major role in Bangladesh, and its potential has not been fully tapped.

5.2 Health Service Consumption

Although data on overall outpatient clinic visits or hospital utilization is not available in Bangladesh, it is possible to use Demographic and Health Survey (DHS) data to compare selected services with other countries (Table 5.1). This data suggest that consumption of maternal and child health services in Bangladesh is quite low. Bangladesh has lower rates of institutional deliveries and use of medical services for antenatal care and treatment of childhood diarrhea. Among 45 countries with comparable DHS data, Bangladesh has the highest rate of home delivery (World Bank, 2003). Hospital deliveries and births attended by a medically trained person are remarkably low in Bangladesh – only 5% of all deliveries were in a health facility, compared to an average of 49% for all other developing countries. By the time of the 2000-01 DHS survey, only 8% of deliveries occurred in a health facility, and a medically trained person attended 22% of all deliveries. In contrast, untrained traditional birth attendants were at 54% of deliveries, and a relative (or no person) was at 24% of deliveries (NIPORT et al, 2001).

Table 5.1 International Comparisons of Health Service Consumption

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Bangladesh</th>
<th>India</th>
<th>Nepal</th>
<th>Pakistan</th>
<th>Average for 45 developing countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of children with diarrhea seen medically</td>
<td>22</td>
<td>61</td>
<td>14</td>
<td>48</td>
<td>39</td>
</tr>
<tr>
<td>% of children receiving full immunization schedule</td>
<td>54</td>
<td>35</td>
<td>43</td>
<td>35</td>
<td>51</td>
</tr>
<tr>
<td>% of births where antenatal care is from a medically trained person</td>
<td>26</td>
<td>49</td>
<td>38</td>
<td>26</td>
<td>71</td>
</tr>
<tr>
<td>Of all deliveries, in facility</td>
<td>5</td>
<td>26</td>
<td>8</td>
<td>15</td>
<td>49</td>
</tr>
<tr>
<td>Of all deliveries, % attended by medically trained person</td>
<td>8</td>
<td>34</td>
<td>10</td>
<td>19</td>
<td>53</td>
</tr>
</tbody>
</table>

Source: World Bank, 2003; based on Demographic and Health Surveys since the 1990s (1996/97 for Bangladesh)
There are other indications that health care consumption is quite low in Bangladesh. In a nationally representative household survey conducted in 2000, 22% of households reported that a household member who had been ill in the month prior to the survey had not sought care (CIET Canada and MOHFW, 2001). Data from the 1999-2000 DHS again showed low levels of use of child health services: only 27% of children with acute respiratory infection (ARI) in the two weeks before the survey were taken to a health facility, compared with 24% of children with diarrhea, and 11% of children with fever (NIPORT et al, 2001). A study conducted in malaria-endemic villages in southeast Bangladesh noted that only 9% of those who reported that they suffered from malaria sought care from a village health care provider within 21 days of the onset of symptoms (Hossain et al, 2001).

Some preventive services have shown relatively higher consumption rates. The 1999-2000 DHS survey showed that 41% of women of reproductive age were using modern contraception, a higher rate than any other country in South Asia, and nearly double the average rate (22.5%) from DHS surveys done in 45 countries since 1997 (ORC Macro, 2003). Bangladesh also has slightly above average levels of immunization coverage compared to other developing countries (Table 5.1). While far from reaching its desired targets, the most recent DHS data show that the proportion of children of age 12-23 months fully vaccinated against BCG, DPT, oral polio, and measles increased to 60% in 1999/2000 (NIPORT et al, 2001). More notably, the proportion of children 12-59 months who received Vitamin A capsules twice a year reached 80% in 1999/2000 (NIPORT et al, 2001). On the other hand, antenatal care coverage is much lower than average, even for most other countries in South Asia.

Ensor et al (2002) found that overall levels of per capita consumption of the essential service package (ESP) – which is targeted toward the poor, women, and young children – would have to increase by 40% in order to achieve desired consumption levels. Consumption of the child health component of the ESP would have to increase by 12% to reach desired levels. The same study found that consumption of maternal health services was particularly low relative to desired levels; consumption would have to increase by 122% to reach the desired per capita consumption level. Two critical questions remain: (1) How can public demand for the ESP be raised to match the health needs? (2) Can access to quality essential health services be met by relying entirely on the public sector, or can the much larger private sector be used?

5.3 Public/Private Shares of Services

Bangladeshis are much more likely to use private providers than public providers for most of their curative care services. In a background study on household use of health services conducted in 2003, the preliminary results show that of those who sought care outside the home for an illness, 87% of urban residents used private providers, compared to 75% of rural residents (HEU/IHE/NIPORT, 2003). The private chambers of allopathic providers were used as the first source of care for 32% of the cases, while pharmacies were used 26% of the time. Another 10% of the cases were seen at private hospitals, private non-allopathic providers saw 9%, and the public sector was used 21% of the time. The qualified private providers were used twice as often as unqualified allopathic providers (excluding pharmacies). Since the unqualified allopathic providers vastly outnumber the qualified providers, and since the outpatient workloads between the two appear comparable (Chapter 4), it is likely that the public are more likely to view their allopathic provider as qualified to practice medicine, even when they do not have an MBBS degree.
Other surveys show that consumption of outpatient curative services are largely in the private sector. The 2000 Service Delivery Survey (SDS) found that the public sector accounted for only 21% of visits in the last month, whereas NGO and for-profit providers covered 30%, and alternative private practitioners (APPs) had 49% of the visits (CIET Canada and MOHFW, 2001). The same survey also found that visits to a private provider were more likely to be for curative care (90%), compared to visits to a public provider (71%). Another study reported that 75% of the first point of contact for care occurs in the private sector (Sen, 2001). Levin et al (2001) also found that people used primarily village doctors and traditional practitioners for health care, and together they accounted for almost two-thirds of the care utilized. A study of infant mortality and health seeking behavior in a rural area of Bangladesh found that 90% of parents sought treatment for their sick children from private providers (Bhardwaj and Paul, 1986). The same study reported that 53% of sick children received treatment from APPs; the majority of these were kabiraj, followed by non-qualified allopathic providers.

International comparisons of the distribution of the use of public and private health services are difficult to come by, but data from comparable DHS surveys provide some insights. These surveys show that Bangladesh stands out for its high level of dependence on the private sector for treatment of childhood diarrhea, ARI, and institutional deliveries (Figure 5.1). Although other South Asian countries also have a high dependence on the private sector for childhood curative services, Bangladesh leads the region, and is second only to Haiti among all 45 countries with comparable data. Of children with diarrhea in Bangladesh, 22% were brought to a health facility. Of those children, 92% were seen in a private sector health facility. Of children with ARI, 33% were brought to a health facility. Of those children, a private provider saw 89% (Gwatkin et al, 2000).

**Figure 5.1 – International Comparison of the Share of Medical Care Used in the Private Sector For Selected Services**

![Bar chart showing the share of medical care used in the private sector for selected services in Bangladesh, India, Nepal, Pakistan, and the average for 45 developing countries.](source: World Bank, 2003; based on DHS since the 1990s (1996/97 for Bangladesh)
Bangladesh’s position is even more striking when making international comparisons of obstetric services. The most significant point is that Bangladesh leads the world in deliveries that occur at home – about 91% of all deliveries in the three years preceding the 1999-2000 DHS (NIPORT et al, 2001). Of those few deliveries that occur in a health facility, Bangladesh still has a substantial share occurring in private facilities (40%). Public facilities provided more treatment for obstetric complications (73%) than private qualified allopathic providers (27%), yet private providers performed a higher proportion of caesarean sections (56%) than public providers (44%) (ACPR and UNICEF, 2001). The higher proportion of caesarean sections in the private sector may suggest that there is a problem with supplier-induced demand: patients using private providers have higher caesarian section rates than would be needed because these providers have an incentive to give more services, a common issue where the private sector is poorly regulated (Peters, 2002).

The use of private providers is not restricted to the rich, as the poor also have a high dependence on private providers for childhood curative care for ARI and diarrhea (Figure 5.2). However, as noted above, there may be differences in the type of private provider used, with the poor more likely to rely on unqualified practitioners, and the better off able to afford qualified physicians.

**Figure 5.2 – Proportion of Richest and Poorest Quintiles Using Public and Private Health Services**

![Diagram showing proportions of richest and poorest quintiles using public and private health services for institutional deliveries, childhood ARI treatment, and childhood diarrhea treatment.]

Source: World Bank, 2003; based on Demographic and Health Surveys in the 1990s (1996/97 for Bangladesh)

Data from the 2000 Bangladesh Household Income and Expenditure Survey (BBS 2001) support the view that the poor are more likely to rely on traditional providers and pharmacy salesmen for their health care compared to richer groups (Table 5.2). Although it is not clear from the survey whether a “private doctor” means an MBBS qualified doctor or any village doctor, it is clear that qualified government doctors, when practicing privately, are much more likely to be used by richer patients, with a rich/poor quintile ratio of 3.8.
### Table 5.2 Distribution of the First Source of Health Care for The Latest Illness (in Percent), According to Income Quintile

<table>
<thead>
<tr>
<th>Source of care</th>
<th>Poorest 20%</th>
<th>20-40%</th>
<th>40-60%</th>
<th>60-80%</th>
<th>Richest 20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public doctor</td>
<td>4.1</td>
<td>5.1</td>
<td>7.7</td>
<td>7.1</td>
<td>8.1</td>
</tr>
<tr>
<td>Public non-physician</td>
<td>3.8</td>
<td>2.9</td>
<td>5.3</td>
<td>3.8</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Total public sector</strong></td>
<td><strong>7.9</strong></td>
<td><strong>8.0</strong></td>
<td><strong>13.0</strong></td>
<td><strong>10.9</strong></td>
<td><strong>11.5</strong></td>
</tr>
<tr>
<td>Private doctor</td>
<td>22.8</td>
<td>25.3</td>
<td>25.6</td>
<td>24.2</td>
<td>22.7</td>
</tr>
<tr>
<td>Government doctor in private practice</td>
<td>8.0</td>
<td>9.1</td>
<td>12.6</td>
<td>15.6</td>
<td>30.0</td>
</tr>
<tr>
<td>NGO doctor</td>
<td>--</td>
<td>1.2</td>
<td>0.0</td>
<td>0.7</td>
<td>0.4</td>
</tr>
<tr>
<td>NGO non-physician</td>
<td>0.1</td>
<td>0.6</td>
<td>0.5</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Pharmacy salesman</td>
<td>44.7</td>
<td>44.7</td>
<td>39.1</td>
<td>39.2</td>
<td>26.2</td>
</tr>
<tr>
<td>Traditional provider</td>
<td>10.4</td>
<td>8.3</td>
<td>6.1</td>
<td>6.6</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Total private sector</strong></td>
<td><strong>85.9</strong></td>
<td><strong>89.2</strong></td>
<td><strong>84.0</strong></td>
<td><strong>86.6</strong></td>
<td><strong>85.2</strong></td>
</tr>
</tbody>
</table>

Source: Bangladesh Household Income and Expenditure Survey (BBS 2001) and author’s calculations

The case for institutional deliveries shows a different picture than that of curative child health care, not only because there is a higher reliance on the public sector (Figure 5.2). The types of providers and facilities providing institutional deliveries are more comparable in private sector facilities, even as most deliveries occur in private homes. Figure 5.3 shows that there are enormous differences in the use of private institutional deliveries between the richest quintile (8.7% of deliveries) and poorest quintile (0.1% of deliveries) in Bangladesh; a rich/poor ratio of 87. Of all countries with comparable data, Bangladesh has the greatest inequality in the use of private institutional deliveries, but also ranks behind only Nepal and Pakistan in terms of inequality of public sector institutional deliveries (World Bank, 2003). In sum, women have very little access to any institutional delivery care in Bangladesh, and the rich predominantly consume the little that is used in both public and private sectors.
5.4 Determinants of Consumption / Health Care Seeking Behavior

In this section, we summarize the data available in Bangladesh on determinants of health service use, focusing on physical, financial, and social barriers, and users’ perceptions of health services. It is known that physical access to service providers, convenient opening times, financial access, education levels, social and cultural factors, awareness of service providers, perceptions of their services, and other household and provider characteristics are known to influence the levels of consumption of health services and the choice of provider. The surveys that have been used to demonstrate these relationships tend to simplify what in reality may be a more complex calculus. In addition to the well-known factors that influence access to care, for the individual, the choice of provider is often a calculus that depends on the specific illness and beliefs of the patient about different medical systems and providers. For example, Ashraf and colleagues (1982) point out that traditional providers tend to be more commonly used for conditions where western medicine is thought not to be effective, whereas allopathic medicines are used for many acute infections. However, in most pluralistic medical systems, it can be expected that patients will consult providers from different sectors simultaneously, as they have different expectations from different providers (Young, 1983). For example, the expectations may differ with respect to pain relief, disability, cure, or spiritual obligations. People may also consult different providers in sequence, depending on the response to the first treatment received.

In a background household survey about health services use/consumption (HEU/IHE/NIPORT, 2003), the preliminary results on 342 children who received care for an illness showed a familiar dependence on private providers: 43% were seen by a qualified private physician, 30% by an
APP, and 27% were seen at a government facility. The main reasons for their choices are illustrated in Figure 5.4. These results suggest that knowledge about the provider’s experience is particularly important in choosing private practitioners, whereas cost and physical proximity are more important reasons for those who chose a public facility. For those who chose an APP, the second most common reason was familiarity with the provider, a factor that had few responses among those who chose public providers. The provider’s behavior, and the availability of medicines were less frequent reasons for selecting a particular provider. Since respondents gave answers about their chosen provider rather than why they did not choose other providers, it is possible that some of these factors could also be reasons why some providers are not chosen (e.g. they are avoided because medicines are not available).

**Figure 5.4 – Main Reason for Choosing a Specific Provider for Treatment of the Most Recent Child Illness**

![Figure 5.4 – Main Reason for Choosing a Specific Provider for Treatment of the Most Recent Child Illness](image)

Source: HEU/IHE/NIPORT, 2003

### 5.4.1 Physical Access

Numerous studies have shown that physical access to health services is an important determinant of consumption in Bangladesh. Location is one of the most important factors to determine the access to health services in Bangladesh as documented in the CIET baseline survey (CIET Canada and MOHFW, 1999). Geographic access at least partially explains why consumption rates are higher in urban areas compared to rural areas (NIPORT *et al*, 2001).

Physical access is a barrier to maternal and child health services in particular. In the 1999-2000 DHS, 79% of women reported that the lack of a health facility nearby was a constraint to consumption (Streatfield *et al*, 2001). In the same survey, 50% of women responded that getting
to the health facility was a problem to them. Levin and colleagues (2001) confirmed the significant negative association between both distance to the provider and travel time and the use of health services. A child was less likely to be taken to a qualified allopathic provider or a traditional practitioner than a village doctor, if the travel time was 40 minutes or greater compared with travel time of 15 minutes or less. Other research has shown that a majority (74%) of sick children in a rural area of Bangladesh were taken less than two miles for treatment; and that a majority of those children were seen by APPs. In contrast, children who were taken more than two miles for treatment received health care from qualified allopathic providers (Bhardwaj and Paul, 1986).

These findings strongly suggest that the distance from the household to the health provider is an important factor in determining whether or not to use a health provider. Because of the importance of physical access, the large number and close proximity of APPs to most rural Bangladeshis give them a comparative advantage over other providers in the public and private sectors.

5.4.2 Financial Access

The cost of health care can be a strong determinant of health care use, as well as a cause of poverty. Ability to pay is a particularly important determinant of access when high proportions of health care are financed privately, and without any type of financial risk protection from health insurance. In Bangladesh, 60% of all health expenditures in 2000 were paid out-of-pocket by individuals (64% of all health expenditures were estimated to come from private sources), so that people’s ability to pay for care is important (WHO, 2003a). There is essentially no social security or private health insurance, although public hospitals are intended to provide a form of insurance in case of serious illness by providing care that is intended to be free at the point of delivery. However, data to demonstrate the poverty impact of illness and disease, or to demonstrate how health financing interventions can reduce these risks, are not readily available in Bangladesh.

Different types of cost items can be barriers to the use of health care. Health care costs can be divided among direct medical costs (e.g. medicines and service fees), direct non-medical costs (e.g. transportation costs) and indirect costs (e.g. traveling and waiting time, lost earnings). In the SDS, the cost of medicines was the most important cost element that prevented people from using health services, followed by transportation costs (CIET Canada and MOHFW, 2001). For women in Bangladesh, the issue may be further complicated by their ability to obtain funds for health care. In the 1999-2000 DHS survey, 71% of women stated that difficulty in getting money needed for treatment is a constraint to health service consumption (Streatfield et al., 2001). So even if the cost of medicines could be reduced, such as through non-profit organizations that are able to purchase drugs in bulk and distribute essential drugs more efficiently, other approaches may be required to deal with patient transport costs, and with gender bias in household decision-making.

Another consideration is how health expenditures are distributed. A background study analyzing the Bangladesh Household Income Expenditure Survey (Peters et al., 2003), it was found that 88% of private health expenditures are going to private providers, and that rich pay far more for medical care than the poor in real terms (the richest/poorest quintile ratio was 6.2) (Figure 5.5). It’s noteworthy that even though the poorer people spend less per episode of illness, a greater
proportion of that expenditure goes to private providers. Thus the poor are in fact more dependent on private care, contrary to a common belief that private care is for the rich.

As a proportion of total income, health spending was found to comprise 6.8% of the total income, with the richer groups paying a slightly higher proportion than poorer groups. However, when examining health spending as a proportion of total non-food expenditure, the relationships change (Figure 5.6), indicating how important health spending is to most Bangladeshi’s. Over 17 percent of all non-food expenditure is spent on health, with the poorest four quintiles spending relatively more than the richest quintile.

As noted earlier, poverty is correlated with both lower health spending and with lower consumption of modern health care services. For example, very poor households are less likely to use both public and private health services (CIET Canada and MOHFW, 2001). In combination with an increased likelihood of being sick in the first place, the poor are thus more likely to have unmet need for health care.

**Figure 5.5 – Private Payments on Health per Capita per Episode to Private and Public Providers in Bangladesh by Income Quintile**

![Figure 5.5](image)

Source: BBS, 2001 and authors’ calculations
Gwatkin et al (2000) disaggregated the Bangladesh 1996-97 DHS data by wealth quintiles based on assets of the household, and then reported the use of health services (Table 5.3). The largest differences between rich and poor were found for medically trained deliveries, antenatal care, treatment for ARI, and absence of any childhood immunizations. For example, they found that the poorest 20% of children with ARI are less likely (23%) than richest (51%) to be taken to any medical facility for treatment. There were far smaller differences in the treatment of childhood diarrhea and use of contraceptives. In Bangladesh, there have been decades of social marketing and public programs to support family planning and oral rehydration therapy, and to some extent childhood immunizations. Although the poverty relationships is not as marked for immunization as with these other services that have been promoted, it appears that these approaches are associated with decreased differentials between the rich and the poor in the use of oral rehydration therapy and contraception.
Table 5.3 – Wealth Differences in Health Service Consumption

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Poorest 20%</th>
<th>Richest 20%</th>
<th>Population Average</th>
<th>Rich/Poor Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of surviving children (12-23 months) who received all vaccinations (BCG, DPT, oral polio, measles)</td>
<td>47%</td>
<td>67%</td>
<td>54%</td>
<td>1.4</td>
</tr>
<tr>
<td>Proportion of surviving children (12-23 months) who received no vaccinations</td>
<td>18%</td>
<td>5%</td>
<td>12%</td>
<td>0.3</td>
</tr>
<tr>
<td>Proportion of children (under five) with diarrhea in last two weeks who received ORT</td>
<td>62%</td>
<td>68%</td>
<td>61%</td>
<td>1.1</td>
</tr>
<tr>
<td>Proportion of children (under five) with diarrhea in last two weeks who were taken to any medical facility for treatment</td>
<td>22%</td>
<td>24%</td>
<td>22%</td>
<td>1.1</td>
</tr>
<tr>
<td>Proportion of children (under five) with ARI in last two weeks who were taken to any medical facility for treatment</td>
<td>23%</td>
<td>51%</td>
<td>33%</td>
<td>2.2</td>
</tr>
<tr>
<td>Proportion of births for which a woman received at least one antenatal care consultations by a medically trained person (doctor, nurse, or midwife)</td>
<td>14%</td>
<td>59%</td>
<td>26%</td>
<td>4.2</td>
</tr>
<tr>
<td>Proportion of births for which a woman received two or more antenatal care consultations by a medically trained person</td>
<td>9%</td>
<td>51%</td>
<td>20%</td>
<td>5.7</td>
</tr>
<tr>
<td>Proportion of births attended by a medically trained person</td>
<td>2%</td>
<td>30%</td>
<td>8%</td>
<td>15.0</td>
</tr>
<tr>
<td>Proportion of married women who report use of modern means of contraception</td>
<td>39%</td>
<td>49%</td>
<td>42%</td>
<td>1.3</td>
</tr>
<tr>
<td>Proportion of married men who report use of modern means of contraception</td>
<td>46%</td>
<td>54%</td>
<td>49%</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Source: Gwatkin et al., 2000; Bangladesh data based on DHS 1996/97

5.4.3 Social and Cultural Context – Gender

The social and cultural context has an important impact on the patterns of health service use in Bangladesh. Social and cultural factors particularly affect the role of gender and the distribution of household decision-making. The mobility of women in Bangladesh is improving, but is still limited (Levin et al., 2001). Women are less likely to utilize health services, particularly from qualified allopathic providers. Decisions to seek care are often taken jointly with the husband and in-laws (Levin et al., 2001). DHS data show that 44% of women reported difficulty in getting permission to go to a health provider as a constraint to health service consumption (Streatfield et al., 2001). In addition, 49% of women reported that finding someone to accompany them was a
problem. Amin and colleagues (1989) found that men who were sick were more likely than women to utilize modern qualified providers in rural Bangladesh. The gender bias may reflect beliefs that it may not be appropriate for women to be seen by a male provider. In addition to the long-standing cultural biases against women, the fact that the health providers available in rural Bangladesh are predominantly male (see Chapter 4) suggests that the problem of women’s access to care will not be easily solved.

There is also a considerable body of evidence to document how gender bias also affects the use of children’s health services. The 1999-2000 DHS data indicate that boys are more likely than girls to be vaccinated against BCG, DPT and oral polio, and measles, and to be taken to a health facility if sick with ARI or diarrhea (NIPORT \textit{et al}, 2001). In the rural sub-district of Matlab, it was reported that the contact rate with a health provider for treatment of diarrhea was significantly lower for girls than boys (Bhuiya and Streatfield, 1995). In a study examining the use of health services among children who died, it was found that qualified allopathic providers (both public and private) were utilized far more for boys (80%), exceeding the male proportion (57%) of total infant deaths, whereas non-qualified allopathic providers and homeopaths provided most of the health services for female infants (Bhardwaj and Paul, 1986).

Gender differences in health spending is not as clear-cut. One study of public sector health expenditure found that on average, more money was spent on males compared to females (Ensor \textit{et al}, 2002). However, analysis of the Bangladesh HIES (Peters \textit{et al}, 2003) shows that in nearly all income quintiles, spending on women is greater than on men or children (Figure 5.7).

\textbf{Figure 5.7 – Out Of Pocket Spending on the Health of Women, Men, and Children By Income Quintile, Bangladesh, 2000 (Annual amounts in Taka)}
5.4.4 Patient Perceptions of Providers

Users’ perceptions about providers are another important set of determinants of choice of health provider, in addition to being considered an important outcome in their own right. Although there is relatively little data on patient or client satisfaction in health care in Bangladesh, what is available suggests that clients are more satisfied with private than public providers. In the 2000 service delivery survey, 41% of households reported that they think public sector health and family planning services are “bad”, whereas only 10% of households thought the same about private providers. Conversely, only 10% of households thought that public health services were “good”, while 25% thought the same about private providers (CIET and MOHFW, 2001).

Table 5.4 summarizes the main reasons why the households were not satisfied with public or private health and family planning services (CIET Canada and MOHFW, 2001). Relative to the private sector, poor staff attitudes and problems with the lack of medicines or their quality were the biggest problems with the public sector. In the private sector, users’ perspective of the biggest problem was having to pay for expensive medicines, though availability of doctors and nurses also seemed to be a problem.

Table 5.4 – Commonly Identified Problems in Public and Private Health and Family Planning Services

<table>
<thead>
<tr>
<th>Problem</th>
<th>Proportion of Respondents Reporting as a Problem in:</th>
<th>Public/Private Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of, and poor quality of, medicines</td>
<td>58%</td>
<td>18%</td>
</tr>
<tr>
<td>Bad service</td>
<td>40%</td>
<td>33%</td>
</tr>
<tr>
<td>Bad staff attitude</td>
<td>25%</td>
<td>6%</td>
</tr>
<tr>
<td>Difficult to reach</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Have to pay for medicines, expensive medicines</td>
<td>17%</td>
<td>41%</td>
</tr>
<tr>
<td>Lack of doctors, nurses, specialists</td>
<td>14%</td>
<td>32%</td>
</tr>
<tr>
<td>Lack of different services</td>
<td>14%</td>
<td>24%</td>
</tr>
<tr>
<td>Dirty and poor equipment and facility</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Doctors not available</td>
<td>13%</td>
<td>No data</td>
</tr>
<tr>
<td>Extra payments to doctors and other workers</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Too few beds, lack of facilities</td>
<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: CIET Canada and MOHFW, 2001
In the background study on household use of health services, satisfaction with child health services was also assessed for 342 children who were treated for an illness outside the home (HEU/IHE/NIPORT, 2003). As shown in Figure 5.8, there was little difference in overall levels of satisfaction between users of different types of providers.

There were, however, important differences in the reasons for satisfaction (Figure 5.9). Of those children who were seen by a qualified private provider (43% of cases), courtesy, perceived outcome, and explanation about the treatment given were the most important factors in providing satisfaction. For those seen by an APP (30%), treatment outcome, explanation about treatment, and cost of services were the most important factors, whereas cost, perceived outcome, and courtesy were the top reasons given for those who used the public sector (27%).

**Figure 5.8  Levels of Satisfaction with Child Health Services According to Type of Provider**

Source: HEU/IHE/NIPORT, 2003

Other studies also provide insights into how satisfaction with health services affects consumption. For example, 54% of female respondents in the 1999-2000 DHS reported lack of confidence in health services as a reason for not using those services (Streatfield et al, 2001). In the SDS there were differences in levels of satisfaction between types of providers. The proportion of users satisfied with overall services was 62% for public sector services, 88% for qualified allopathic providers (for-profit and NGO), and 88% for APPs (CIET Canada and MOHFW, 2001). User satisfaction may be another important reason why consumption is much greater for private providers, and for APPs in particular.
5.5 Conclusions

This chapter confirmed that Bangladeshis overwhelmingly use the private sector for their health care, though much of this care is taken from unqualified providers and other APPs. This adds urgency to the call in Chapter 4 to focus energies on improving quality of care. Yet in the case of maternal health services, there is the added problem of remarkably low levels of utilization, particularly for delivery and antenatal care.

The data also highlights that there is considerable gaps in information and experience concerning the demand for health care in Bangladesh. There is little experience in how to influence demand for higher quality of health services. Family planning and use of ORT, which have benefited from long public health education campaigns, are associated with relatively small disparities between rich and poor in Bangladesh. But it is not known how behavior change communications can be used to influence the type of care offered by health providers. Interventions are needed to test how to empower people to demand better quality of health services from both private and public providers. The biggest need is in maternity services and general health services for girls and women.

The dependence on out-of-pocket financing of health care puts Bangladeshis at risk of poverty and to pass up needed medical treatment. This is more so for the poor. Interventions to reduce the financial impact of drug and transport costs have not been tested in Bangladesh, and the
effectiveness of interventions such as subsidies, demand-side financing, or health insurance on financial protection is not yet known on a large scale. These ought to be tested.

Taken together, the findings in this chapter emphasize the importance of people’s reliance on different aspects of the private sector for their health care. More than ever, there is a need in Bangladesh to create policies and test strategies that will not only reduce the harm caused by an unregulated and undirected private sector, but also to take advantage of the private sector to address basic public health goals of improving quality, access, affordability, and accountability of health services in the quest to improve the lives of Bangladeshis.
Chapter 6. Interaction between the Public and the Private Sectors in HNP

Reviewing the interaction between government and the private sector in health generates several key conclusions. First, the range and magnitude of government engagement with private providers is not congruent with their importance. The bulk of interaction takes place in terms of regulation and with regard to private clinics and hospitals. APPs have very little interaction with government. Thus, public-private engagement has largely excluded service providers of greatest importance to the poor. There are, however, positive experiences, including a number of pilot initiatives at public-private partnership, to work with private, mostly non-profit, service providers, e.g. nutrition, TB/leprosy, immunization, family planning, urban primary health care and immunizations. In addition, the involvement and collaboration with private actors has occurred sometimes in policy discussions and formulation, though this has not been a consistent feature.

Second, the government stewardship responsibilities to the health sector could be enhanced. There is little collaboration with professional and providers organizations, or support for self-regulation. Currently professional and provider organizations are primarily playing the role of trade unions. Neither consumer nor patients’ organizations have yet emerged strongly to play an advocacy role, nor to engage in monitoring of service quality and outcomes. Instruments to engage private actors require government officials to perform tasks very different from their traditional activities.

Third, misperception and low capacity underlie weak public-private engagement. The policy-makers’ interviews reveal that there is a limited understanding of the private sector size and role in provision of care, especially for MCH services in rural areas. Most policy makers believe that the bulk of private provision is tertiary care for the rich.

Broad-based efforts are needed to improve quality of private health services and specific initiatives focusing on APPs. In addition, we call for an increased capacity of the MOHFW and strong engagement of the key stakeholders, through the setting up of a Public-Private Task Force in the MOHFW.

6.1 Introduction

The previous chapters described the size and characteristics of the private health sector supply and the demand and consumption of private health services by the population. This chapter will focus on the interaction between the government of Bangladesh and the private health sector. It will attempt to shed some light on the current situation and the existing experiences in the country, but also draw on some of the perspectives that governmental actors and private actors have on the issue of collaboration. It aims at providing and informing the debate on the two sides and it will conclude by suggesting some options to improve the interaction between public and private sector in HNP in Bangladesh.

6.2 Current Situation

As described in the previous chapters, it is clear that the private sector, in its many, varied forms, is the predominant source of health services for the people of Bangladesh. Health policy in Bangladesh, as in many developing countries, has traditionally focused on the public sector, and, in particular, on administration of public facilities. Notwithstanding the public-sector focus, however, there are a number of areas in which public and private actors interact. Below, this
interaction is presented according to the following categories: governmental regulation; self- and non-governmental regulation; service and facilities planning; information dissemination; disease surveillance; contracting; and, grants and subsidies.

6.2.1 **Governmental Regulation**

Regulation of health services is a central role for governments in health systems with private delivery. While virtually all such health systems have the basic components of health service regulation in place, in many developing countries, there is a huge gap between the legal provisions and implementation (Afifi et al., 2003). This is also the case in Bangladesh. Regulations are in place relating to most key inputs for health services, including: premises, equipment, and education and licensing of medical and health workers. Regulations also exist with regard to pricing of goods and services. Annex 6 summarizes all formal regulatory instruments in the health sector in Bangladesh. The Directorate of Health Services, headed by the Director-General of Health Services (DGHS) is responsible for implementation of most regulations. An autonomous government agency, the Bangladesh Medical and Dental Council (BMDC), is responsible for undertaking and enforcing registration, as well as approval of curriculum for medical education programs. Another autonomous agency, the Bangladesh Nursing Council (BNC) recognizes nursing and allied health training institutions.

The standards specified in the laws are significantly out of date, and therefore not applicable to the current status and state of development in the health sector. For example the provisions for maximum fees for surgical operation, normal deliveries and diagnostic tests were established in 1984, and have neither been updated nor revoked since then.

The key problems in the health sector related to regulatory failure are lack of knowledge about private health care service provision, and low quality of private health care services. The effectiveness of regulation is very limited. At the most fundamental level, major constraints appear to be insufficient capacity and attention to regulatory issues. There are too few human and financial resources devoted to regulation. It is evident that the capacity of the government bodies to implement this legislation is weak, or non-existent in some cases. While registration is formally required to practice, the vast majority of providers practice without being registered (Health Economics Unit, 1998ab). Inspections for monitoring of service quality are not possible with available resources. There are nearly 85,000 health personnel in the DGHS, hence it is not an absolute shortage of human resources that explains the weak capacity. Rather too few staff are assigned to these activities, and there is a shortage of personnel with relevant training.

Even a substantial portion (30%) of inpatient facilities, which are fewer in number and easier to identify, operate without registration (BBS, 1998). Inspection of health facilities occurs only when a license is initially given. Subsequent re-licensing is done based on self-reported information.

Out-of-date standards and rates established in regulation seriously undermine compliance. The fact that the standards or values set in the law are so incongruent with reality in private practices and clinics, diminishes the leverage and potential influence of the regulations.

6.2.2 **Self- and Non-governmental Regulation**

The role of professional and provider groups is another critical element of a well-functioning regulatory framework. In virtually all well-performing health systems, these non-governmental
bodies undertake extensive quality assurance activities, with varying degrees of oversight by government (Afifi et al, 2003). The technical expertise and credibility of these bodies makes them invaluable partners in developing standards for education and practice. They often play a substantial role in implementation of regulation as well.

There is a substantial number of professional and provider organizations in the health care field in Bangladesh (see Box 6.1). Currently, these bodies undertake few self-regulation activities. To date, the organizations function primarily as trade bodies, that is, they focus their activities on protecting the interests of their provider-members as businesses. The GOB does involve representatives from these organizations in some policy initiatives, for instance consultation on proposed legislation. This interaction tends to be informal, and sometime raises issues of transparency. However, these activities mainly do not involve professional or provider organizations in implementation. The degree of governmental support and oversight for self-regulation by professional or provider bodies is likewise low.

### Box 6.1 – Potential Self-Regulatory Bodies in Bangladesh

The **Bangladesh Medical Association** (BMA) is the main representative organization of the medical profession. Its formal objectives include improvement of medical sciences and enhancing the status and honor of physicians. In practice, its main concerns relate to protecting the interests, rights and privileges of its members. Physicians working both in the public and private sectors are members of the BMA. Many other professional societies of special medical/surgical disciplines are affiliated with the BMA. The professional journal of BMA is published irregularly.

Private medical practitioners have an association of their own, namely the **Bangladesh Private Medical Practitioners’ Association** (BPMPA). Many of its members are also members of the BMA.

The professional association of registered nurses is the **Bangladesh Nursing Association**.

Similarly, the **Pharmaceutical Society of Bangladesh** (PSB) is the apex professional association of graduate pharmacists. Diploma pharmacists have a separate professional society.

Private pharmaceutical manufacturers (mainly the larger ones) have their own organization, the **Bangladesh Aushad Shilpa Samity**.

The owners of retail pharmacies have a society of their own, the **Bangladesh Chemists and Druggists Samity**.

The owners of private clinics and laboratories have recently formed their own association in the name of **Bangladesh Private Clinic and Diagnostic Owners’ Association** (BPCDOA). It has a nine-member committee to fix more or less uniform charges and to address quality of services issues. Like the other professional associations mentioned here, this entity also, functions more or less as a trade organization.

Source: Hye, 2003

Consumer or patient organizations are not developed, nor is a role established for them in regulation or government activities. Victims of malpractice or mistreatment can only make an
appeal to the Director General of Health Services (DGHS), an event that is fairly uncommon. When asked, private providers confirmed that no other non-governmental groups strongly influence their environment (HEU/IHE/NIPORT, 2003).

### 6.2.3 Planning

In mixed-delivery health systems, service and facility planning must take into account the existing private sector capacity, as well as their plans for development. Otherwise, the impact of public sector construction and development is reduced through duplication and “crowding out”. Service and facility planning in Bangladesh is undertaken by the MOHFW. Currently, these planning activities are based only on public facilities and services. Some private hospitals and clinics evidently receive information from the government as to planned development (see Table 6.1). However, information about private capacity appears not to be taken into account in facility and investment plans.

#### Table 6.1 – Public/Private Sector Interaction by Type of Provider

<table>
<thead>
<tr>
<th></th>
<th>Non-allopathic providers N=62</th>
<th>Pharmacists Drug vendors N=72</th>
<th>Hospital/Clincs Clinicians N=41 Managers N=32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently not involved with government activities</td>
<td>100%</td>
<td>90.3%</td>
<td>N/A</td>
</tr>
<tr>
<td>Receives information on health sector planning</td>
<td>0%</td>
<td>5.6%</td>
<td>11 (26.8%)</td>
</tr>
<tr>
<td>No monitoring visits in last 3 months</td>
<td>74.0%</td>
<td>58.3%</td>
<td>N/A</td>
</tr>
<tr>
<td>Uncertainty about government policies “Important” or “Very Important” constraint to operations</td>
<td>51.6%</td>
<td>68.0%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: HEU/IHE/NIPORT, 2003 and authors’ calculations.\(^{12}\)

### 6.2.4 Policy Making

In mixed-delivery health systems, private providers are typically involved, through a range of mechanisms, in the policy making process. Most often this involvement is formal, and provider representative bodies have an official “seat at the table” in deliberations regarding policy development. In Bangladesh, representatives from the more formal and organized professional and provider groups (allopathic qualified physicians; private clinics/ hospitals) are sometimes involved in policy development and implementation in the health sector, especially where such policies affect the private sector. Typically, these representatives serve as members of formal government appointed bodies or committees. Many components of the service delivery sub-sector, such as traditional healers, homeopaths, pharmacists, are less organized and more atomistic. Not surprisingly, neither they nor their representatives are involved in the policy making process. Uncertainty about government policies towards the private sector was mentioned as an important constraint to their operations by a large majority of the private providers interviewed (see Table 6.1).

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\(^{12}\) The percentages were calculated among the private actors who provided an answer to the question.
6.2.5 Information Dissemination

In addition to regulation, information dissemination activities are a critical part of a government’s stewardship in the health sector. Such activities constitute a substantial part of government activities in the health sector in successful mixed-delivery health systems. Governments usually partner with self-regulatory and consumer or patients’ organizations in implementing these activities. Information disseminated to consumers usually relates to appropriate health-seeking behavior and what constitutes high-quality health care. This knowledge guides patient consumption and preferences toward higher quality care and providers. Better informed patients are also less likely to pressure providers for unneeded, even harmful interventions – pressure to which private providers are known to be responsive. Information dissemination to providers about policies, regulatory and planning activities promotes compliance and reduces uncertainty in private investment and development. Information dissemination to providers increases knowledge, and improves coordination and clinical practice.

In Bangladesh, government information dissemination activities appear to reach a limited portion of health providers. From the provider survey, 40.6% of hospital or clinic managers receive some information about health sector planning for example. A smaller portion of clinicians (26.8%) indicated that they receive similar information. Beyond the formal provider group however, virtually no information is received from government (see Table 6-1 above). With regard to information dissemination activities to consumers – though very little analysis is available – it appears that such efforts are limited to special programs (family planning; child health; TB) and, with the exception of family planning, are associated with donor-driven initiatives.

6.2.6 Disease Surveillance

Disease surveillance is a central responsibility of government in the health sector. For surveillance systems to be effective, it is essential that all providers of health care actively contribute information. It is equally important that all providers, both public and private, participate in programs to appropriately identify, treat and/or refer patients. Currently in Bangladesh there is no system in place for reporting of infectious diseases from private sector in the main surveillance system. Private providers are not legally required to report disease patterns nor the number of cases treated. The exception to this situation is the reporting of tuberculosis cases in the context of the government collaboration with NGOs (see Box 6.2).

6.2.7 Contracting

Engaging in long-term purchasing arrangements with private providers is the most influential instrument to guide independent service providers. The interest of private providers in a predictable revenue flow yields the government purchaser strong leverage. Being typically long-term, health services contracts require and generate frequent communication and interaction with private providers, and, constitutes an important component of a government’s overall interaction with the private sector (Taylor, 2003).

In Bangladesh, a number of pilots have engage NGO providers via contracting to provide health care services. These experiences constitute a rich resource for evaluating and improving the public-private interaction. So far, most of these initiatives have been donor-financed. Until recently, the MOHFW has been relatively inactive in this regard.
Box 6.2 – Government-NGO Collaboration to Implement the National TB Program

In 1994, the Government signed two Memoranda of Understanding separately with BRAC and the Leprosy Coordinating Committee, the latter being an umbrella of NGOs working on leprosy. Both agreements, renewed on annual basis, state the principles of collaboration in implementing the National Tuberculosis Program (NTB) in defined districts and thanas. The government proves its commitment and flexible approach to TB control and the NGOs increase coverage, quality and sustainability of their services. NGOs’ resources are channeled to provide standardized TB services, to rural and less accessible areas, through the use of community health workers (CHWs). The results are very encouraging. The BRAC program achieved high rates of case detection and treatment compliance, with a cure rate of at least 85% (Chowdury et al., 1997). In addition, when compared to government TB program the involvement of CHWs was found to be more cost-effective in rural Bangladesh. With the same budget the BRAC program could cure three TB patients for every two cured in the government program (Islam et al., 2002). The successful collaboration in TB control in Bangladesh has been acknowledged internationally (Kumaresan et al., 2000) and could serve as a model for other programs in the country. Crucial to the success seems to be the clear identification of roles and responsibilities of the different actors. The division of responsibilities is presented in the following table, and reporting of tuberculosis cases is clearly mentioned under the NGOs’ responsibilities.

<table>
<thead>
<tr>
<th>Area of Collaboration</th>
<th>Government</th>
<th>NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation</td>
<td>National Guidelines on Overall Coordination</td>
<td>Specific Areas</td>
</tr>
<tr>
<td>Case Finding and Holding</td>
<td>Equipment/Supplies and Referral Centers</td>
<td>Diagnosis, Treatment and Follow-up</td>
</tr>
<tr>
<td>Training</td>
<td>Training Materials and Training of Trainers</td>
<td>Local Training</td>
</tr>
<tr>
<td>Drug Supply</td>
<td>Central Procurement Distribution</td>
<td>Local Storage, and Supply Indent</td>
</tr>
<tr>
<td>Monitoring and Supervision</td>
<td>Registers/Forms/Overall Monitoring/Supervision</td>
<td>Registration/Reporting, and Local Monitoring/Supervision</td>
</tr>
<tr>
<td>Behavior Change Communication</td>
<td>National Campaigns</td>
<td>Local Campaigns</td>
</tr>
</tbody>
</table>

Source: Barkat et al., 2003

6.2.8 Grants and Subsidies

In some health systems, governments support private service providers via grants or subsidies. Since the funds are not formally linked to any service or output, such arrangements are usually applied to NGO service providers, whose activities are linked to government’s sector objectives. In Bangladesh, there are some instances of such support to NGO providers (see Box 6.3). As with contracting however, these experiences are taking place mainly in connection with donor supported programs and pilot activities.
Box 6.3 – The Example of the Bangladesh Population Health Consortium

The Bangladesh Population Health Consortium (BPHC) stands out as a prominent partnership venture in the area of HNP in Bangladesh. This public-NGO partnership is a component of DFID’s support to the government’s Health and Population Sector Program. In 1988, BPHC began supporting NGOs to deliver maternal and child health and family planning services to the poor and under-served communities in Bangladesh. Since 1988, more than 100 NGOs and 150 projects have been supported. BPHC supports locally based Bangladeshi NGOs, largely working in rural areas, predominantly with hard-to-reach and under-served populations. Some NGOs have the capacity to provide the full range of Essential Services Package (ESP) services while others focus on particular elements, for example reproductive health (Schuler et al., 2002). All participating NGOs have strong links to the communities. In the year 2000, approximately 2.2 million people in 59 Upazilas received ESP services through 37 small and medium-size NGOs. BPHC is managed by a group of 12 professional staff with diverse expertise. A three-member financial team is responsible for financial monitoring and auditing of the NGOs’ financial activities. Major achievements are illustrated in the table below.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Numbers</th>
<th>Percent</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women who received at least two antenatal care (ANC) consultations out of total deliveries</td>
<td>28959</td>
<td>74.0</td>
<td>30.3</td>
</tr>
<tr>
<td>Deliveries conducted by qualified person out of total deliveries</td>
<td>14439</td>
<td>36.9</td>
<td>N/A</td>
</tr>
<tr>
<td>Women receiving at least one postnatal care (PNC) consultations within 42 days of delivery</td>
<td>19886</td>
<td>62.1</td>
<td>N/A</td>
</tr>
<tr>
<td>Contraceptive Acceptance Rate (CAR)</td>
<td>N/A</td>
<td>63.0</td>
<td>53.8</td>
</tr>
<tr>
<td>Neonatal death</td>
<td>968</td>
<td>25.8/1000</td>
<td>50.4/1000</td>
</tr>
<tr>
<td>Maternal death</td>
<td>71</td>
<td>1.9/1000</td>
<td>4.3/1000</td>
</tr>
</tbody>
</table>

Source: Barkat et al, 2003

6.3 Perceptions of the Public Sector towards Working with the Private Sector

The information described below was collected during the semi-structured interviews conducted with a total of 21 policy makers and managers in the government system at central level to elicit their views of policy making in the health sector, especially with regard to public/private mix of services and the overall role of the private health care sector in achieving national health goals. Mid-level government officials were interviewed to solicit their views on private provision from those directly in charge of implementation of health sector policies (Forsberg and Axelsson, 2003).

Many of the persons interviewed felt that there is not a clear and well-communicated government policy towards the private health sector. However, it was said in some of the interviews that the government has recently decided to contract out some health services to private actors. More active supervision of the private for-profit providers in Dhaka district has also taken place recently following an initiative taken by the new government to improve services in the private sector.
Senior officials tended to describe the private health sector as providing tertiary care to well-off people. The widespread use of private providers at other levels and by all socioeconomic groups, as documented in surveys, was not put forward by most respondents. Many saw the close connection between the private and the public sector as a problem. The most apparent expression of the connection is that many doctors hold positions in both the public and the private sector. The fact that publicly employed doctors often work in the private sector and therefore lose focus on their duties in the public sector was often described as a problem by the persons interviewed.

6.4 Perceptions of the Private Sector towards Working with the Public Sector

As part of the policy-makers interviews, four private health care providers were interviewed to provide a private sector perspective on government health sector policies and the interaction between the private and the public sector. In addition, during the provider survey several questions elicited their perspective of the interaction with the government (HEU/IHE/NIPORT, 2003).

Private providers in general perceived there to be little interaction between themselves and government programs and activities. Again, the informal and non-allopathic providers perceived the least interaction. Nevertheless, all groups of providers expressed strong willingness to work with the government and the MOHFW. The majority expressed an interest in working with the government to expand their involvement in health promotion activities – an area where private providers are typically perceived as weak. In addition, the private clinic managers indicated that training of private staff would be a useful support from the government (see Table 6.2).

While there was a surprisingly large amount of interest in working with the Government, private sector representatives expressed reservations, which they attributed to corruption and lack of accountability in financial management. “Support by donors to health care provision could go directly to private actors. When funds go through the government there is corruption and too much diversion/leaking of funds.” Or “One major reason why the public sector is not a good choice for provision of care is that the accountability of the government is poor. The quality of public services therefore becomes very poor.”
Table 6.2 – Public/Private Sector Interaction: the Perception by Type of Provider

<table>
<thead>
<tr>
<th></th>
<th>Non-allopathic providers N=62</th>
<th>Pharmacists Drug vendors N=72</th>
<th>Hospital/Clinics N=41</th>
<th>Managers N=32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government regulations apply to work</td>
<td>90.3%</td>
<td>100%</td>
<td>N/A</td>
<td>100%</td>
</tr>
<tr>
<td>Want to collaborate with MOHFW</td>
<td>88.4%</td>
<td>75.0%</td>
<td>N/A</td>
<td>93.5%</td>
</tr>
<tr>
<td>Interested in getting involved in health promotion and prevention</td>
<td>69.4%</td>
<td>80.6%</td>
<td>N/A</td>
<td>96.9%</td>
</tr>
<tr>
<td>Stating influence by other actors</td>
<td>N/A</td>
<td>4.2%</td>
<td>N/A</td>
<td>21.9%</td>
</tr>
<tr>
<td>Stating that training of private staff would be useful support from government</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>(87.5%)</td>
</tr>
</tbody>
</table>

Source: HEU/IHE/NIPORT, 2003 and calculations by authors.13

6.5 Analysis

Reviewing the interaction between government and the private sector in health in Bangladesh generates several overarching conclusions.

*The range and magnitude of government engagement with private providers is not congruent with their importance in serving the population and reaching health sector objectives.* The government is not fulfilling an important part of its stewardship responsibilities to the sector as a whole – focusing instead on the administration of the public service network. The minimal attention and resources devoted to regulation indicates that health services regulation is a fairly low priority issue.

There is little collaboration with professional and provider organizations, nor support for self-regulation. Currently professional and provider organizations are primarily playing the role of trade organizations. Neither consumer nor patient organizations have yet emerged to play an advocacy role, nor to engage in monitoring of service quality and outcomes.

There is duplication and inefficiency of service and facility development due to planning process that does not include existing capacity or planned development of private facilities. This leads to unnecessarily high amounts of unpredictability and risk in development of private facilities and capacity. Segmented planning is also undermining the impact of public investment in health service provision.

6.5.1 Positive Developments in Public-Private Engagement

There are some promising bright spots, including a number of pilot public-private partnerships; as well as the involvement and collaboration with representatives from the private hospitals and clinics in policy discussions and formulation. In addition, in the past 10 years, a number of pilot

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13 The percentages were calculated among the private actors who provided an answer to the question.
initiatives have been undertaken to work with private, mostly non-profit, service providers to provide access to quality services for these population groups. Much has been learned from these experiences about the opportunities and challenges of “harnessing” the private sector to meet health goals in the Bangladeshi context. For example the collaboration between the national tuberculosis program and large NGOs could serve as an example for other programmatic areas. To date, however, few of these pilot initiatives have been expanded or “scaled up”. Building on these initiatives, to apply “lessons learned” and to reach greater numbers of people remains an important unused opportunity in Bangladesh health sector policy. Encouragingly, recent statements by the GOB indicate increasing awareness of and openness to working with the private sector.

6.5.2 Service Providers of Greatest Importance to the Poor

In general, the bulk of interaction between the government and private providers takes place with regard to private clinics and hospitals (see Tables 6-1 and Annex 6). Less formal, less organized providers, such as non-allopathic practitioners, including traditional birth attendants, and drug vendors and retail pharmacists on the other hand have very little interaction with government. This is unfortunate, as the poorer and more rural populations tend to utilize the latter.

6.5.3 Misperception and Low Capacity Underlie Weak Public-Private Engagement

A number of factors undoubtedly contribute to the current poor state of public policy toward the private health sector.

- There appears to be limited knowledge of the role (instruments) of the government in guiding the private sector towards contributing more towards social objectives related to access and service quality, in particular.

- There appears to me some misunderstanding regarding the current state of the private health sector in Bangladesh. The policy-makers’ interviews revealed that there is a limited understanding, indeed, even misunderstanding of the private sector size and role in provision of care, in particular to the poor in rural areas. Most policy makers believe the bulk of private provision is concentrated in tertiary care in the capital, overlooking the significant role alternative providers play in serving the poor and especially for maternal and child health services in rural areas.

Instruments to engage private actors (providers and representative organizations) are inherently complex to operate. They also require government officials to perform tasks very distinct from their traditional activities related to administration of public facilities. There is currently very little capacity to implement such instruments in the MOHFW or in local government bodies.

The bulk of health services are provided by alternative private practitioners, who are a heterogeneous, highly fragmented and unorganized part of the service delivery sector. This segment of the health services sector is consistently the most difficult to monitor, engage and influence. Experience from many countries, both developed and developing, reveal that initiatives to influence service provision in this sector is particularly challenging. They are less organized, often practice illegally or quasi-legally – and hence are very difficult to engage in public private partnerships.
Chapter 7. Main Findings and Policy Options

7.1 Main Findings

(a) Overall health service consumption in Bangladesh (from any source, public or private) is low compared to levels of reported illnesses and to levels in other countries. This is especially so for maternal and child health services.

(b) The poor are far more likely to forego medical treatment, with differences between rich and poor households being the largest for medically trained deliveries, antenatal care, treatment for ARI, and immunizations. The differences nearly disappear when comparing the use of modern contraceptives or oral re-hydration therapy for diarrhea, two services where there has been extensive social marketing.

(c) Women and girls tend to receive less medical care than men and boys.

(d) The private sector is used for the overwhelming majority of outpatient curative care, while the public sector is used for a larger proportion of hospital and preventive care. This broad division of roles cuts across economic strata of the consumers, contrary to a common perception that private sector caters to mainly to the tertiary care needs of richer populations.

(e) There are major gaps in knowledge concerning the private health sector – the actual numbers of providers, the services they provide, the conditions under which they practice their trade, their incentives and disincentives, etc.

(f) One very well established fact is that a majority of private providers of health services in Bangladesh (referred to in this report as alternative private practitioners) do not have formal training and recognized qualifications in allopathic medicine. The poor, especially, make heavy use of these APPs.

(g) The bulk of private health service providers are males (the exception being traditional birth attendants), which poses a major problem of access to their services by women.

(h) Although there is relatively little known about the quality of care of individual private providers, or the health facilities they work at, the available information suggests that assuring technical quality is a significant problem, particularly among alternative private practitioners.

(i) A majority of consumers, however, report to be satisfied with the private services they have received, and rate them superior to government-provided services. Alternative private practitioners are given preference over qualified doctors mostly on account of their easy access. Availability of drugs is also reported to be a key factor in choosing private practitioners (qualified or not) over government facilities.

(j) In spite of the obvious importance of the private sector, health policy in Bangladesh thus far has focused on the public sector and, in particular, on administration of public facilities. There has been insufficient attention paid to the potential of using the private sector more systematically in the pursuit of societal goals in health. There have been some instances such as the collaboration with NGOs (e.g., National Tuberculosis Program, Integrated Nutrition Project, social marketing of contraceptives), and a number of pilot initiatives as in urban primary health
care. Such initiatives have yet to be scaled up and lessons from these experiences yet to be generally applied to HNP program.

(k) Government regulations are in place for many aspects of health service provision in private facilities but enforcement has been uneven. The main constraints appear to be insufficient capacity and attention. There has been little collaboration between the government and professional and provider organizations in ensuring adequate standards, and no public support for self-regulation. Neither consumer nor patient organizations have yet emerged to play an advocacy role nor to engage in monitoring of service quality and outcomes.

In many ways, both the public and the private sectors have failed to meet the essential health care needs of the people in terms of both access and quality. The relevant question is: can the performance of the private sector be improved to meet the needs of the people and to provide the value for the money they spend for their health care?

7.2 Implications for Policy Formulation

The above messages suggest that there are several areas where a reformulation of government policies would be desirable, with a view to helping the attainment of the social goals in health that have become established public policy – for example, as enunciated in the government’s December 2002 interim PRSP. The central policy implication is to revisit the role of government in HNP, given the realities of resource and capacity constraints in the public sector, the already dominant place held by private actors in the financing and delivery of HNP services and the serious concerns about quality, access, accountability and governance with regard to both private and public services. In particular, the following policy areas would appear to deserve priority in government thinking and action in the next several years.

7.2.1 Under-Consumption of Health Care by the Poor and Women

The fact that many patients have a preference for private providers strongly suggests that the observed under-consumption of certain essential health services, especially by poor households and by women, cannot be remedied without increasing the access of under-served populations to private providers. The problem is particularly important for maternal health services, especially assisted delivery by a skilled attendant. The more traditional government approach of expanding the supply of services provided by government employees out of public facilities is not working for large segments of the population. The gender distribution of the providers is an important determinant on the decision to seek care, particularly for women.

7.2.2 Service Quality and Outcomes

Private health services (mostly clinical services) appear to be of good quality in the eyes of consumers. This judgment is likely based on those characteristics of private services that can be easily assessed by patients, such as ease of access, degree of courtesy/respect, and being able to procure both advice and medicines in one place. Much more problematic for consumers is the ability to assess correctly the technical quality of private treatment received or to relate such treatment to outcomes of illness episodes (good or bad). To make up for this important deficiency, and ensure that in most cases consumers derive good value from their purchases of privately provided services, deliberate and well-conceived collective action will be required. Issues of quality need to be looked at separately for the formal and informal sectors as public
policy interventions would be different for these two groups of providers. The multitude of provider types in the private sector warrants a mix of different policy options.

7.2.3 The Knowledge Base

While various public interventions could be conceived based on what is now known about the private health sector in Bangladesh, the large knowledge gaps that exist would magnify the uncertainty always associated with new policies and courses of public action. The knowledge base about private health services needs to be widened to enable the progressive refinement of policies and programs.

7.3 Policy Options

The following policy options were discussed during stakeholder consultations in early May 2003 with government officials, private sector actors, civil society, the academia, and development partners. While there was broad agreement on the need to increase the engagement with the private sector and on the value of the options presented here, it was agreed that further debate, consultations, pilot tests and studies are needed before policy decisions are taken.

Provision

- Develop a clear public policy towards the private sector that that harness the valuable resources that are available in this sector
- The government needs to create “head room” in its public expenditure envelope so that some public resources will become available for influencing the behavior of private providers through contracting with private providers and subsidizing care for the poor
- Bring APPs into service provider system by working with them in strengthening skills and increase the number of formally trained staff through training and encourage liberalization of the medical labor market
- Increase quality benchmarking, performance based competitive pressures and incentives to attract private practitioners to work in low coverage areas in addition to traditional regulatory and quality assurance techniques

Consumption

- Make information about the quality and price of private providers readily available to consumer, especially for the poor
- Introduce targeted subsidies and community level insurance for the poor and social insurance mechanisms for civil servants and formal sector workers
- Use strategic financial incentives (i.e., fees for doing vaccinations etc) and social marketing techniques to overcome other barriers to appropriate health seeking behavior

Public private interaction

- Increase competition between public and private sector through competitive and selective contracting and performance benchmarking.
• Introduce internal markets (make public providers compete for public funding on a performance basis) and new public sector management techniques (ie contracting out, contracting in, management contracts etc).

• Redefine the role of the MOH and strengthen its core stewardship capacity in areas such as strategic planning, monitoring and evaluation, coordination, regulation, quality control and enforcement.

More specifically, the options described below are initial ideas to address the 3 main sets of issues raised, i.e., under-consumption, quality concerns and knowledge base. These options need to be pilot-tested and evaluated first, before being scaled up nationally, but such pilots should be large enough to yield meaningful lessons.

7.3.1 To Address Under-Consumption of Services by the Poor and Women

Pilot contracting private providers with government funding: the government has already had some experience in contracting out some of its services out to non-profit organizations, but most of these models have been through donor-financed projects and have yet to be scaled up. Serious consideration needs to be given to the option of larger scale contracting of HNP service provision to the private providers, financed by public funds. The recent government discussion to contract out the management of 350 community clinics and Union Health and Family Welfare Centers is a positive step. Such contracting should, however, follow a transparent and fair process for the selection of firms/NGOs and should include rigorous monitoring and accountability procedures, to ensure both the quality of care and the efficient use of public resources. A clear description of the services to be provided and the inclusion of essential maternal and child health services is important. Contracting arrangements should be performance-based; i.e., payments could be designed as results-based financing, so that contract fees are linked to agreed outputs and health outcomes.

Expand social marketing: Bangladesh has a positive record of social marketing in contraceptives and oral rehydration therapy. Social marketing has been shown to reduce inequalities in access to such commodities. This experience could be expanded to other essential health-promoting commodities, such as bednets and soap, whose increased consumption would be beneficial to health outcomes.

Explore insurance / risk-pooling and prepayment mechanisms: Since people are paying for private sector HNP services from their pocket already, well-designed community insurance schemes could be feasible, if coverage of appropriate benefit package with acceptable quality could be assured. Such schemes would not only pool risks and resources for curative services for minor illnesses, but also provide for catastrophic coverage (if public subsidy for such coverage is considered appropriate) and could include incentives for seeking preventive services by building differential co-payments or deductibles. The Bangladesh experience with Grameen Bank’s schemes for their members might helpful in designing locally appropriate community insurance mechanisms. The inclusion of maternal and child health services in benefit packages is crucial, particularly for assisted delivery and complications requiring hospital care. Insurance schemes could be of different types in terms of the benefits package, kinds of beneficiary pool, and other aspects, ranging from micro-insurance schemes at the community level to the social insurance programs covering large populations employed in the organized sector.
Expand direct information campaigns: Such campaigns should address under-served households to enhance their appreciation of the importance of the health services they are not seeking – and the risk linked to the care obtained from unqualified practitioners. Most public information campaigns have so far focused on individual and household behaviors directly impacting on health; more attention needs to be paid to changing health-care seeking behaviors.

Explore demand-side subsidies: Public resources may be used to provide health coupons or such similar instruments to poorer population groups, giving them the necessary purchasing power to consume essential services from the private sector; this approach puts the choice of providers in the hands of the consumers, and empowers them. The success of demand-side subsidies depends on the availability of appropriate services of acceptable quality; hence, this option needs to be used in conjunction with other policy measures geared towards quality improvement, e.g., accreditation.

7.3.2 To Improve Service Quality and Outcomes in the Private Sector

A recurring theme of this study is the need to focus on the quality of health care. There are extremely weak and insufficient systems for assuring the quality of health care in Bangladesh, and as a result, there is little information about the quality of care. To improve quality and accountability in the health sector, it is important to not rely on a single strategy. If Bangladesh’s focus on quality becomes merely a program to regulate the health sector, it is unlikely to change the quality of health care significantly in the near future. It is more reasonable to tackle the quality issues on several fronts, using strategies that may be characterized as “top-down”; “bottom-up”, “leading edge”, and “driving force” (Table 7.1). The different strategies for addressing quality involve different actors, have complementary objectives, and have their own limitations and timeframes.

Table 7.1 Quality Improvement Strategies Relevant to Bangladesh: Multiple Fronts

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Examples</th>
<th>Objectives</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top-down</td>
<td>Licensing, registration accreditation</td>
<td>Set minimum standards</td>
<td>Limited impact in informal sector; depends on good governance</td>
</tr>
<tr>
<td>Bottom-up</td>
<td>(i) Consumer education &amp; advocacy</td>
<td>(i) Raise demand &amp; expectations for quality; redress harms</td>
<td>(i) Long run solution, but limited experience in countries where education levels are low, modest successes have been achieve in specific areas</td>
</tr>
<tr>
<td></td>
<td>(ii) Pilot quality improvement projects in leading organizations</td>
<td>(ii) Strengthen in-house capacity</td>
<td>(ii) Limited scale</td>
</tr>
<tr>
<td>Leading edge</td>
<td>Collaborative learning networks</td>
<td>Improve performance and change patterns of practice</td>
<td>Little experience in low-income countries</td>
</tr>
<tr>
<td>Driving force</td>
<td>Financing mechanisms linked to clinical practices</td>
<td>Influence provider behavior to improve quality</td>
<td>Medium to long term solution; there is need to first develop group purchasing of health services through insurance or pre-payment</td>
</tr>
</tbody>
</table>

The top-down strategies usually involve government agencies setting standards of care, most often with an objective of demanding a minimum level of qualification and safety. In Bangladesh, most standards in healthcare concern the qualifications of staff and physical inputs
at health facilities, rather than whether quality assurance processes, such as clinical guidelines or continuing medical education. Most top-down approaches are mandatory, though accreditation by professional bodies is more often a voluntary process. In many other countries accreditation is mandatory because large payers (e.g. governments and insurance companies) will require accreditation for an organization to be eligible for funding. Top-down approaches work best when the criteria can be easily measured and enforcement is straightforward; this is far from being the case in Bangladesh. While improvements and additions could be made to top-down strategies in Bangladesh, concentrating efforts on these approaches is not likely to make substantial improvements in quality in the short and medium term, since most providers work outside the formal sector, and the governance environment is weak.

Bottom-up approaches involve both demand and supply sides of the equation. On the demand side, such strategies involve educating and empowering consumers and consumer organizations. The main purpose is to enable the public to expect and demand better health care, or in some cases to redress harm caused to patients (top-down approaches can also concern redress). Consumer ratings of providers, facilities, and products (e.g. pharmaceuticals) can lead to changes in the behaviors of providers or the quality of products. Although there is a tremendous theoretical appeal of approaches that reduce information asymmetries between patients and providers, in practice, they have had limited success. Where successful, as in the case of reducing the demand for antibiotics for sore throats, the campaigns were quite targeted, and occurred in conditions where education levels and access to health services are much higher. Supply side strategies involve individual pilot projects by innovative and leading health care institutions. The limitation with these approaches is that they often depend on the individual circumstances of the hospital or organization undergoing the changes, and are not taken to a larger scale. Yet both types of bottom-up strategies are lacking in Bangladesh, and are worth initiating soon, even if their impact is more likely to be felt in the medium to long term.

Probably the most gains in the short and medium term would be made through so-called leading edge approaches, characterized by collaborative learning networks. These strategies involve pulling together networks of providers and facilities to establish improvement priorities, with each implementing improvement projects in a framework that uses up-to-date quality improvement methods and information sharing. In contrast to top-down strategies that try to set minimum standards, these approaches seek to improve care, and to continually develop best practices, while building human and institutional capacity. They are particularly effective in conditions where health systems are fragmented, as is clearly the case in Bangladesh. While collaboratives are fast becoming the leading form of healthcare quality improvement in North America and Europe, they have only recently being introduced in developing countries.

Finally, financing mechanisms can be considered as a driving force for quality improvement. Financing tools can be linked to the demonstration of good practice or good outcomes though subsidies, quality-linked payment rates, or contracting that is partly based on quality provisions. Their purpose is to influence provider behavior in a way that improves the quality of care and increases accountability. The main limitation with these strategies in Bangladesh is that people make most healthcare payments on an individual out-of-pocket basis, so that the ability to use the power of group purchasing to influence provider behavior is lacking. When health financing is based on out-of-pocket fees, the main incentive is for providers to offer more care and more intensive care than might be needed, and not necessarily to improve the quality of care. Until more coherent health financing systems are put in place (e.g. health
insurance or pre-payment programs), the ability to use financing mechanisms to improve quality in Bangladesh is limited. In the short to medium term, pursuing public sector contracting for health services where would help to build up experience with financing strategies.

Whatever sets of strategies are chosen to improve quality, leadership and consensus building will be important parts of the first steps. The strategies and technical components will need to be seen as being endorsed by influential decision-makers in the political, professional, and civic arenas, and also that the clinical aspects are developed/endorsed by the top clinicians. Government should play a leading role in catalyzing these initial steps. For example, government may establish a task force or commission to develop and oversee its quality improvement strategies. Another way government can immediately support a movement to improve quality in healthcare is to support research and assessments of quality of healthcare. Providing information on the quality of current practices is important to raise awareness and support for improving quality, and is also needed to provide a basis for setting standards and benchmarking, and to get health workers involved in quality improvement activities.

Based on the above considerations, the following policy options aimed at improving quality are aimed at both the formal sector, i.e., the qualified allopathic providers and facilities and (b) the informal sector (APPs):

Institute specific initiatives to improve quality of services provided by alternative private practitioners: Encourage the development of APP representative organizations, both local and national, through formal involvement in consultation and policy dialogue. Expand existing initiatives (contracting, training, information dissemination) to include APPs where viable; of particular relevance are the informal providers of maternal and child health services, including the traditional birth attendants.

Direct information campaigns to households: A direct information campaign, as mentioned above, can increase the consumption of services. It can also influence the demand for increased quality of services, resulting in pressure on private providers to improve their practices.

Promote the formation of consumer organizations in health: This would supplement and reinforce the ability of individual consumers to demand better quality services and to represent their concerns and even negotiate more competitive prices. Consumer organization can also play a role in the monitoring of quality of care in the private sector.

Subsidize training of private providers: This option is particularly useful for APPs, whose qualifications and skills are variable and inadequate in most cases. Recognizing the ineffective enforcement of the laws that ban their illegal practice, an alternative or complementary public policy might be to equip them with acceptable levels of knowledge and skills, both to improve their effectiveness and reduce the potential harm they cause to the public.

Upgrade the regulatory framework: This should include the revision of outdated regulations and identification of appropriate mechanisms and resources for enforcement of existing, appropriate regulations. Considering the existing, limited capacity to monitor and enforce regulations, this may be a long-term goal. Self-regulation, is also an complementary professional/provider associations need to be identified and their capacity to play the role of a self-regulatory body needs to be strengthened.
Explore accreditation: Private providers and facilities should be accredited, with a reliable system of regular monitoring and maintenance of standards, so that the consumers can have a basis on which to judge the quality of services. This option should be linked to direct information campaigns to households.

Explore franchising: This involves brand name development of health services, to give the consumers of health care a way to choose providers with an assured standard of services. Franchising could also give the providers a sense of belonging and pride.

7.3.3 To Improve the Knowledge Base for Policy-Making

Subsidize further research, including operational research and pilot initiatives: This was emphasized in the stakeholder consultations as a pre-requisite for making policy decisions on public-private interaction. Filling information gaps and testing new approaches was recognized as essential for enhancing the private sector contribution to health outcomes.

To enrich our understanding of the dynamics of the private sector, further work should include a more in-depth analysis of: (a) factor markets (pharmaceuticals, medical equipment, consumables, etc); (b) labor market dynamics; (c) capital markets; and (c) potential for insurance markets). A broadening of knowledge base is also necessary on other related subject areas. It must be stressed however, these suggestions for further studies are not to be misconstrued as a reason to delay policy actions for which considerable evidential basis already exists. A distinction must be made between operations research to pilot-test the policy options and the other research activities aiming to generate new knowledge.

While the specific areas of research would need to be determined through future discussions, some suggestions are listed here:

- Conduct a more comprehensive, nationally representative survey of private sector providers, their consumers (geographical and socio-economic strata), types of services provided, prices of these services, quality, client satisfaction, their level of training, types of medicine practiced. Such a follow-on survey should include all types of alternative providers as well, particularly traditional birth attendants, and should include a comparative analysis of strengths and weaknesses of private providers, including NGOs.

- Carry out econometric analysis of the private health care market, including an analysis of the supply-demand curves, price-elasticities, unit-costs and such other aspects that could enlighten the policy-makers more about the economic drivers of supply of, and demand for, private services.

- Conduct a further analysis of HNP-related commodities (pharmaceuticals, vaccines, baby food formula, hygiene products, bed nets, etc.), to study both supply and demand side factors relevant to these markets and look at ways of building public-private partnerships in these areas.

- Conduct a labor market assessment, including the market dynamics of supply and demand in relation to human resources, and the incentive mechanisms influencing providers in the private sector.
• Conduct a full-fledged study of governance issues as they apply to private as well as public sector, including the issue of dual practice.

• Based on a thorough analysis of the various markets relevant to HNP services, develop a strategy for creating a more competitive environment among the private providers and also between the public and private providers, using public policy as a facilitating tool.

Develop better information systems: Expand the health information system to collect more reliable data from the private sector, especially with regard to communicable diseases.

Information sharing: Such efforts would aim at disseminating information to policymakers, managers, and other key actors in the public sector to enhance their understanding of the private sector and vice versa.

7.3.4 The Way Forward

This section provides some pointers on how the policy options might be realized into action. The authors do not wish to be prescriptive about the solutions for the issues emerging from their study. Rather, public policy should evolve through a participatory process in Bangladesh, with the active and broad-based involvement of all stakeholders. Therefore, the policy options presented here - both the "what" and the "how" - are merely a starting point for national debate.

As the Government is preparing its new Health, Nutrition and Population Sector Program (HNPSP), the findings of this study and the other related studies under the AAA work could serve as a useful vehicle for policy dialogue, taking a fresh perspective on sector reforms needed to achieve HNP outcomes as part of the MDG.

In order to advance such national policy debate and enable the government of Bangladesh to better harness the potential of the private sector for the achievement of health outcomes, the following are possible next steps:

• Set up a Public-Private Task Force in the MOHFW to provide a focal point for evolving processes and activities towards a fruitful relationship between public and private actors. This task force would promote, institutionalize, and coordinate public-private interactions. This would be a temporary measure until durable processes, systems, financing mechanisms, and regulations relating to public/private partnership in the health sector are well-established and absorbed by the relevant agencies.

• Create the necessary fiscal space or “head room” in the public resource envelope, so as to ensure the availability of the substantial additional resources needed to finance increased engagement with the private sector and the required pilots on a large enough scale to make them replicable (over and above the current health sector budget, most of which is already committed to public sector provision). One way of doing this would be through demand-side financing initiatives, micro-insurance schemes or other community financing mechanisms.

• Capacity development in the MOHFW to enhance its engagement with the private health sector. Such capacity requires the development of new types of skills, in areas that have not traditionally been among the functions of MOHFW. The capacity of other relevant
actors, such as civil society, development partners, and private sector actors should also be considered. This would include substantial education for public sector staff on the size and distribution of private HNP sector in Bangladesh, and ways of building partnerships with private actors; similarly, training and confidence-building activities targeted at the private sector would also be critical.

- **Participatory policy-making and more inclusive planning and programming:** The findings of this and other related studies, should be actively and widely disseminated, as the for national policy debates, involving stakeholders at all levels so that a broad-based set of policy options is developed. Private sector actors should be included in such process and a full consideration given to private sector capacity in service and facility planning. Participatory policy debate should take advantage of the i-PRSP, which already includes some of the ideas outlined in this report.

- **Pilot activities to test the selected policy options.** Once specific policy options are selected through consensus, they need to be tested through operations research to determine their feasibility and measure their impact in the Bangladeshi context. The design of such pilots should build on previous experience, and evidence already available about public-private partnerships, demand-side financing, micro-insurance schemes, contracting with results-based financing and other such ideas.

A **preliminary timeline** for the next steps is suggested as follows (this needs to be agreed with the Government):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of other related studies (financing, governance, etc.)</td>
<td>August 2003</td>
</tr>
<tr>
<td>Dissemination of existing evidence, multi-pronged communication exercise, consultations across the country</td>
<td>July to December 2003</td>
</tr>
<tr>
<td>Development of broad-based HNP Policy Options</td>
<td>December 2003</td>
</tr>
<tr>
<td>Initiation of Pilot Interventions (e.g., micro-insurance, results-based contracting with private sectors, demand-side subsidies)</td>
<td>January 2004</td>
</tr>
</tbody>
</table>
Table 7.2 Summary of Issues and Suggested Policy Options

<table>
<thead>
<tr>
<th>Issue to Address</th>
<th>Policy Options</th>
<th>Targeted Private Actors</th>
<th>How Does it Work?</th>
<th>Global Examples of Options Used in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the Knowledge Base</td>
<td>Subsidize research and Pilot tests</td>
<td>All</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information Systems</td>
<td>Providers of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information sharing</td>
<td>All</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under-consumption of services</td>
<td>Insurance/risk-pooling</td>
<td>Health insurance companies Service providers</td>
<td>Increase in consumption through financial protection</td>
<td>Bolivia&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Social marketing</td>
<td>Service providers Suppliers The media</td>
<td>Increased supply of health goods and services</td>
<td>Central America&lt;sup&gt;15&lt;/sup&gt; Indonesia&lt;sup&gt;16&lt;/sup&gt; Tanzania&lt;sup&gt;17&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Contracting</td>
<td>Service providers (for-profit, NGOs)</td>
<td>Increase in supply and coverage of health services</td>
<td>Senegal/Madagascar&lt;sup&gt;18&lt;/sup&gt; Cambodia&lt;sup&gt;19&lt;/sup&gt; Haiti&lt;sup&gt;20&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Demand-side subsidies</td>
<td>Qualified private providers</td>
<td>Public subsidies are given to targeted vulnerable populations, giving them a choice of providers from whom to buy care</td>
<td></td>
</tr>
<tr>
<td>Quality of services and health outcomes in the private sector</td>
<td>Information campaigns to consumers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subsidize training of private providers</td>
<td>Service providers (Allopathic, APPs)</td>
<td>Increased knowledge, skills, and practice of providers Increased demand from consumers of quality services</td>
<td>India&lt;sup&gt;21&lt;/sup&gt; Pakistan&lt;sup&gt;22&lt;/sup&gt; Guatemala&lt;sup&gt;23&lt;/sup&gt; Pakistan&lt;sup&gt;24&lt;/sup&gt; The Gambia&lt;sup&gt;25&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Promote the formation of consumer organizations in health</td>
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<tr>
<td></td>
<td>Upgrade the regulatory framework</td>
<td>Service providers (Allopathic, APPs)</td>
<td>Incentives to increase beneficial services, disincentives to provide poor quality services</td>
<td>Lao P.D.R.&lt;sup&gt;26&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>Promote self-regulation</td>
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<td></td>
<td>Explore accreditation</td>
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14 Dmytraczenko et al, 1999a; 1999b  
15 Saade et al, 2001  
16 Alisjahbana et al, 1995  
17 Schellenberg et al, 1999; 2001  
18 Marek et al, 1999  
19 Bhushan et al, 2002; Loevinsohn, 2000  
20 Nieves et al, 2000  
21 Chakraborthy et al, 2000  
22 Luby et al, 2002  
23 O’Rourke, 1994  
24 Miller et al, 1995  
25 Greenwood et al, 1990  
26 Stenson et al, 2001a; 2001b
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This annex briefly documents the process by which the HNP Policy Options AAA work evolved, how the PSA for HNP sector of Bangladesh was developed, and the framework of the AAA task within which the PSA fits. The process involved extensive consultations with various stakeholders at different stages. Apart from the workshops conducted specifically for the AAA work, inputs were used also from the Divisional Workshops held in the context of the preparation of the new Health, Nutrition and Population Sector Program (HNPSP). Various issues relevant to the sector were raised and discussed in these workshops, and these ideas needed to be organized within a framework that lends itself to analysis and study with a view to developing policy options which takes account of determinants and actors key to achieving the Millennium Development Goals.

A broad framework of HNP determinants as a context for the PSA for HNP

The rationale for the focus of the study was developed based on the following schematic about the determinants of health outcomes relevant to the MDG. The schematic shows four broad sets of determinants of HNP outcomes:

(i) genetic factors (what a person is born with)

(ii) behavioral factors (what a person does to himself/herself)

(iii) environmental factors (what the environment does to one’s health; e.g., physical, chemical, biological, social and cultural environment, all of which affect our health in a myriad ways)

(iv) the HNP services (which are a part of the environment, but have a special place in this framework because of their direct impact on health and because they are more amenable to action by the HNP sector). HNP services, in turn, are divided into public and private sectors. All too often, HNP services are narrowly construed to include only the public sector services. The main focus of this study is on the private sector, with a view to engaging more effectively with them in the pursuit of social goals relevant to HNP outcomes.

For each set of determinants (except genetic factors, which are less amenable to direct intervention and are mentioned here merely for the sake of completeness), relevant actors are identified and corresponding roles are suggested for the MOHFW. If one looks at the long list of roles that the MOHFW is currently trying to play with respect to the public sector services, it may point to at least one reason why the Ministry’s roles with respect to the private sector actors remain unfulfilled. The limited capacity of MOHFW is exhausted on the public sector, leaving little or no capacity to play its legitimate and important roles vis-à-vis the private sector (a similar deficiency would also be found in terms of MOHFW roles on environment and behaviors). Inadequate attention to the stewardship of the private sector combined with difficulties in the management of public services, result in problems on quality and access to HNP services on the whole.
### Table A1.1 A framework of HNP determinants

<table>
<thead>
<tr>
<th>Determinants</th>
<th>HNP SERVICES</th>
<th>ENVIRONMENT</th>
<th>BEHAVIORS</th>
<th>GENETIC FACTORS</th>
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</thead>
<tbody>
<tr>
<td><strong>Actors</strong></td>
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<td></td>
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</tr>
<tr>
<td>Public Sector</td>
<td></td>
<td></td>
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<tr>
<td><strong>Private Sector</strong></td>
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<tr>
<td>Non-health Ministries, private &amp; State-owned industry, transport, the population</td>
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<tr>
<td>Individual, Household, Community levels</td>
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<td></td>
</tr>
<tr>
<td><strong>Role of Ministry of Health and Family Welfare (MOHFW)</strong></td>
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<td></td>
</tr>
<tr>
<td>Policy-making, Planning, Regulating, Monitoring, Informing, Financing, Service Delivery</td>
<td>Policy-making, Planning, Regulating, Monitoring, Informing Financing (for the poor) Purchasing (on behalf of the poor)</td>
<td>Coordination and collaboration with relevant other ministries, private sector actors and communities to facilitate action.</td>
<td>BCC&lt;sup&gt;29&lt;/sup&gt; Collaboration with other ministries and private sector actors.</td>
<td></td>
</tr>
</tbody>
</table>

### Technical Missions

Three Technical Missions were fielded (April 15-21, 2002; May 26-30, 2002 and November 17-28, 2002) which held discussions and consultations with various stakeholders, including GOB, NGOs, for-profit private sector actors, development partners, academia, civil society and health consumers. During these missions, an effort was made to identify gaps in information, needs for further studies and sector issues that warranted greater focus. Consultation workshops were held in the six Divisions of the country and not merely in Dhaka, so as to obtain the perspectives of stakeholders across the country at various levels of the health system as well as beneficiaries / clients of the system. Since GOB was holding Divisional workshops in preparation for HNPSp at about the same time, the AAA process latched on to these workshops to develop the analytical agenda that might be most relevant to the policy discussions emerging from them.

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<sup>27</sup> HRD: Human Resource Development (i.e., planning, and production of the necessary human resources for the HNP sector)

<sup>28</sup> HRM: Human Resource Management (i.e., deployment, maintenance, in-service training, compensation and other aspects of management of the staff and personnel for the sector)

<sup>29</sup> BCC: Behavior Change Communication (i.e., communication efforts aimed at changing human behavior at the individual, household and community levels towards better HNP status)
The studies that were eventually included for funding by the DPs, were chosen based on these consultations. The consultations were also used to disseminate, more widely, the findings of the Health Futures Study, the fore-runner of the HNP Policy Options AAA initiative.

Apart from the PSA for the HNP sector, the other four studies are: a health labor market assessment (conducted by CIDA), an alternative health financing options study (WHO), a governance study (Netherlands), and a study on decentralization (Sida and EC). Having zeroed in on these five studies, resources were mobilized through the DPs who form part of the HNP consortium in Bangladesh. A conscious and deliberate attempt was made to broaden the ownership of the AAA work beyond the Bank; the Bank played a key role, however, in facilitating and pursuing the five studies with the respective financing agencies. While the studies are at various stages of maturation, it is expected that all five of them would be completed by mid-2003 and the Policy Options work would take place soon thereafter.

While the first two technical missions focused on disseminating existing information and developing the overall AAA framework, the third technical mission prepared the ground for the PSA exercise. The mission reviewed existing relevant literature, consolidated the consultative process, formulated detailed study outlines, and identified individuals/institutions for collaboration on the data collection and other activities of the PSA. The mission met with relevant government officials, representatives of development partners, private sector (including NGO) stakeholders, professional associations, consumer groups, and research institutions. The Mission also undertook field visits to observe certain models of Public-private Partnerships (PPPs) already under implementation in Bangladesh.

One of the key agreements reached with GOB during the Third Technical Mission is that a Technical Review Committee would be set up, with GOB in the lead and with representation from private sector actors, academia and professional groups. Such a Review Committee would comment on all the reports produced under the umbrella of the AAA work and serve to bring the Bangladeshi perspective fully into consideration. In line with this approach, the current report would also be reviewed by the Technical Review Committee (in addition to the Bank’s internal process of peer reviews and departmental reviews).

**The AAA Framework and how the PSA fits into it:**

This report presents the findings of the PSA for HNP in Bangladesh, which is just one of the five related studies being carried out simultaneously. The five studies together would inform the HNP Policy Options paper that would be prepared through a broad-based participatory process involving the Bangladeshi actors in the public and private sectors.

The following sequence of actions illustrates the mix of consultative and analytical tasks under the AAA work. Also evident are the inter-linkages between the five studies.
Figure A1.2 The AAA Framework – sequence of process steps with timelines

<table>
<thead>
<tr>
<th>Date</th>
<th>Mission Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2002</td>
<td><strong>First Technical Mission</strong>: <strong>Stakeholder Consultation</strong> (Wider dissemination of Health Futures Study and other relevant data; consensus on information gaps and research needs)</td>
</tr>
<tr>
<td>May 2002</td>
<td><strong>Second Technical Mission</strong>: (continued consultative process; better specification of studies to be undertaken; clearer definition of the Concept Note for the AAA)</td>
</tr>
<tr>
<td>November 2002</td>
<td><strong>Third Technical Mission</strong>: (continued consultative process; final determination of five studies, identification of development partners, sources of funds for the five studies)</td>
</tr>
<tr>
<td>Dec 2002 to April 2003</td>
<td><strong>PSA for HNP (World Bank + DFID)</strong></td>
</tr>
<tr>
<td>May – June 2003</td>
<td>Review processes, stakeholder consultations and finalization of each individual study</td>
</tr>
<tr>
<td>July- Sept. 2003</td>
<td>Dissemination of study findings, and development of HNP Policy Options through a participatory process</td>
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</table>

**Next Steps in developing HNP Policy Options**

The Private Sector Assessment being one of five studies, it is only one piece of the puzzle. It is important to pool the evidence arising from it along with the remaining four and along with the various other sources of existing information, such evidence should be disseminated and debated widely across the nation through a broad-based participatory process. Such process would then result in the development of HNP Policy Options which would be based on evidence and consultation, owned broadly in the country and could usefully contribute to the future planning and programming for the sector.
Annex 2: Global Evidence on Modalities to Engage the Private Sector to Improve Maternal and Child Health Outcomes

1 Introduction

The mandate for greater international attention to maternal and child health outcomes has recently been reaffirmed. The maternal and child Millennium Development Goals (MDGs) call for a reduction of maternal mortality by three-quarters and child mortality by two-thirds by 2015. Knowledge generated by safe motherhood programming in the last decade has provided a greater understanding of the public sector role and contribution to maternal mortality reduction. However, in most low-income countries there are anecdotal reports of the rapid spread of private sector provision of maternity care and there is a limited understanding about the current and potential role of, and the risks and opportunities of harnessing private sector capacity in pursuit of the MDGs (MacDonagh et al., 2003). A recent review of the last twenty years of experience in child health programs highlighted that the traditional focus of child health programs has been on health service delivery in the public sector (Claeson et al., 2000). Child health programs have largely ignored, or partially attempted to work with, the private sector (Bustreo et al., forthcoming; Waters et al., forthcoming).

This annex reviews the global evidence on modalities for mobilizing and working with the private sector to improve maternal and child health outcomes. With regards to maternal health we focus on: antenatal care, skilled attendance at delivery and basic/comprehensive obstetric care. We attempt to identify experiences and policy options that are most relevant for the ongoing discussion in the Bangladeshi health sector. Governments have used a number of modalities – although in a fragmented and limited way – to encourage and expand private sector behavior that is beneficial to child and maternal health and to limit potentially harmful behavior by the private sector. These modalities include contracting, commercialization and social marketing, regulation and standard setting, information dissemination and training, and franchising. The sources for this annex include published and unpublished literature. Rigorous evaluations and scientific comparison are scanty in the reviewed literature. Some of the documents provide descriptive case studies, whereas others allow for comparisons of outcomes between an intervention group and a control group, or between pre- and post-outcomes for an intervention group.

The annex is organized in sub-sections according to the modalities. Each sub-section contains: (a) a definition of each modality and general applications in the health sector; (b) a review of evidence on interventions specific to child and maternal health; and (c) a box with a more in-depth description of one intervention in child and/or maternal health. It should be noted that the described interventions may not have addressed only child and maternal health, but were included if a substantial portion of the intervention benefited children and mothers. The box examples have been selected for their particular relevance to the Bangladeshi context and because the sources applied the most rigorous study methodology. The chapter is summarized in Table 1, which lists, for each modality, the specific examples of interventions, sources of information, principal beneficiaries, private sector actors, and mechanisms through which the intervention translated into improved health outcomes.
2 Contracting

Contracting is used to purchase a specific service, of a defined quantity and quality, from a specific provider, for a specified period of time and implies an ongoing relationship (Taylor, 2003). Contracting with private actors for health and related goods and services has been used to address a wide range of policy issues in the health sector, such as increased quality and coverage, lower costs, and reduced administrative burdens. Contracting for health services is the most commonly used form of contracting (Palmer, 2000), but has also been applied to medical equipment (Mills, 1998), distribution of vaccines and other pharmaceutical products, and support services such as catering and cleaning (Mills, 1998; McPake and Banda, 1994). Evidence from developing countries is limited, but some evidence has emerged. Basic health services were provided more efficiently through contractual agreements with the private sector in Zimbabwe (McPake and Hongoro, 1995). However, in South Africa, the overall costs to the government of contracting with the private sector were similar to or higher than services provided directly by the government (Mills, 1998; Mills et al, 1997; Broomberg et al, 1997). Evidence from South Africa and India suggests that the quality of services provided by contracting with private actors was similar or better than government provided services for some aspects (e.g. cleanliness) and worse for others (e.g. dietary services) (Mills, 1998).

2.1 Evidence from Specific Interventions in Child and Maternal Health

In Senegal and Madagascar, two large-scale projects, both started in the mid-1990s, contracted with NGOs to provide nutrition services to children under-five and their mothers. The projects achieved significant improvements in the nutritional status of children. In one intervention zone in Madagascar, malnutrition decreased from 25% to below 10%. In Senegal, severe malnutrition of children 6-11 months decreased from 6% to 0% and moderate malnutrition of children 6-35 months decreased from 28% to 24% (Marek et al, 1999). The evidence on the improvement of maternal nutrition was less clear.

The government in Haiti introduced a one-year pilot to study the effect of performance-based contracting in improving provider performance of healthcare NGOs. Three of Haiti’s NGOs, providing basic health services, including maternal and child health and family planning services, were included in the pilot. While provider performance in the area of child health improved, i.e. the immunization coverage increased in all three NGO service areas, performance was relatively weak in meeting prenatal care targets, probably because of the need for ongoing counseling and behavioral change. In prenatal care, the percentage of women with at least three prenatal visits increased from 32% to 36% in NGO 1, decreased from 49% to 44% in NGO 2, and decreased from 18% to 16% in NGO 3 (Eichler et al, 2001a; 2001b).

In Guatemala the government contracted out large-scale basic health services, including maternal and child health services (Nieves et al, 2000). In Cambodia, the government contracted with NGOs to increase the supply of maternal and child health services (see Box 1).

Box A2.1 - Contracting for Maternal and Child Health Services in Cambodia

Contracting was used to increase the supply of child, maternal, and other health services in Cambodia. The Ministry of Health contracted with NGOs to deliver a package of services at the health center level. The Ministry of Health was involved extensively in designing, monitoring,
and managing the contracts. The services included preventive services, such as immunization, family planning, antenatal care, and nutritional support, and curative care, such as diarrhea, ARI, and tuberculosis. The project implemented two models of contracting. In the contracting-out model, NGOs had complete responsibility for delivery of the specified services, directly employed their own staff, and had full management control. In the contracting-in model, NGOs provided only management support health staff employed by the government. The government funded operating costs through existing channels. Recent research compared the outcomes of the two contracting approaches and one control area through household and health facility surveys. It was found that districts covered by the two contracting approaches consistently outperformed the control districts as measured by observed changes in 11 pre-defined health service coverage indicators. The contracting-out approach outperformed the contracting-in approach. For antenatal care, service coverage increased by 160% in the control districts, by 233% in the contracted-in districts, and by 402% in the contracted-out districts. For child immunization, the changes were 56%, 82%, and 158% for control, contracted-in, and contracted-out, respectively.

Sources: Bhushan et al, 2002; Loevinsohn, 2000; Soeters and Griffiths, 2003

3 Commercialization and Social Marketing

Commercialization and social marketing constitute a modality through which producers and sellers agree to expand delivery of health related goods to target populations. In return, the government or project undertakes actions to make the product more profitable, for example by increasing demand through consumer education. Commercialization and social marketing have been utilized to increase sales of goods such as soap for handwashing (Saade et al, 2001; see also Box 2), insecticide-treated bednets to prevent malaria (Schellenberg et al, 1999; 2001; Abdulla et al, 2001), and ORS to treat diarrhea (Ferraz-Tabor, 1993; Koul et al, 1991). Social marketing has also been used extensively to increase knowledge and use of family planning methods.

3.1 Evidence from Specific Interventions in Child and Maternal Health

Commercialization and social marketing was used in Tanzania to increase the sales and use of insecticide-treated bednets. As a result of the intervention, child mortality due to malaria decreased by almost 30% and anemia prevalence by more than 60% (Schellenberg et al, 1999; 2001; Abdulla et al, 2001). In Central America, a handwashing initiative worked with soap producers, NGOs, and the media to encourage improved handwashing practices (see Box 2).

Box A2.2 – Commercialization and Social Marketing in Central America

The Central American handwashing initiative applied commercialization and social marketing techniques to address high rates of diarrhea among poor, rural groups in Costa Rica, El Salvador, Guatemala, and Honduras. The project worked with soap producers, NGOs, and the media to improve handwashing practices and increase the demand for, and supply of, soap for handwashing. The project task force conducted baseline market research on handwashing practices, which was beneficial to the soap producers’ marketing strategies. It also developed public health messages that stressed the importance of correct handwashing practices before preparing and eating food, after defecation, and after changing or cleaning a baby. The marketing departments of the soap producers used the public health messages to increase demand for soap. The messages were reinforced through the local media and NGO-conducted community outreach educational campaigns. As a result of the intervention, handwashing behaviors improved.
considerably and the prevalence of diarrhea among children under five years of age was reduced by 4.5%.

Source: Saade et al, 2001

In Indonesia, a study called the “Regionalization of Perinatal Care” combined different modalities including social marketing. The main components of the intervention were: (a) establishment of 10 birthing homes staffed by trained midwives in 27 villages in the intervention area and the installation of two-way radios in each birthing home, the 3 health centers, and the referral hospital; (b) training of TBAs to improve their knowledge, skills, and practice and training physicians at health centers and village-based midwives at birthing homes on danger signs and appropriate case management of pregnant women, including care of the newborn; (c) an emergency transport system; and (d) social marketing to improve the knowledge of women, families, and communities about danger signs during pregnancy and delivery (Alisjahbana et al, 1995). The perinatal mortality rates were not statistically different between intervention and control areas. Maternal mortality decreased in the intervention area over time, but levels were too low to draw conclusions in relationship to the interventions.

Another two interesting examples come from Uganda. First, SOMARC (Social Marketing for Change) and the Uganda Private Midwives Association collaborated to launch the Market Day Midwives project, which set up midwives in community markets as a distribution system for family planning. SOMARC provided each midwife with a sales booth, training and a uniform, and sold the products to midwives at wholesale prices (Futures Group International, 1998). Second, Commercial Market Strategies (CMS) provided training in business skills, marketing and credit management, and produced a Business Handbook for Private Health Providers. The three-year project is expected to provide training and finance to 280 private healthcare providers (Commercial Market Strategies, 2003).

4 Regulation and Standard Setting

Health regulation has been defined as “the range of factors exterior to the practice or administration of medical care that influences behavior in delivering health care” (Brennan and Berwick, 1996). Most developing countries have in place some form of basic regulation in the health sector, covering issues such as registration and licensing, dangerous and unethical health services, and legislation on the production and distribution of drugs (Bennett et al, 1994). In some cases, such as Thailand, the regulatory framework is considered quite comprehensive (Teerawattananon et al, 2003). However, several studies have reported gaps in regulatory frameworks (Birungi et al, 2001; Kumaranyake et al, 2000); that inadequate resources are allocated to monitoring and enforcing health regulations (Brugha and Zwi, 1998; Birungi et al, 2001; Yesudian, 1994; Hongoro and Kumaranyake, 2000; Bhat, 1999; Teerawattananon et al, 2003); and that health regulation can be captured by interest groups and used for their own purposes (Ngalande-Banda and Walt, 1995; Soderlund and Tangcharoensathien, 2000), rendering formal regulations ineffective in practice.

4.1 Evidence from Specific Interventions in Child and Maternal Health

The promotion of the unnecessary use of infant formula constitutes a negative influence of private actors – producers and suppliers – on feeding practices and health outcomes. To combat this harmful influence, WHO and UNICEF developed the International Code for the Marketing
of Breast Milk Substitutes in 1981 (WHO, 1981). A number of countries have applied this code to the regulation of production and distribution of infant formula. For example, when applied in the Philippines, this regulatory intervention achieved significant declines in the distribution of free and low-cost infant formula between 1986 and 1988 (Popkin et al, 1990).

In Lao P.D.R., the government enhanced and enforced regulations on the sale of pharmaceutical products by pharmacists and drug sellers, resulting in considerable improvement in the quality of prescription practices and sales of crucial medicines (Box 3).

**Box A2.3 – Regulation of Pharmacists and Drug Sellers in Lao P.D.R.**

In developing countries in general, there are problems associated with provision of pharmaceuticals by private firms. These problems can have significant implications on the health status of the population, and are exacerbated by the fact that the private sector is the largest retailer of pharmaceuticals in many developing countries. In addition, patients in these countries often bypass the medical system by engaging in self-care and often turn directly to pharmacies for medical advice. In Lao P.D.R., the government carried out a pilot regulatory intervention to address prescription practices and advice given by pharmacists and drug sellers. The regulatory initiative included four annual inspections of each private pharmacy, feedback to the pharmacists from the inspections, enhanced enforcement through application of sanctions for gross violations, and improved information dissemination about applicable regulations to private pharmacies and drug sellers. The intervention resulted in considerable improvement of service quality provided by private pharmacies and drug sellers, as measured by indicators such as increased availability of essential drugs and information given to customers, and decreased mixing of different drugs in the same package.

Sources: Stenson et al, 2001a; 2001b

5 Information Dissemination and Training

Information dissemination and training is another modality that can be used to influence the behavior of private sector actors and consumers of health and related goods and services. The combination of addressing the supply side – by training, for example, private practitioners – and the demand side – through educating consumers to demand beneficial health goods and services – is an important one, as several studies have shown that focusing only on provider knowledge results in a lower probability of actually changing undesirable behavior (Choudhry and Mubasher, 1997; Davis et al, 1995; Ibrahim and Isani, 1997; Paredes et al, 1996; Tawfik et al, 2002).

5.1 Evidence from Specific Interventions in Child and Maternal Health

In India, the care of sick children provided by private practitioners was addressed through training and information dissemination. The intervention consisted of informing the providers of standard case management guidelines for ARI, diarrhea, and fever; giving feedback on their performance; gaining their commitment to practice according to specific guidelines; and monitoring of their practices. An evaluation of the intervention reported significant improvements in history taking and examination and counseling practices for ARI, diarrhea, and fever (Chakraborty et al, 2000). A similar intervention in Pakistan improved the case management of sick children provided by private practitioners, as measured by the extent to
which they followed behavior recommended by the Integrated Management of Childhood Illness strategy (Luby et al, 2002). In Kenya and Indonesia, one-on-one meetings between educators and pharmacists and drug sellers resulted in increased sales of ORS and reduced sales of antidiarrheal drugs (Ross-Degnan et al, 1996). The Bangladesh Rural Advancement Committee (BRAC) experimented with training of community health volunteers to manage ARI, which resulted in increased skills and case recognition when compared to untrained volunteers (Hadi, 2003).

In many developing countries public sector antenatal care coverage is higher than delivery care coverage. Many women seek delivery care from the informal sector, most notably from Traditional Birth Attendants (TBAs) (MacDonagh et al, 2003). The informal sector covers a very wide range of activity and skills, from TBAs to the “unorthodox” deliveries that take place in spiritual churches in Southeast Nigeria (Etuk et al, 1999). Training of TBAs has been conducted in many parts of the world to improve the quality of care provided during delivery. Although the experiences and record of reducing maternal mortality are mixed, there are successful examples of how the training of this large group of informal private sector providers can contribute significantly to maternal health (Box 4).

**Box A2.4 – Training of Traditional Birth Attendants (TBAs)**

Many of the studies on private sector involvement in maternal health addressed the training of TBAs. Three can be considered “controlled” trials as they compared results in two or more groups, although no randomization of training occurred. These studies, which were conducted in Pakistan (Miller et al, 1995), Guatemala (O’Rourke, 1994), and the Gambia (Greenwood et al, 1990), showed marked improvements in TBA knowledge and skills, number of antenatal check-ups, receipt of tetanus toxoid injections, number of referrals to health centers and hospitals, as well as health outcomes such as decreases in perinatal and maternal mortality. Several studies had a pre- and post-evaluative component but no comparison group and these also showed decreases in perinatal and maternal mortality. One study showed a decrease in maternal mortality by over 50% after a three-year TBA training program (Brennan, 1988). One study in Bolivia resulted in a decrease in the perinatal mortality rate from 75 to 31/1,000 over 2 years (Howard-Grabman, 1993). Two studies showed a decrease in neonatal mortality due to tetanus, and, in fact, neonatal tetanus was completely eliminated as a cause of infant mortality in rural Haiti (Dehne et al, 1995; Berggren et al, 1983). Overall, TBA knowledge, skills and practice improved after training as measured by indicators like the use of sterilized blades to cut the umbilical cord and the percentage of mothers who started breastfeeding within the first hour after delivery. The upgrading of TBA skills also led to improvement in prenatal care, as measured by increases in the number of prenatal visits. Equipping TBAs with safe birthing kits was shown to add considerably to improved outcomes due to the training alone. In one study, patient satisfaction was also shown to improve from 79% of women stating that they would return to the TBAs before training to 94% after training (O’Rourke, 1994).

Besides the training of TBAs, interventions to improve clinical skills in maternal health of private providers include several examples. In Zimbabwe and Romania, private physicians, pharmacists, and nurse-midwives were trained in safe and effective use of contraceptives (Deloitte & Touche Tohmatsu International, 1997). In Ghana there have been several small-scale skills training initiatives with private midwives. In Ghana, an initiative by the Ghana Registered Midwives Association worked to include family planning in the routine services offered by
midwives in their private practices. In the later half of the 1990s, training in post-abortion care was provided to private midwives in Ghana (Billings et al, 1999). In Kenya, private midwives benefited from an 18-month training project (Intrah, 2003). In Cambodia in 1995, midwives who work both in government health centers and after hours in private practice domiciliary care were trained in life saving skills (EngenderHealth, 2003). In Uganda, Family Care International has worked with the Uganda Private Midwives Association to provide training for its members in provision of “youth friendly” reproductive health services (Family Care International, 2003).

6 Franchising

Franchising is a modality through which private sector actors are given access to a brand name, supplies, and management support in exchange for following certain procedures and guidelines. If the franchisee does not comply, the franchise license may be revoked. While franchising could potentially be applied in many areas of health, to date the strategy has mainly been used in family planning services (Montagu, 2002). Franchises for family planning or reproductive health are now implemented in India, Mexico, Pakistan, and the Philippines, and are being developed in Burma, Ecuador, Ethiopia, Honduras, Kenya, and other countries (Montagu, 2002).

6.1 Evidence from Specific Interventions in Child and Maternal Health

In Kenya, the Sustainable Healthcare Enterprise Foundation (SHEF) is operating a franchise model that provides incentives to franchisees to follow good practices for the handling and distribution of essential drugs and medical supplies. Franchisees receive a supply of high quality drugs and supplies at low cost, management support, and training provided by SHEF. In return, they must follow an operating manual, which includes information on diagnosis and treatment and procedures for good drug management. This franchise model is currently covering a population of 100,000 through 26 franchised outlets (SHEF, 2003).

7 Other Modalities

We found limited evidence on the impact of different finance mechanisms on maternity care provision, access, and consumption. However, it is likely that certain policies have an impact, e.g. caesarean sections are sometimes excluded from insurance policy or conversely, a policy may directly influence over-use of this procedure. For instance, in Chile there were reports of a link between private health insurance and delivery through planned cesarean section not related to medical reasons (Murray 2000). In India a study showed that the probability of delivery through c-sections was four times greater in the private sector than in the public sector (Mishra and Ramanathan, 2002). In China, a study undertaken to examine the impact of user fees on consumption of reproductive health services by women in two rural counties in Yunnan Province, observed a negative association between quality of maternal health care and the degree of privatization. In addition, the introduction of user fees with privatization imposed a barrier to consumption of formal health care for many (Kaufman and Jing, 2002). However, social health insurance has been found to be positively associated with maternal and child health outcomes (Box A2.5).

Box A2.5 – Reducing Maternal and Child Mortality through Health Insurance in Bolivia

Bolivia has had high maternal and child mortality rates over the past several decades. Despite continued efforts by the government to provide access to health care, consumption of formal
health services remained low, and in 1994 only 42% of deliveries occurred in health facilities. In 1994 the government established the Bolivian Insurance for Mothers and Children, which aimed at providing key maternal and child health interventions free of charge to the consumers. The participating institutions included MOH facilities, social security hospitals, and a small number of private non-profit organizations. Consumption of maternal and child health services increased since 1996 in the area covered by the program, particularly institutional deliveries and care of pneumonia in children under five years of age. Consumption was strongest among the poor and relatively high for adolescents, a group not previously using formal health services to a large degree. Drug availability increased in primary level facilities, although problems with stock availability still persisted.

Sources: Dmytraczenko et al, 1999a; Leighton and Novak (2002)

Several schemes have also been identified to help providers set up and run private practices. Some projects we describe below seem to have potential but are generally small-scale and the long-term sustainability once donor project funding has ended is unclear. These pilots have tended to focus on low-technology interventions, ambulatory care, and normal delivery. Examples include the establishment of private midwife-provided family planning services in Indonesia and midwife-owned clinics in the Philippines (JSI-RTI Philippines, 2003); and a loan scheme to help midwives with transportation costs in Cambodia (EngenderHealth, 2003). In Kenya, the Futures Group Europe initiated a small network of 38 private sector midwives to provide a range of reproductive health care services. The Ministry of Health supplied the midwives with free contraceptives and vaccine supplies, and free bednets and malaria treatment. The income generated by sales of the bednets was used as a revolving fund for the midwives (Futures Group Europe, 2003).

8 Conclusions

We have described several modalities used by governments in different parts of the world to better utilize the private sector’s potential to contribute to improvement in maternal and child health outcomes. Although the experiences are fairly limited and scattered, some promising modalities have been identified, which could be considered as options for the current health sector debate in Bangladesh. Of particular relevance are the experiences of training informal sector providers, coupled with consumer education, both for child and maternal health. In addition, contracting of maternal and child health services, especially to NGOs, and the financing alternatives such as social health insurance seem to be applicable to the Bangladeshi scenario.
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Annex 3: Surveys of Private Providers and Consumers

(Background Study by Sushil Howlader, and Syed Al Sabir)

Summary

1. Introduction

In Bangladesh, the size of the private component of the health sector is considerably large. Considered in terms of the volume of the out-of-pocket expenditure on healthcare, the private sub-sector is even larger, although in terms of the number of providers it is smaller, than the public one. Effective entanglement of the private sub-sector may lead to rapid increase of coverage and magnitude of services provided per capita. It can reduce inequity since the private providers serve the poor and the disadvantaged more than do the public providers, specially in the backward areas of the country (Hamid et al 2003). It can enhance provider efficiency through increased competition (Lerberghe et al 1997; Mills 1998); inefficiency is usually an integral feature of the public sector.

The next health sector plan will attach special emphasis on adoption of strategies and interventions which can accelerate provision of healthcare to the vulnerable groups of the population and one important option being considered is to involve the private sub-sector to realize this goal. The first step toward this end is to understand the private HNP sub-sector and assess its actual and potential capacity to provide services and the demand for its services among the consumers. The purpose of this study is to gather information to assess the capacity and competence of the private providers and the demand for their services.

2. Objectives and scope of the study

The study had the following major objectives:

- to get a description of the private sector from a provider and a consumer perspectives based on information from a limited number of sites, and
- to provide a basis for formulation of hypotheses for a larger study of the private health sector in Bangladesh.

3. Methods of Data Collection

The present study used a purposive, multi-stage sample design starting from the administrative divisions of the country to get a description of the private sector from a provider and a consumer perspective based on information from a limited number of sites with an intention to provide a basis for formulation of hypothesis for a larger study of the private health sector in Bangladesh.

The study collected information from 32 hospitals or clinic managers, 41 clinicians, 72 pharmacists or drug vendors, 26 traditional practitioners, 36 homeopaths, 1798 households and 1219 consumers. The sampling, while purposive, included a representation of a (a) qualified and unqualified providers, (b) urban and rural localities, (c) for-profit and not-for-profit providers and (d) private providers close to a public facility. Also, the sample covered all the six administrative divisions of the country.
4. Findings of the survey

The survey covered three types of respondents: private providers, exit clients and household. The findings have been presented for each category of respondents separately.

4.1. Findings of the provider survey

Data were collected to assess the existing capacity of the private facilities, services provided and activities done by them, quality of healthcare provided by them, the nature and level of interaction between the public and private sub-sector, and the business environment of the private providers. The major findings are as under:

4.1.1. Capacity of private providers

- The private providers are basically small enterprises. The size of the facilities in terms of number of beds and number of inpatients is considerably low although the number of outpatients is large. The mean number of beds in the hospitals and clinics was only 10. About 36 percent of them have only 5 beds or even less and 42 percent have 20 beds or less. The number of inpatients treated there per week was also low. The mean number of inpatients was only 17 and about 62 percent treated even less than 10 inpatients during the week prior to survey. However, the inpatients included both males and females and both adult and children. The mean number of outpatients treated per week was as high as 154, and 74 percent of them treated more than 50 outpatients in the week.

  The other providers are also small-scale enterprises. The pharmacies on average sold drugs to 32 customers per day. The homeopathic doctors on average treated 20 patients and the traditional providers only 8 patients per day.

- The private hospitals/clinics do not have adequate manpower. About 91 percent of the hospitals/clinics do not have any full time specialized doctor. About 85 percent do not have any full time general duty medical officer; most of the facilities use part-time medical persons. 25 percent of the facilities do not have full time nurse.

- The level of knowledge about the treatment protocols for even some of the crucial conditions such as diarrhoea, ARI, TB, pre-aclampsia and post-partum bleeding is extremely low among all the private providers except the clinicians of the private hospitals/clinics. While most of the clinicians have knowledge about the basic treatment procedures for the diseases, they do not have adequate knowledge about all the procedures required to be followed.

- The out-of-pocket payments of the patients constitute the sole source of revenue to the vast majority of providers although a few hospital/clinics are getting some financial supports from the donors and the government.

4.1.2. Services provided/activities done

- Most of the hospitals/clinics provide both essential and non-essential healthcares and provide some important reproductive and child health care items. More than 80 percent of the hospitals/clinics provide general medicine/obstetric and gynecology, pediatrics and
antenatal care (ANC) and, in addition, run pathology lab and sell drugs. Two thirds of them provide family planning services.

- The pharmacies sell drugs to the persons who visit them with prescription as well as those without prescription, and interestingly the number of persons is almost equal in two groups of customers. The homeopathic and traditional practitioners treat mostly the patients of ARI, STI-sexual disorder, gynecological diseases, and skin diseases.

- The hospitals/clinics provide health care also to the patients referred by other providers. More than 80 percent of the hospitals/clinics regularly receive referred cases. And the patients are referred to them from various types of facilities including the public facilities. They also occasionally refer patients only to the public facilities.

The other providers do not receive any referred cases but more than 70 percent of them refer the patients to the hospitals suffering from conditions such as complicated cases, surgical cases, ARI and gastrointestinal diseases.

4.1.3. Maintaining quality of healthcare

Prescribed protocols and guidelines and regulations by the government are intended to maintain the quality of the care delivered by the private providers, but the private providers were not found to be adequately abiding by the protocols, nor is the regulatory mechanism properly effective. 44 percent of the private hospitals/clinics claimed to be maintaining protocols, but at the same time 41 percent of them admitted that they do not maintain any.

Although all the managers of the hospitals/clinics reported that they abide by regulations, but the majority (66 percent) said that their compliance with regulations is confined only within maintaining registration. However, a high proportion of the hospital managers said that regulations have positive effects on the performances of the providers. 86 percent of the pharmacists said that they have drug license, but only 50 percent of the homeopathic and other traditional providers have so. The vast majority of homeopathic doctors and other traditional providers do not have even any registration. Only 38 percent of the pharmacists said that they do not sell expired drugs, and only 10 percent said that they do not sell drugs for addiction. But a high proportion of the pharmacists and other providers said that regulations have positive effects. It appears that most of the providers of each category do not follow the necessary regulations, and a significantly high proportion of them do not have even license. One-third of the hospital managers said that there was no monitoring visit to the facilities during the last three months. Most of the other providers said the same.

However, some of the hospital managers and pharmacies categorically said that regulation has a number of negative effects --- the regulators harass, charge money, and create obstacles to these activities.

4.1.4. Interaction between public and private sub-sectors

- The private hospitals/clinics are not involved in public health activities to any significant extent. Most of the managers of hospitals/clinics reported that they are occasionally involved by the public sub-sector managers to work only for BCC on HIV/AIDS family planning and for immunization. But almost all of them are quite keen
to contribute to the preventive care health promotion activities, BCC and reproductive health activities at the local level. The other providers are not involved in the public health activities at all. They are also willing to be involved.

- 75 percent of managers of hospitals/clinics reported that they want to enter into some contract with the government, although they do not have any at present. 50 percent of them held that contracting with them will be based on authorization with them and that advanced payment will be needed to enter into such agreements.

- The majority of the managers of hospitals/clinics did not receive any information from the government on any health issue. Among the other providers, almost none got any information from any source.

4.1.5. Business environment

The majority of the managers of hospitals/clinics and the other providers considered provision of quality services, efficiency, good staff and good relationship with customers are important factors to earn professional/business strength.

4.2. Findings of Exit Client Survey

4.2.1. Background characteristics of exit clients

- Most of the exit clients interviewed were in the middle-age groups.

- Three-fourths of the clients of hospitals/clinics were females. But the majority of clients of other types of providers were males.

- Most of the clients of each type of providers had at least primary level education.

- The landless households constituted a high proportion of clients (varying between 27 percent and 36 percent among the provider types).

- The clients belonged to all income groups; and more than 40 percent of them were in the two lowest income quintiles for each provider type. The mean monthly income of clients’ households varied from Taka 6082 to Taka 8046, indicating that the majority of the clients were relatively well off, if considered in the context of the rural economy of Bangladesh.

- However, as already indicated, a sizeable section of the clients (varying between 15 percent and 29 percent) had food deficit at least during some months of the year, and thus belonged to the poor group.

4.2.2. Use of healthcare

- The main reasons for visiting the providers, as cited by the clients, were to receive reproductive healthcare from the hospitals/clinics, and to receive care for minor ailments and Non-ESP from pharmacies and other providers.

- The clients of hospitals/clinics received mostly the following specific care: antenatal care (11%), delivery care (6%), FP (8%), other RH care (12%), care for ARI and diarrhoea
(10%), care for fever (6%), for gastrointestinal diseases (5%), and for severe abdominal pain (7%). The major cares received by the pharmacy clients were those for fever (18%), ARI (10%), gastrointestinal diseases (10%), skin diseases (8%), and problem of heart/BP (6%). The major cares received by the clients of homeopathic and traditional providers were same as those received by the pharmacy clients.

- A high proportion of clients visited the providers under survey after having visited the other providers, including public facilities and MBBS doctors; and they waited more than 20 days before visiting the survey providers.

- During the current visit (at the survey time), most of the hospital clients received consultation or prescription and most of the patients of all other types of providers received medicine.

### 4.2.3. Reason for choosing provider

Experience of provider was the main reason for the majority of clients to have chosen any type of providers, except the pharmacies; the main reasons for choosing a particular pharmacy were the familiarity with provider and expected availability of medicine.

### 4.2.4. Cost of treatment

- The mean cost of outpatient care was Taka 163 and that of inpatient care was Taka 6786.

- Each customer of pharmacy, having prescription with him/her, had to spend Taka 129, but each customer who did not have prescription with him/her spent Taka 33.

- A customer of homeopathic providers and traditional providers on average spent Taka 39 and Taka 119, respectively.

### 4.2.5. Perceived quality of care

- About 80 percent of clients of any provider, except the inpatients of hospitals/clinics, were either fully or partly satisfied with the healthcares received. The corresponding figure for the hospital inpatients is lower (60 percent).

- The courtesy of providers was considered by the clients as the main reason for their satisfaction. Perceived health outcome and the amount of time spent by providers in explaining the condition also were important reasons.

### 4.2.6. Perception about public facilities

- Most of the clients of each provider type (more than 78 percent) had visited public facility earlier. The main reasons for visiting public facility, as mentioned by them, were experience of provider, behavior of provider, availability of medicine, and familiarity with provider.

- More than 74 percent of clients of each type of providers considered the quality of care received from the currently visited providers better than that received from elsewhere earlier.
• The main reasons for perceiving healthcare received from the current providers better were higher quality of care, better behavior of providers, and shorter waiting time.

4.3. Findings of household survey

4.3.1. Background characteristics of households

• Most of the respondents (women) are middle-aged, the mean age being 32 years.
• 36 percent of women are illiterate.
• 50 percent of households under survey are landless.
• 48 percent of women belong to the lowest two income quintiles.
• The average monthly income of a household is Taka 6637.
• 30 percent of households suffer from food deficit for some months in the year.

4.3.2. Disease profile and use of healthcare

• During 60 days before the survey, 35 percent of household members suffered from fever, 12 percent suffered from diarrhoea, 7 percent from ARI, 7 percent from skin diseases, and 5 percent from severe abdominal pain.
• There was no major difference between the urban and the rural households in the types of diseases the household members suffered from.
• The prevalence of childhood diseases was higher and that of Non-ESP diseases lower in the poorest households than in the richest households.
• The sick persons of the households received health care from different facilities: public providers, private qualified providers, and non-allopathic and indigenous providers. In the recent period, more than 80 percent of households received reproductive health care, and among them the richest households received healthcare mainly from the private qualified providers and the poorest households from the private qualified providers and the alternative private providers. The households received healthcare also for childhood diseases, communicable diseases, minor ailments, and non-ESP diseases. For all these cares, most of the richest households visited the private qualified providers and most of the poorest households went to the alternative providers. A considerably high proportion of households both in the richest and the poorest income groups, but higher in the poorest group, did not receive any care at all.
• During last pregnancy, 50 percent of women received antenatal care. The proportion of pregnant women who received antenatal care was over 60 percent in the richest households and around 40 percent in the poorest households.
• More than 85 percent of women had their last delivery at home. The proportion is much higher in the rural areas than in the urban areas and in poorest households than in richest households.
• More than 70 percent of women prefer the public facility to the private facility for receiving care for birth complications.

4.3.3 Services received from providers
• During the latest visit, the sick household members received mainly consultation/prescription from the public and the qualified private providers, but mainly medicine from the alternative private providers.

4.3.4 Reason for choosing a private provider
• Experience of provider was the main reason for choosing a private provider, while cost and proximity are the main reasons for choosing public providers.

4.3.5 Cost of healthcare
• The cost of healthcare per episode per person was Taka 628 for the rural households and Taka 722 for the urban households.
• The cost widely varied between the richest and the poorest households, being Taka 879 on average for the richest households and only Taka 293 for the poorest households.
• The average cost of healthcare (per episode per person) for all households was Taka 659.
• The average cost at private facility (qualified) was Taka 1087 and at public facilities Taka 496, while it was only Taka 139 at alternative private facilities.

4.3.6 Perceived quality of care
• More than 80 percent of household members who visited the qualified private providers or the alternative private providers were fully or partly satisfied, but the corresponding figure is lower than 80 percent for the public providers.
• Courtesy of providers and perceived health outcome are main factors causing satisfaction to the majority of respondents. However, a considerably high proportion of women said that cost of care is an important factor causing satisfaction to the users of public facilities.

5. Conclusions and recommendations

The major findings of the surveys are:

• The private providers constitute a large component of the health sector. They provide healthcare to a considerably large number of clients of all types, including the poor, women and children, and provide a variety of cares, including different components of ESP.

• The individual capacity of the private providers is very limited. Each of them can serve only a small number of patients each day. They are more competent to provide a limited number of cares, specially of outpatient and ESP types.
• Most of the private providers do not follow the necessary medical protocols and the regulation of the sub-sector is extremely inadequate.

• The amount of coordination and interaction between the two components of the health sector is negligible.

• The private providers are keen to collaborate with the public sector through some arrangements.

• Most of the exit clients are satisfied with the services of the private providers and prefer the private providers to the public ones.

• A substantially large amount of demand for services of the private providers exists at the household level.

• A considerable amount of unmet need for healthcare exists in the households --- many households, including even the relatively rich ones, do not seek any healthcare.

The major recommendations of the study are:

• It can be argued based on the findings of the present study and some previous studies that the performances of the health sector cannot significantly improve unless the large component of the sector, i.e., the private sub-sector, expands and improves its services. The private providers should be trained more and the private facilities should be equipped more so as to enable them to provide quality care.

• The private providers should be effectively regulated.

• More coordination and interaction between the two components of the sector should be established.

• The government can enter into some contracting arrangements with the private providers specially in the remote and disadvantaged areas, and thus provide incentive to them as well as properly regulate them in their provision of healthcare. This may rapidly increase the coverage of the sector and improve the quality of care.

• The present study has a number of limitations. It covered only a small number of providers of different types, that too in a few selected areas. One important type of private providers, (the indigenous/informal practitioners) have been completely left out. The study interviewed only the clients of the survey providers. Although the study covered a large sample of households, the households were selected from only a few areas. The study is not comprehensive, nor does it describe the national situation. The findings should be treated with caution and considered as hypotheses which are likely to be valid in at least some areas of the country.

In order to capture the national situation on the study issues, a broad based survey should be undertaken using a nationally representative sample of all types of providers and consumers.
Annex 4: Interviews of Policy-Makers and Managers

(Background Study by Birger Carl Forsberg and Henrik Axelsson)

Summary

In order to elucidate attitudes and practices versus the private health sector in the government system in Bangladesh a number of interviews were conducted with senior managers at ministry level in March 2003. A limited number of managers at district and sub-district level were also interviewed. Lastly, representatives from some for-profit and non-governmental (trustees) organizations were interviewed in order to obtain their opinion on public-private interaction in the health sector. Altogether, 22 interviews were carried out.

The main findings from the interviews were:

- There is broad support for an increased role of private actors in care, either through the for-profit sector or in the NGO sector.

- At the same time there is a general opinion among officials in the Ministry of Health and Family Welfare (MOHFW) that the public sector will and should continue to provide health care, especially to the poor and the rural population. The most common way of looking at the role of the private sector is that it should complement the public sector and help the government in carrying the burden of care.

- There appears to be less orientation among the staff of MOHFW towards an active promotion of the private sector, less so towards a privatization of existing government functions.

- Many of the persons interviewed felt that there is not a clear and well-communicated government policy towards the private health sector. However, it was said in some of the interviews that the government has recently decided to contract out some health services to private actors. More active supervision of the private for-profit providers in Dhaka district has also taken place recently following an initiative taken by the new government to improve services in the private sector.

- Senior officials tended to describe the private health sector as providing tertiary care to well-off people. The widespread use of private providers at other levels and by all socioeconomic groups, as documented in surveys, was not put forward by most respondents.

- Generally there is concern over the quality of care in the private sector among government officials. There is also concern over the existence of dual practices, i.e. doctors being employed in both public and private sector at the same time.

- Many respondents expressed that there should be clear rules and regulations for private providers and that means should be put in place to allow the MOHFW to monitor and enforce these rules and regulations.

Options for action as follow-up to the findings:
1. The government could consider establishing a clear policy with regard to the private sector, be it the NGOs or the for-profit providers. The policy could emerge from an active dialogue with representatives of private health care providers.

2. The government should consider the widespread use of private practices at all levels in the country. At the moment officials at central level focus their attention on tertiary care when the role of the private sector is considered.

3. The government should review and possibly revise the current rules and regulations of private practices. Mechanisms should be in place for monitoring the rules and regulations and for subsequent enforcement when required. This was a need expressed by many respondents in the interviews.

4. The government could consider involving all health care providers in a process to develop quality assurance instruments that would be applicable to health services, irrespective of who delivers it.

5. The government should address the issues related to dual practice among doctors. Sustainable solutions to the problems arising out of dual practice should be sought.

6. Further efforts should be made to create public-private partnerships and foster a climate of mutual trust and benefit in the health sector across all providers.
Annex 5: Case Studies of Public-Private Partnerships in HNP in Bangladesh

(Background Study by Abul Barkat et al)

Summary

INTRODUCTION

This is the report on a review of thirteen known cases of public-private partnerships in the area of health, nutrition and population in Bangladesh. HDRC (Human Development Research Centre), in Dhaka, carried out this review on request from the World Bank Resident Office in Dhaka.

OBJECTIVE AND METHODOLOGY

This review of twelve cases in the health, nutrition and population sector takes an account of the innovations in public-private partnerships for finding out the workable options with the private sector. Collection of information and analyses of the same largely followed the Case Study Outline suggested by the ToR from the World Bank. Review of relevant literature and interview of key informants in the HNP sector were adopted. Besides, two follow-up meetings were held at the World Bank Office in Dhaka for completion of this study.

MAJOR FINDINGS

BGMEA-UNFPA-MOHFW Partnership in the Garments Sector

The major actors in this intervention, implemented during May 1998-December 2002, were BGMEA (Bangladesh Garments Manufacturers and Exporters Association), UNFPA (United Nations Fund for Population Activities) providing financial support, and the BCC (Behavioural Change Communication) Unit of MOHFW (Ministry of Health and Family Welfare) providing technical support. The objective of the intervention was to improve the Reproductive Health Behaviour of the garment factory workers. This project addressed the very poor women workers in the garment factories, who had a shortage of time and money to visit physicians for any necessary healthcare, especially reproductive healthcare.

The strategies adopted by this intervention were:

i. Raising awareness on Reproductive Health and Gender Equity among the garment workers.

ii. Increasing involvement of the workers in the Reproductive Health practices.

iii. Raising awareness for use of contraceptives to prevent STD/AIDS.

As a catalyst to other direct inputs into the project, a strong linkage was established with the BCC Unit of MOHFW for obtaining BCC support from them.

Garment workers were targeted at 175 selected garment factories at Malibagh in Dhaka, out of which 85% were female workers and the remaining 15% male workers. In this approach, the
target groups were first disaggregated on the basis of gender. The Technical Cell of the BCC Unit in MOHFW provided resource persons from the BCC Unit to deliver lecture on gender issues, and assisted in preparing IEC materials on Gender and Reproductive Health issues.

The implementation was constrained by the poverty and lack of time of the busy garment workers to access reproductive health care. The garment workers worked for longer hours and had less interest to participate in the plant level advocacy meetings.

The intervention seemed bogged down into slow pace at the preparatory phase. As such, certain special steps were taken up in order to motivate the stakeholders emphasising their inherent interest in the intervention contributed in the ease of implementation. BGMEA decision makers/planners and garment factory owners were briefed about the necessity of sound health of the workers to increase productivity which will increase economical empowerment of the workers. Officials of BGMEA and UNFPA had successfully defined the issues and problems relating to the garment workers and had established working procedures with a mutual approach and understanding with the garment factory owners. The costs of intervention were apparently nominal, because the major activities were concentrated on lessons on reproductive health following plant level orientation meetings. The need for technical persons from the BCC Unit has emerged for imparting of training to the target garment factory workers on gender awareness.

BPHC

BPHC (Bangladesh Population Health Consortium) stands out as a prominent partnership venturer in the area of HNP in Bangladesh. This public-NGO partnership, is a component of DFID’s support to the GoB’s Health and Population Sector Programme (HPSP). In supporting HPSP, BPHC’s aim is to build partnerships between NGOs and the Government- both centrally and at the local level. In 1988, BPHC began supporting NGOs to deliver maternal and child health and family planning services to the poor and under-served communities in Bangladesh. BPHC continues its commitment to improving access to health services for the poor. Since 1988, more than 100 NGOs and 150 projects have been supported. BPHC supports locally based Bangladeshi NGOs. The majority of these NGOs work in rural areas, predominantly with hard-to-reach and under-served populations.

*BPHC’s partner NGOs followed both a standard and customised approach to health service delivery within ESP. NGO strategies for service delivery were situation-specific to the needs of the particular community or working area. BPHC, in association with its partner NGOs, has devised a clear poverty-focused service delivery mechanism. Under the technical assistance of BPHC, NGOs identified poor communities using a household expenditure survey. The poorest are being provided free services, medicines free of cost or at subsidised prices, and due attention in carrying referral patients.*

Gonoshwasthyo Kendra’s Community-Based Health Intervention

GK (Gonoshwasthyo Kendra) started its operations in Savar from the time of Bangladesh Liberation War in 1970. Over the years, it has expanded its operations in other parts of the country and taken a pioneer role in promoting people’s access to health rights. GK owns a large hospital in Savar, and a pharmaceutical company (producing medicines on generic names). GK University (including a medical college), an Urban 24-Hour Hospital, Health Insurance and Community Health Programmes are some of GK’s major achievements. Towards developing
sustainable primary healthcare model, a shift from "community based approach" to "community base approached" is being practised in Nallapola since 2000. A health centre with adequate facilities has been constructed by GK on land provided by the community. The health centre intends to serve population from 10 villages. The centre is offering basic ESP services parallel to public outlets and field workers. However, for EPI, the health centre is occasionally used by the Government workers. A health committee is functioning with one representative from each of the 10 villages. Services are provided on set fees and some form of exemption mechanism for the poor is in place. Households are encouraged to buy health card, which enable services at a reduced co-payment rate.

Gonoshwasthyo Kendra has another health clinic in Jarun Village of Konabari Union in Gazipur District. The major service being rendered from there is EPI. The land for that health clinic, as in case of the one at Nallapola, has been donated by the local community. Paramedics attend the patients. They collect TT, polio and other vaccines from Gazipur Sadar Upazila and administer them on the visiting patients (children for vaccination). The total amount of vaccines lifted by them each time from EPI is for 200 patients in total. The paramedics send Monthly Activity Completion Reports to the local (Gazipur Sadar) Upazila Health Complex.

GK has achieved considerable progress in recruiting and training community health workers (paramedics and midwives) and creating provision for quality referral services from its Hospital. Trained service providers, mostly females, from the community members who are living in the villages and always accessible for services beyond fixed clinic hours. Strong BCC Programme in the community through community health workers and holding village health fairs. The main drawback of GK approach is that it is weak with respect to partnership with the public sector and operating parallel to GoB facilities and field workforce. It is also weak in forming community organisations. Qualified physicians are not available in GK to provide higher level consultation on fixed days from the health centres.

**Grameen Kallyan**

Grameen Kallyan has been operating since the year 1996. The major actors in this organisation are: Grameen Kallyan, Grameen Bank members, and non-members of Grameen Bank. The target beneficiaries are the rural poor families (within / outside Grameen Bank members). It is Grameen Bank’s long-term experience flowing from its involvement in micro credit operations that the rural poor in Bangladesh are prone to serious casualties emerging from natural calamities as well as from personal or family-based handicaps from time to time. This type of vulnerability deprives them of the opportunity to continue their thrift savings sustainably. In addition, the level and quality of social security, especially in the area of medicare being at one of the lowest, Grameen Bank thought of introducing microfinancing coupled with quality healthcare services toward improved health status of the rural poor.

The goal of Grameen Kallyan is to provide sustainable quality primary healthcare services. The objective of Grameen Kallyan is using Micro Health Insurance as a means for healthcare services. The existing interventions of Grameen Kallyan spreads through the districts of Tangail, Dhaka, and Comilla. This organisation does not receive any donor aid. In this sense, it is limited to being a partnership of the nature of Private (NGO)-Community Venture. The major activities included in Grameen Kallyan are: raising premium, consultation services, selling essential medicines, selling pathological services, referral of pathological cases to outside laboratories,
referral of patient cases for prescription to outside doctors, payment of certain fees to a patient in case of admission to an outside hospital on referral.

Grameen Kallyan’s services are two-fold: (a) management of microfinancing through health insurance, and (b) provision of healthcare services. Grameen Kallyan, from time to time, also arranges for Healthcare Camps especially in the area of care for Cataract. In various Health Camps, Grameen Kallyan takes on adoption of specialised expertise of various internationally renowned medical experts from Bangladesh as well as from outside Bangladesh.

ICDDR,B’s Chakoria Community Health Project

The major project participants are: The Chakoria Upazila Health Complex of ICDDR,B (International Centre for Diarrhoeal Disease Research, Bangladesh), Union level Health and Family Welfare Centre, Community Clinics at the ward level and Satellite Clinics at the village level, and local NGOs. The project is targeted toward the rural low income population—especially the hardcore poor women and children. Chakoria Community Health Project (CCHP) is the implementing agency. ICDDR,B, with technical and financial support from the Swiss Red Cross (leading a consortium of German, Dutch and Swiss Red Cross Societies) has been implementing this project since 1994. GoB contributes to implementation of the project by way of extending EPI services, supplying family planning contraceptives through UHC and UHFWCs, and attending the referral cases sent in by local NGOs.

The nationwide anti-NGO backlash in 1994 originated from Chakoria. This reaction to modern development efforts in this area and elsewhere in the country resulted, at times, in physical assaults on NGO workers—especially female workers. The social life of Chakoria is also quite precarious with incidences of robbery and clashes over land disputes, quite often resulting to numerous cases of in-violence and murders. In addition, most households in the study areas were disadvantaged. This was manifest in poor economic status, crowds living in poor physical and unhygienic water-and-sanitation situation.

Major health outcomes in the intervention area (or closest proximity) have been reported to be:

- An effective networking between the community and government is established
- Self help organizations have been activated to provide health services
- Health awareness of the community people has increased
- Use of ORS has increased and management of diarrhoea has been improved.

The bulk of the health services to the people of the project is coming from such public sector providers as AHIs and HAs for EPI services; FWVs and FWAs for reproductive health and family planning services directly through UHC, H&FWC; and Community Clinics and Satellite Clinics with strong community support provided by SHO/VHP.

ICDDR,B followed the following strategies for implementing the CCHP, Chakoria

- Hiring the project staff and imparting training to them
- Knowing the community and building close relationship with them
• Identification of indigenous organizations through data collection
• Bringing Health on the Agenda of the organizations
• Conducting People’s Participatory Planning (PPP) and actions with selected organizations.

Specific objectives of the intervention were:
• Formulating strategies to ensure community participation in health activities
• Identifying and establishing a threshold level external input and impetus to community initiatives without making them dependent on external agencies
• Improving public health by raising awareness about health and health problems
• Promoting appropriate preventive and curative measures
• Disseminating information on available health related resources in the locality
• Studying the impact of project activities on community health.

Major activities accomplished for attainment of the overall objectives have been:
• The project was launched during the later part of 1994 with a possibility to continue up to 2004. There are currently 36 full time and field-based personnel involved with the project in addition to 6 part time staff located in Dhaka.
• A self-help promotion committee has been formed, with representatives of the ICDDR,B, the project itself, donors and self-help organisations with a view to ensuring total participation of all stakeholders in steering the project.

There are a number of constraints in implementation of the project. Relief mentality of the local community as a result of the extreme vulnerability of the entire Chakoria Upazila to natural disasters has turned Chakoria to a relief-prone area like other places of the Cox’s Bazar District. There was demand for complementary curative health services (preferably from NGOs) and, contrarily, the anti-NGO sentiment of the people including the conservative-minded people were bogged down in religious taboos. The Health Volunteers are subject to a high rate of dropouts from the project (as high as 5%), due to their search for higher levels of financial benefits.

Community initiatives have been funded by the village-based organisations with technical support from the Chakoria Community Health Project of ICDDR,B. SHO helps the beneficiaries to attend the VHPs and patients are purchasing Family Health Cards for a year with Tk. 50 for the family members. As for the poor families, cost of a health card is Tk. 10 only. Community financing through donation of lands and cash and increasing tendency of the community to pay for services are a major indicator that support may be extended for continuation of the VHP operations system in the long run.

The monitoring activities are accomplished by way of a participatory approach. The approach has been participatory implying that the needs assessment, planning, implementation of action and monitoring of the impact have been done with the members of the indigenous organizations.
It has been possible to derive the benefits from the project during the last 8 years. Self-help organisations have been activated to provide health services. A large number of women have been participating in health-related activities. Health awareness of the community people has increased. Use of ORS has increased, and efficiency in management of diarrhoea has improved. An effective networking between the community and the Government has established.

**IOCH**

IOCH (Immunisation and Other Child Health) Programme is particularly focused on the creation of partnerships between the public and private sectors which will ensure that poor, women and children have access to the Essential Services Package (ESP) as envisaged in the Health, Nutrition and Population Sector Programme. The purpose of the IOCH programme is to improve access to good quality essential health services through the development of partnerships between public and private health sectors for the wellbeing of the hard-to-reach and the under-served.

The project was designed to be implemented through sharing of various activities among the involved partners.

The major constraint reported to act against smooth implementation of IOCH activities is that there is shortage of private practitioner’s support and necessary feedback from them for smooth implementation of the project.

**NNP**

NNP (National Nutrition Project) is the successor to the BINP (Bangladesh Integrated Nutrition Program), a bilateral project supported with loans from the World Bank and implemented by the Government of Bangladesh. Considering the significant potentials for replication of the BINP model of nutrition intervention in Bangladesh, GoB has taken up NNP as an improvement on BINP as well as drawing heavily on BINP’s experiences.

In order to carry out smooth implementation of the project, an NNP Management Committee has been constituted. This Committee meets once every month. The Committee is chaired by the Secretary, MOHFW and the Director of Programme Support and Technical Unit of the PMU, as its Member-Secretary. The PMU will be responsible to the Steering Committee and the NNP Management Committee. NNP activities at the district, upazila, union and village levels are being coordinated and monitored by the District Nutrition Management Committee (DNMC), Upazila Nutrition Management Committee (UZ NMC), Union Nutrition Management Committee (UNMC) and Village Nutrition Management Committee (VNMC).

In the programme’s countrywide intervention, there are more than 5 million children who participate in the growth monitoring and nutritional promotion programmes, and over 1 million pregnant and lactating women benefit from weight monitoring and counselling. Although NNP does not target through "means testing", based on experiences from similar projects, most beneficiaries come from the poorest households within the community. In addition, the entire population benefit from the interventions of the national-level services component. Project benefits mainly include the following:

- Direct nutritional and health benefits to malnourished children and pregnant and lactating women including steep reductions in severe child malnutrition and deaths
- Reduction of stunting, increased numbers of children growing normally
- Improved pre-pregnancy nutrition status
- Increased pregnancy weight gains

Bangladesh Rural Advancement Committee (BRAC) and other selected NGOs are implementing NNP in respective geographical pockets of Bangladesh.

Collaborative arrangements exist for Behavioural Change Communications materials development and activities (HPSP Behavioural Change Communications unit), breastfeeding promotion and protection (Bangladesh Breastfeeding Foundation), micronutrient fortification (the Institute of Public Health Nutrition and the Bangladesh Small and Cottage Industries Corporation), operations research (ICDDR,B), independent quality assurance for field data (Bangladesh Bureau of Statistics, the Institute of Nutrition and Food Science at Dhaka University, and Helen Keller International), and training (the IPHN and the National Institute for Population Research and Training, the Institute of Child and Mother Health, and BRAC). UNICEF provides important collaboration for BCC, operations research, salt iodization, and general technical assistance.

Since the start-up of the project in May 1997, the members of BRAC’s women’s groups have been assisted by 130 CNPs to motivate all their children under two years of age (including the newborn) to bring these children to the Growth Monitoring and Promotion (GMP) sessions held at 130 CNCs each month.

There are certain constraints in NNP. Sometimes, there are shortages in supplies of iron tablets and vitamin-A capsules. Initially, the pace of project implementation was slow.

As per the world Bank’s requirements, centrally administered monitoring and evaluation under NNP are being coordinated in two ways: project- MIS under the Field Implementation Cell of the PMU, and independent monitoring, with responsibility to coordinate evaluation surveys and ensure comparability, under an independent monitoring function.

In the case study area at Shaharasti Upazila, about 82% enrolled children gained weight. Among the adolescents girls, BMI (Body Mass Index) increased and a significant achievement has taken place on nutritional perception, knowledge and practice among the increased numbers. BMI of the pregnant women has increased. The newborn babies had their weights higher than the earlier average weight for the newborn.

The GoB has designated the Bangladesh Bureau of Statistics (BBS), the Institute of Nutrition and Food Science, Dhaka University (INFS), and Helen Keller International (HKI) as lead agencies for support and capacity building for independent monitoring under BINP, and these institutions will serve NNP in the same capacity. BBS will undertake data quality assessments in NNP upazilas. INFS will design the behavioural surveys, conduct analysis of extracted service records, and undertake special studies as called for by the PMU. HKI will modify its ongoing nutritional surveillance program to include a subset of NNP upazilas (funded externally) as well as provide technical assistance to NNP monitoring and evaluation. The assessment of nutrition-related behaviours, social mobilization efforts and participants’ perceptions will be contracted.
Opinion leaders are involved in the process for defining clear terms of reference for Nutrition Management Committees at each level and by developing a set of simple monitoring indicators by which community leaders on the committees can monitor progress. Separate learning activities on low birth weight reduction through multiple micronutrient supplementation, and caring practice for cognitive development of children will be carried out in BINP and carried into NNP with support of UNICEF.

NSDP (NGO Service Delivery Project)

NSDP (NGO Service Delivery Project) in Bangladesh is the second phase of National Integrated Population and Health Programme (NIPHP), and aims at provisioning of services designed under the national strategy HPSS and one-stop-shopping programme ESP (Essential Service Package) offered under HPSS or in a more comprehensive manner. NSDP’s purpose is to assist NGOs previously supported by NIPHP (funded by USAID) as well as new NGOs approved by USAID to:

- Attain and sustain demonstrable technical levels in provision of essential services (ESP)
- Increase the use of essential services, especially among the poor
- Make and implement well-informed decisions about on what services to provide and the methodology for this purpose
- Mobilise and effectively utilise financing from all possible donor sources other than USAID.

While RSDP, the predecessor project of NSDP was focused on NGO-complementing or NGO-supplementing of GoB’s activities, NSDP is concentrated on NGO-partnership with more ownership and sense of status on the part of NGOs enabling them to perform more efficiently than before. NSDP is a partnership of eight organisations, each making special contributions.

NSDP’s objectives are to:

- Expand the range and improve the quality of ESP services provided by NGOs at the clinic and community level
- Increase the use of ESP services provided by NSDP NGOs, especially by the poor
- Increase the capacity of NGOs to sustain clinic and community-based service provision, institutionally and financially
- Influence GoB policy, in coordination with other donors, to expand the role of NGOs as providers of ESP services within the national health system.

Aimed at attainment of the foregoing objectives, NSDP’s broad range of services include the following:

- Child Healthcare
- Family Planning and RH
- BCC and Marketing
- Limited Curative Care
- Communicable Diseases Control.

The size of the project has been designed as a massive one right from the onset. NSDP is operating in 62 districts and serving more than 1.5 million people per month through 278 static clinics, 412 upgraded clinics and 13,554 satellite clinics. Forty-one national/regional/local NGOs with 3,534 staff and 5,941 depot-holders have been involved in managing the activities.

In NSDP, supply of contraceptives including Injectables and EPI logistics is, sometimes, very irregular, and does not always match the required consumption-supply pattern. Coordination at the top and upper level of the project hierarchy is quite often better than the one at the lower level (of implementation).

The objectives of NSDP reveals that the provisioning of quality of ESP services at clinic and community level and poor are fundamental focusing arena of the programme. Careful scrolling through the available NIPHP and NSDP documents further reveals that in the latter programme the improvement in providing quality ESP services has to be attained through enhancing the improved client-provider interactions (CPI), strengthening training and quality assurance system, and addressing gender-related barriers to service utilisation at both clinical facilities and community level.

In NSDP, USAID’s money gets channelised directly to respective implementing NGOs through NSDP Headquarters in Dhaka.

The fees for ESP services to be paid by the beneficiaries vary from Tk. 3 to Tk. 25 per client per contact.

With regard to monitoring of the project’s activities, the implementing NGO submits MPRs (Monthly Progress Reports) to GoB through THFPO. GOB reviews the project performance through these performance reports. In addition, indirect performance monitoring is also accomplished in the Monthly Coordination Committee Meetings at the local level and at the central level. An implementing NGO has its own monitoring and evaluation system, as agreed on and approved by the NSDP authority. No special monitoring is conducted by the donor or GOB, but they occasionally visit the project activities at the field level.

PPP at Brahmanpara

PPP is a MOHFW programme under HPSP, the vision of which is to provide a framework for developing health sector wide partnership for the delivery of the Essential Services Package, as defined by MOHFW policy, to the target population in Bangladesh. The target population is poor, particularly women and children. NICARE and British Council jointly run this programme.

PPP aims to combine healthcare provided through community-based schemes with the resources available from the public, traditional and modern private health sectors to create an integrated health scheme. This vision of PPP places considerable importance on the involvement of local people in developing and implementing the PPP component. Community-based Health Schemes (CHS) are the foundation of PPP health services. A CHS is run by members of the scheme to provide healthcare for a community population of about 6,000. Members pay through a financing mechanism such as weekly or monthly contributions and/or user charges. The designed PPP
models will cover 53 Mouzas in Brahmanpara through 24 CHSs in its 8 unions. 5 CHSs are already in operation and 10 others are in process of development. The remaining 9 CHSs will be covered in the next two years.

The first set of demonstration sites of PPP (Public-Private Partnership) ventures, in the Brahmanpara Upazila, is managed locally by a Pilot Task Group, which comprises of local MP, Union Parishad Chairman, TNO, national and local MOHFW managers, CHS representatives, local NGOs, local officers from social welfare, youth development and rural development departments, and local health provider representatives.

A baseline survey on need, perception, consumption and expenditure pattern for ESP services in Brahmanpara Upazila of Comilla District was conducted in October 2000. Perceived economic status reveals that 33% of the population is poor, only 2.2% consider them as extreme poor. Findings of gender status reveals that 45% females can talk to non-relative males at their own decision. 49% can visit doctor/healthcare centre at their own decisions. Alarmingly 38% cannot perform anything at their own decisions. Health seeking behaviour reveals that for main ailments 95% availed informal private sector (village doctors mainly). But for grave illnesses, 75.7% visit GoB. Villagers have to travel 6 km on an average, and 61% of them went on feet. The reasons for choosing particular healthcare are shorter distances, low expense and round-the-clock availability.

CHSs make a partnership agreement with the MOHFW and/or Local Government to pool funding and/or resources to some degree. A condition is that the CHS:

- covers the whole community including very poor members who will be exempt from charges,
- provides the MOHFW Essential Services Package (ESP) as a minimum,
- provides for a general practitioner role to:

Existing NGOs may be the channel for existing MOHFW funding received from HPSP donors, and this funding or resourcing may be recognized in the Funding and Commissioning Partnership Agreement. Primary stakeholders, including the poor, particularly women and children, are invited, along with other local stakeholders, to participate, in the development process for the PPP models.

The three approaches to implementation of PPP has been the following:

- The Direct Approach, where the UHFPO, reporting both to his line Manager and the local Pilot Task Group, has instigated the setting up of a Community Health Committee (CHC), which is elected from a series of stakeholder group discussions in the proposed CHS catchment area.

- The Local Government Approach, under which the Union Parishad acts as the committee which sets up CHSs within the Union. The Union Parishad gets trained using technical assistance from the Bangladesh Academy of Rural Development (BARD).

- The NGO Approach, with NGOs working in the area were invited to submit a proposal for the facilitation of setting up CHSs and partnership arrangements in specified Unions. This
approach has led to the setting up of clinic in the beneficiaries’ own villages, minimising the sufferings from travelling long distances to obtain ESP services.

The following major activities have so far been completed in PPP at Brahmanpara:

Community Health Scheme Development Process, Action Plan & Budgeting by Community Health Committee, Identification of Least Advantaged through Participatory Poverty Assessment for Cross Subsidy/Exemption, Domiciliary Services (1 day/week), Extension of Facilities, and Involvement of Community Health Volunteers:

Particular stumbling blocks on way to PPP’s implementation have been the following:

- The spirit of ‘We vs. They’ spirit rather than a ‘We’ spirit still lurks at the end of the concerned GoB personnel.
- Relatively slower pace of GoB’s inter-departmental participation and coordination at the Upazila level as a result of especially GoB’s bureaucratic delays in graduation from plan to implementation.
- The elected representatives on the sub-committees at the Upazila and Union levels are often prone to changes due to their replacement by new representatives after each election.

*Significant positive features of PPP at Brahmanpara Upazila were the following:*

- It facilitated a process of dialogue among stakeholders (women, teachers, farmer, community leaders, religion leaders, day labourers, youths (formal or non-formal leaders).
- CHS also work as a watch dog in preventing gender-based violence in their community.
- PPP model in Brahmanpara encourages that every member of the community has a right to have a voice and to participate in shaping their community and in improving the quality of life.
- A service improvement action plan (SIAP) for the UHC has been developed by the hospital staff in a participatory process facilitated by PPP. Using this action plan UHC services are improving in a planned way.

The three models of PPP in Brahmanpara Upazila are being geared toward sustainable operations by way of drawing on old and on-going experiences. Some of the critical activities currently taking place to develop the PPP component include:

- Relationship building to facilitate partnership between MOHFW, local government, communities, professional associations, private organisations, and individual healthcare providers in the *pilot areas*.
- Information gathering and research.
- Participation of all stakeholders in design, planning, implementation, and monitoring and evaluation.
The project needs the following additional initiatives for improved performance in future:

- CHS executive committee should be more effective
- Washing space, toilet facilities, and waiting room need to be improved
- Coordination, mutual trust, share and care among the Government, NGOs and the communities should be strengthened further
- In PPP, gender-desegregated data are necessary to monitor gender dimensions
- In order to improve intensive client provider communication, the BCC approach is one of the most important strategies of the Health and Population Sector. BCC activities in PPP area need to be strengthened.

**SMC’s Blue Star Project**

SMC (Social Marketing Company) has been implementing an FP project in collaboration with the Government titled Blue Star Programme (BSP). It is a full-swing project based on a prior pilot project that had been operated during June 1998 – December 2002.

The goal of the project is to expand the market for injectable contraception by increasing access to sources of supply. The objective of the project is: To enhance the capability of the private medical practitioners to offer quality services thus making them a potential source for providing clinical family planning services with health services. The collaborating agencies / individuals are: SMC Ltd., Upazila Family Planning Officer, and the Graduate Medical Practitioners (GMPs) in the pilot phase replaced later on with the NMGPs. As such, it may be said the type of partnership involved in this project of the type of Private Commercial-NGO-Government. The project does not receive any external donor support, and is implemented solely through SMC’s own funds. The project is spread all over Bangladesh based in each of the Upazilas. The target beneficiaries are Urban and Semi-Urban Women in the Reproductive Age.

The major activities are:

a) SMC sales force first identify the interested providers based on the criteria provided by SMC Head Office

b) SMC provides training to the BSP (Blue Star Programme) providers in collaboration with GoB and Engender Health and promotional support to the providers

c) SMC sells commodity to the providers

d) Customers pay for the product and administrations

e) Providers report their administration to SMC on a regular basis

f) SMC reports to GoB Upazila Family Planning Officer on a particular MIS Format on a regular basis.

**TB Control: BRAC and the Damien Foundation**

*BRAC Smearing Centre in Mymensingh District*
In the Mymensingh District, BRAC has 126 contact persons who identify and pick up the suspected TB patients from amongst their respective local communities. Each of the contact persons has undergone three-day training on identification and detection of TB patients. With support of the contact persons, the TB patients come to BRAC Smearing Centre for necessary follow-up actions like diagnosis, treatment and necessary advice. Privately referred patients are also the receivers of services from this Smearing Centre. The supplies of drugs for the patients are being made totally by the National TB Programme (NTCP). BRAC is represented in Monthly Meetings at the Office of the local District Civil Surgeon. A NTCP Consultant pays regular visits to this Smearing Centre in order to monitor the progress of various activities. GoB is responsible for supply of drugs, consultant’s services, and regular monitoring meetings. BRAC is responsible for community mobilisation, detection of patients, collection of sputum, and treatment.

Damien Foundation TB Leprosy Hospital at Shambhuganj

The TB Hospital at Shambhuganj Thana of Netrakona District was set up in 1993-94. In order to increase its services to the local community and to closely align its programme with the guidelines of NTCP and NLP as well as to improve its own cost-effectiveness, Damien Foundation implements four projects- in the districts of Tangail, Mymensingh, Netrakona and Rajshahi. The Coordinating Office is in Dhaka City. The Foundation has excellent collaboration with the Government’s NTCP. In order to reduce duplication and overlapping of services, Damien Foundation has also signed a MoU with GoB. The Foundation facilitates skills training to the contact persons, provide infrastructure (office, laboratory, hospital and patient beds), diagnosis and treatment services. Medicines are supplied by GoB through the local District Civil Surgeon. As of February 2003, a total number of 13,000 detected patients (89%) have been cured by the Foundation in Netrakona District.

The hospital, having fully provided beds, has an Outpatient department. Besides management of complicated TB patients, it provides general diagnostic and therapeutic services to the population living in the vicinity of the hospital. Each of the Field Workers organises at least three health education sessions in a month. They submit their respective Monthly Reports on a regular basis. If the rate of cure is ever below 90%, the Foundation goes for critical monitoring as to the reasons for such deterioration in success rate. As an additional strategy, the Foundation has also taken up the initiative to use the services of the cured patients in community mobilisation and detection of new TB patients.

UPHCP

The UPHCP (Urban Primary Healthcare Programme) started being implemented since 1998 (Duration 1998-2003). The programme started a bit late due to delays in contracting of implementing NGOs. It is heavily supported with donor funds, with provisions for generation of supplementary funds (toward self-sustenance) at the level of the implementing NGOs. The major actors in this programme are: ADB, Nordic Development Fund, UNFPA, MoLGRDC (GoB), four City Corporations, and the implementing NGOs. The goal of the project is to decrease mortality and morbidity from diseases that can be readily treated or prevented. The target population of the programme are the Slum/Slum-like population in four City Corporation Areas. The objectives of the programme are:
- To improve the health of the urban poor and reduce preventable mortality and morbidity, especially among women and children
- To ensure that the urban poor will receive good quality preventive, promotive and curative services
- To sustain improvements in PHC by building the capability of the local governments to manage, finance, plan, evaluate and coordinate health services
- To introduce structural reforms designed to change the role of the Government and alter the way it relates to the private sector, including NGOs.

The range of services provided by UPHCP covers the entire gamut of ESP. In addition, there is an emphasis on the specific techniques that on which NGOs have comparative advantages, e.g., in motivation and awareness-raising, access to hard-to-reach areas or population segments, and close monitoring.

The following achievements have been made by UPHCP as of February 2003:

- A total of 16 partnership contracts have been awarded to local NGOs and Chittagong City Corporation Health Department for delivering PHC services. All partners have commenced their services.
- Out of a total of 143 Health Centres to be constructed, contracts for 128 have been awarded of which 60 have been completed. Construction in 28 sites were expected to be completed in November 2002 and 10 sites by December 2002.
- The staff of partner agencies and CCHDs are being trained by PIU and local training institutions. The training are likely to be completed by March 2003.

In UPHCP, since last year (2002), irregularity in flow of funds hampered the continuation of numerous activities. Coordination in project implementation at the lower levels of implementation requires significant improvement. Supply of contraceptives and EPI logistics is very irregular and does not match the consumption-supply pattern.

The clients of UPHCP pay fees for the services. On an average, the amount collected as service fees covers 15% of the total annual budget of the programme at the end of the implementing NGOs.

The Project Implementation Units (PIUs) of the City Corporations bear the overall responsibility for implementation as well as monitoring and evaluation jointly with the implementing NGOs. In addition to the routine monitoring done by the PIU and the implementing NGOs, there is another type of M&E system, that is, a functional monitoring system. As a part of monitoring and evaluation, a private consultancy firm conducts management monitoring and facilitates survey by using ISI (Integrated Supervisory Instrument) on a quarterly basis. The whole range of activities taken on in UPHCP seems valuable from the point of view of on-going research into the strategic approach to countrywide implementation of ESP activities. When there are serious questions on who should take the lead role in specific healthcare projects, whose expertise should be exploited in order to achieve professional excellence and what should be the patterns of funding and funds
disbursement- the UPHCP propagates a useful experimental ground in order to arrive at consensus on these pertinent issues.

LESSONS LEARNT AND RECOMMENDED OPTIONS

The experiences of various public-private partnerships now lead to the following lessons that may be useful in case of any future initiatives in the PPP area.

- It is difficult to motivate and involve the business community in development projects, because they are relatively more lopsided toward profit-maximisation.
- NGOs act as efficient organisations to do poverty mapping on localised bases.
- Even a large and highly reputed NGO, once contracted for involvement in PPP may not operate well in the partnership unless the issue (or type of intervention) is not within the mainstream activities of the NGO.
- While involving CBOs or other community-led informal groups in management of PPP, it is not always checked whether the total time to be given by them and whether they have that amount of time (beside eagerness to do so) and whether the project is within the gamut of their felt needs.
- In organisations carrying out micro credit activities, assurance of good quality healthcare is an effective way toward micro-insurance for widening the people’s access to healthcare services.
- Private philanthropy at the community level, sometimes, plays a great role in project financing.
- The anti-NGO spirit engendered by some quarters at numerous areas of the country especially after 1996 should be considered in designing or localising a project.
- Staff dropouts from community development projects are occurring increasingly due to lack of attention to their satisfaction from financial gains from working with such projects.
- Lack of private practitioners’ role in health and immunisation-related partnership projects is a great impediment to project implementation.
- The country’s Health Sector has not yet been blessed with a proper system for ensuring healthcare logistics following strictly the localised disease profiles.
- NGOs and CBOs, in association with local elected representatives form an effective forum for mobilising community support to healthcare projects by way of graduated community contributions, both financial and non-financial.
- Micro credit, coupled with savings, is a good means toward self-help for attainment of health security provided GoB, donors, NGOs and CBOs are engaged into other support activities for healthcare management.
Without the real spirit of mutual ownership between GoB and NGOs, donor-driven or “solely politically” patronised partnership initiatives will not render sustainability to healthcare or nutrition projects. The obstacles, propagated by the “we vs. they” spirit in partners seem not fully and generously documented as yet in Bangladesh.

In efforts for maintenance of gender balanced relationships for ensuring proper family-based attention to healthcare of women, husbands have been left out, largely, as a possible change agent.

As in case of paramedics in healthcare management, the use of non-graduate medical practitioners, after sufficient training to them, may be employed in family planning activities.

In dealing with patients with highly infectious diseases, proper care is sometimes not taken to ensure that the infrastructure of the implementing NGO is effective enough for quarantining the visiting and/or admitted patients.

NGOs (or any other organisation) having proximity to the communities, are effective in detection and identification of patients with highly infectious diseases.

Support from friends, relatives and family members of patients with highly infectious diseases is essential to ensure un-interrupted administration of drugs and medicines, as prescribed (e.g., DOTS).

However well-designed the partnership programme is, the issue of ease and efficiency in funds disbursement seems not attended sufficiently in the design phase of the programme.

In context of the foregoing lessons learnt from the cases under review, a number of mutually exclusive recommendations may be made toward more effective public-private partnerships in the HNP sector for future.

i. GoB should take up arrangements, preferably under the purview of MOHFW, to keep track of what types of partnerships are being taken on and which types of interventions are to be adopted on a continual basis.

ii. In general terms, the future public-private partnerships should emphasise on increased community financing and NGOs’ active participation in implementation, following objective assessment of needs through involvement of all prospective partners.

iii. With regard to decisions on the geographical areas to be intervened and the services to be offered, geographical concentrations of certain disease profiles should be considered.

iv. In future public-private partnerships involving NGOs and private commercial organisations, preference should be given, to NGOs that are financially self-sustaining as well well-experienced in related activities.

v. Prospects for private philanthropists willing to make donations in cash or in kind to public-private partnerships in the HNP sector should be explored.
Annex 6: A Review of Health Regulation in Bangladesh

(Background Study by Dr. Humayun Hye)

Summary

1. Introduction

This Health Regulation Review (HRR) is a component of a larger study, namely the Bangladesh Private Health Sector Assessment (PHSA), undertaken by the World Bank and other development partners. The findings of these studies will be consolidated into a health policy options report, which will be used by the Government of Bangladesh (GOB) and its development partners in planning for the Bangladesh health sector. This Report examines the regulatory environment faced by the private health sector in Bangladesh.

2. Private Health Sector in Bangladesh

There are about 20,000 qualified private medical practitioners who constitute the bulk of health care in the private sector. Besides there is also a good number of traditional (Unani and Ayurvedic) and Homoeopathic practitioners, and very large number of less qualified or unqualified private practitioners of allopathic medicine. A vast majority of the poor depend on the private practitioners for their medical care. Bangladesh Medical Association (BMA) is the apex organization of the medical profession. Private medical practitioners are represented by the Private Medical Practitioners' Association (BPMPA).

In recent times, a large number of private clinics and hospitals have been set up, especially in Dhaka and other urban areas. Many well-to-do people are receiving medical care at these facilities, but at an exorbitant cost. Developed regarding availability of better medical care at private facilities at a higher cost. In the absence of proper regulatory laws, the services provided by the for-profit private sector clinics and hospitals often reflect various types of distortions and anomalies.

Private Health Care Facilities. There are 724 licensed private hospitals/clinics, of which 256 are located in the Dhaka Metropolitan area. There are also 28 private dental clinics. Altogether, there are 945 licensed private diagnostic laboratories, of which 433 are in the Dhaka Metropolitan area. The private clinics and hospitals provide in addition to emergency medical care, a large range of specialized services including different surgical operations. There are about 340 foreign assisted NGOs and about 3,750 locally funded NGOs involved in providing health care services. Ten new medical colleges in the private sector with their attached hospitals provide general and specialized services on a semi-commercial basis. In spite of rapidly growing private facilities, the bulk of specialized tertiary level services are still provided mainly by public sector hospitals.

Pharmaceutical Sub-sector. Pharmaceutical manufacturing and trading is mainly in the private sector. There are 207 licensed pharmaceutical industries (50-60 of them presently defunct) producing 6500 registered medicinal (allopathic) products. The value of local production of allopathic drugs in 1999 was Tk.16,078 million. Nearly 95% of medicinal products used in the country are locally formulated and consumed in the private sector. Most of the basic
pharmaceutical raw materials, however, are still imported. Presently there are about 36,000 licensed retail (allopathic) pharmacies in the private sector.

3. **Formal Regulatory Framework and Instruments**

The regulatory instruments described in this Report are listed in Table A at the end of this Executive Summary. These are classified under three categories: (a) Health Legislations; (b) Health Related Other Legislations; and (c) Legislations not Specific to Health Sector but which affect the private sector in general.

3.1 **Health Legislations**

*The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982* regulates private medical practice, clinics and laboratories which need licenses, renewable every year, from the Director General of Health Services (DGH). Schedules specify minimum floor space for each in-patient bed, essential equipments to be kept and minimum number of doctors and nurses proportional to beds. Schedule A of the Law specified maximum amount of fees that may be charged by private physicians for consultation and by the clinics and laboratories for various services. The provision of maximum consultation fee of private medical practitioners was later revoked under the *Medical Practice and Private Clinics and Laboratories (Regulation) (Amendment) Ordinance, 1984.*

*The Medical and Dental Council Act, 1980* provides for registration of physicians and dentists by the Bangladesh Medical and Dental Council (BMDC). The BMDC has the names of 34,502 medical practitioners in its Register but many of them are dead or not present in the country at the moment. Presently, 3542 Medical Assistants (MAs) are also registered with the BMDC. Qualified nurses are registered by the Bangladesh Nursing Council (BNC) under *The Bangladesh Nursing Council Ordinance, 1983.* The BNC maintains separate registers for qualified nurses, midwives, and others possessing recognized qualifications. Different categories of pharmacists are registered by the Pharmacy Council of Bangladesh (PCB), under *The Pharmacy Ordinance, 1976.* There are about 2500 registered Grade A (or graduate) pharmacists. Of the 40,000 Grade B registered pharmacists, only 5000 are diploma holders; others were trained by the PCB through short-term crash programs.

GOB adopted a *National Drug Policy (NDP)* in 1982 and *The Drugs (Control) Ordinance, 1982* was promulgated to implement it. Under this law, registrations of many undesirable medicinal products were cancelled and *Ayurvedic, Unani* and Homoeopathic medicinal products were brought under the regulatory control of drug laws. Special restrictions were imposed on drug advertisements. A new set of rules in the name of *Drugs (Control) Rules, 1990* was also adopted under the Drugs (Control) Ordinance (1982). Basic drug legislations such as the *Drugs Act, 1940* and *The Drugs Rules (1945 and 1946)* there under are still valid and effective. Much of the routine functions of the Licensing Authority of Drugs (including procedures of licensing, inspection of premises and drug testing, etc.) are still carried out in accordance with the provisions of the Drugs Act, 1940 and rules there under.

The prevailing law for food safety is *The Pure Food Ordinance, 1959.* This law was expected to be implemented by local authorities, such as a municipality, District Board or Local Board. The Food and Water Testing Laboratory in the Institute of Public Health (IPH) in Dhaka is the authorized quality control laboratory under this law. Sanitary Inspectors of the health
services or of the municipal offices are authorized as Inspectors under the Ordinance. *The Breast-milk Substitutes (Regulation of Marketing) Ordinance, 1984* was enacted to promote breast-feeding and to regulate the marketing and certain forms of advertisement of breast-milk substitutes. *The Control of Iodine Deficiency Disorders Act, 1989* was enacted to ensure universal iodization of edible salt.

*The Epidemic Diseases Act, 1897* allowed Government to take emergency measures to prevent the spread of dangerous epidemic diseases. *The Vaccination Act, 1880* is mainly concerned with small-pox vaccination and is redundant now. *The Municipal Administrative Ordinance, 1960* authorizes municipal corporations and committees to adopt special measures to prevent infectious diseases and to restrain infection within the municipality.

### 3.2 Health Related Other Legislations.

Narcotic and psychotropic substances are regulated under *The Narcotics Control Act, 1990*. This law is implemented by the Department of Narcotics Control under the Ministry of Finance. Narcotic and psychotropic drugs are under dual control of the Directorate of Drug Administration and Department of Narcotics Control. Non-therapeutic abortions are legally prohibited under sections 312-314 of *The Penal Code, 1860*. Under this law, abortions (self-induced or induced by others) are considered as serious criminal offences, and are punishable with long imprisonments and fines.

The laws for registration of births and deaths are: (a) *The Births and Deaths Registration Act, 1873*; (b) *Births, Deaths and Marriages Registration Act, 1886*; and (c) *The Municipal Administrative Ordinance of 1960*. The village watchmen (*Choukidars*) were to collect data on births and deaths. The chairmen of municipalities, pourashavas and union councils were authorized *ex-officio* as Registrar of Births and Deaths in their respective areas. Municipal committees are obliged to register all births, deaths and marriages in their respective areas. The minimum legal age of marriage for females was set at fourteen years under *The Child Marriage Restraint Act, 1929*. This was raised to sixteen years under *The Muslim Family Laws Ordinance of 1961*. Under *The Child Marriage Restraint (Amendment) Ordinance, 1984*, the minimum legal age for marriage of females was raised to eighteen years.

### 3.3 Legislations not Specific to Health Sector

*The Companies Act, 1994* is the new law guiding the establishment and operation of companies. *The Factories Act, 1965* provides for the safety of building and machinery, protection of eyes and other safety measures for workers. *The Workmen’s Compensation Act, 1923* provides for compensation to a worker who may incur accidental injury or death during working. *The Trade Mark Act, 1940* provides for the registration and protection of trade marks in Bangladesh.

*The Municipal Administration Ordinance, 1960* empowers the Municipal Committee to levy various taxes, rates, tolls and fees with the previous sanction of the Government. *The Municipal Corporation (Taxation) Rules, 1986* imposes on all professions or trading organizations to obtain an annually renewable *Trade License*. Companies and other for-profit firms are also charged a *Municipal Tax* depending upon their paid-up capital and estimated incomes. Any person or business firm owning a building in the corporation area is also liable to pay municipal taxes depending upon the size of the building and its location.
**Import Policy Order** is issued by the Ministry of Commerce annually. For importing medicinal products, the products must have been registered by the Drug Administration. Clearance certificates from authorized officers of the Drug Administration are needed for clearance of all pharmaceutical products at the port. The **Industrial Policy** recognizes large polyclinics or hospitals set up by companies as industrial enterprises. Such enterprises are eligible to receive ‘industrial loans’ from government sponsored industrial banks and to enjoy 'tax holiday' benefits. However, these benefits are not yet enjoyed by diagnostic laboratories.

Income Tax (IT) is imposed annually by GOB in the budget under **The Income Tax Ordinance, 1984**. Currently (FY2002-'03), an individual having personal annual income above Tk.75,000 has to pay IT at the rate of 10% to 25% of income, the minimum payable being Tk.1,200. Publicly traded companies pay IT at the rate of 30%, and other companies at the rate of 35%. A newly established hospital or clinic enjoys ‘tax holiday’ for five years, provided it is owned by a company registered under the **Companies Act (1994)** and built on its own land. **Value Added Tax (VAT)** is imposed under **The Value Added Tax Act, 1991**. Private sector clinics, hospitals, dental clinics and diagnostic laboratories are to pay VAT at the rate of 15% on the total amount charged on patients. Individual private medical practitioners and specialists are still exempted from paying VAT. The VAT is also payable at the rate of 15% on all imported items. **Custom Duties** are imposed on many imported commodities. Certain essential medical items (e.g. contraceptive drugs and devices, antibiotics, anti-TB/anti-leprosy/anti-malarial/anti-cancer drugs, etc.) and raw materials imported to manufacture these are exempted from paying any Custom Duty.

4. **Regulatory Agencies**

**The Directorate General of Health Services (DGHS).** The DGHS is responsible for the administration of most of the health legislations except the drug legislations. It is responsible for licensing and inspection of all private facilities under the **Medical Practice and Private Clinics and Diagnostic Laboratories Ordinance, 1982**. The **Director of Hospitals and Clinics** at the DGHS/HQ is directly involved in inspection and licensing of private facilities. At the periphery, the District Civil Surgeon (CS) is the chief public health executive. The CS collects epidemiological data from various sources, and reports weekly to the Director/ PHC & DC in the DGHS HQ. At times of epidemics, the reporting is made daily.

**Directorate of Drug Administration (DDA).** The DDA is responsible for the administration and enforcement of all drug legislations. It is also involved in narcotic drugs control in collaboration with the Directorate of Narcotics Control. The DDA is headed by a Director who is supported by 3 Deputy Directors, 5 Assistant Directors, 45 Superintendents of Drugs (SDs) and 7 Inspectors of Drugs (IDs). All officers of the Directorate are empowered to act as “Inspector of Drugs” for the purpose of drug legislations. Medicinal products marketed in the country are required to have DDA Registration. At present there are about 6500 registered allopathic products, and also 3150 Ayurvedic, 1320 Unani and 750 Homeopathic products. The Drug Control Committee (DCC) set up under the Drugs Ordinance of1982 is involved in regulating registration of medicinal products. The Secretary, MOHW is the Chairperson of the DCC; there are 14 other members including one expert each from Ayurvedic, Unani and Homoeopathic systems of medicine. There is a National Drug Testing Laboratory (NDCL) at Dhaka and a Regional Drug Testing Laboratory at Chittagong.
Bangladesh Medical and Dental Council (BMDC). BMDC, established under *The Medical and Dental Council Act (1980)* consists of about 50 members, of whom 36 are *ex-officio* Government officials or representatives of various teaching institutions in the public health sector; one member each is nominated by the two professional associations of physicians (BMA and BPMPA); one member belonging to the legal profession is nominated by the Chief Justice of Bangladesh; and eight Members of the Parliament are nominated by the Speaker. The President of the Council is elected by the Members from amongst themselves. BMDC registers medical practitioners and dentists, and recognizes the standards of teaching and examinations at the medical and dental colleges.

Bangladesh Nursing Council (BNC). BNC was constituted under *The Bangladesh Nursing Council Ordinance, 1983*. The Secretary, MOHFW is the President of the BNC. Of the 25 members of the BNC, only one is from outside the Government representing the professional association of nurses (Bangladesh Nursing Association); other members are nominated by Government Ministries or various government departments. BNC registers qualified nurses and recognizes teaching institutions.

Pharmacy Council of Bangladesh (PCB). The PCB established under *The Pharmacy Ordinance (1976)*, registers different categories of pharmacists, recognizes different teaching institutions and also organizes training courses for less qualified retail pharmacists. The Council is headed by the Secretary, MOHFW and has 15 members. Six members are nominated by professional bodies. The Council elects every year one of its members other than an *ex-officio* member, to be the Vice-President of the Council.

Municipal Committees, Paurashavas and Union Parishads. Municipal Committees were constituted under *The Municipal Administrative Ordinance (1960)*, the Union Parishads under *The Local Government Ordinance (1976)*, and the Paurashavas under the *Paurashava Ordinance (1977)*. These local government bodies are empowered under various health or other legislations to take preventive or punitive actions in respect of infectious diseases, epidemics, vector control, food safety and also registration of births and deaths.

5. **Status of Implementation of the Regulations**

5.1 Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982.

Inspection takes place at the time of first licensing; periodic inspections are not possible with available resources. The monitoring of the standard of premises and quality of services is extremely poor. Schedule C of the law specifies that at least “one Registered Medical Practitioner” and "two nurses" be available for every ten beds. Because the Schedule does not qualify the type of nurse, most private clinics do not appoint any qualified Registered Nurses. They just hire unqualified nursing aids, train them up a little and pass them off as “Nurses”.

The administrative process of licensing is over-centralized and lengthy. Often it takes 4-5 months for an applicant to receive the first license. The DGH can refuse to issue a new license or to renew it but can not force closure on a private clinic; after giving a "show cause" notice, a case may only be filed in the Court. The fees prescribed in Schedule A are unrealistic and not
enforceable. The fixation of fees is not benefiting clients; it is only hindering fair competition among the service providers. Government employed doctors are allowed to carry on private practice which open up many actual and potential distortions within the health care system. The weakness of the regulatory agency and mechanisms is mainly responsible for the poor outcomes. An accreditation process is presently ongoing in the office of the Director of Hospitals and Clinics. It is reported that MOHFW has decided to amend the Ordinance of 1982 to make it more effective.

5.2 The Medical and Dental Council Act, 1980

BMDC can suspend or cancel the registration of a physician or a dentist for unethical behavior or negligence of duty. It has a Code of Medical Ethics, and also a five-member Disciplinary Committee. However, disciplinary action of BMDC is very rare. The Disciplinary Committee could not sit to review complaints since 1997 because of a Court injunction against meetings of the Council. Lack of disciplinary actions by the BMDC allows medical practitioners to be indifferent about their responsibility and behavior towards their patients. Section 30 of the Act prohibits practice of allopathic medicine by anyone other than a registered medical practitioner. But BMDC is quite indifferent about the large number of unqualified persons carrying out practice of allopathic medicine.

5.3 Drug Legislations

The NDP and the Drugs Ordinance of 1982 support WHO's recommendations on essential drugs. After 1982 the availability of essential drugs increased greatly. Because of stringent price control, retail prices of drugs came down sharply. With better competition among the many manufacturers, the prices have by and large remained stable and affordable. The share of primary health care essential drugs in local production increased from 30% in 1981 to about 80% in 1990. It is reported that this share has since fallen back to about 50% mainly because manufacturers find it more profitable again to produce non-essential drugs (the prices of which are no longer fixed by GOB) than the essential ones (the prices of which are still being fixed). Some of the restrictions imposed under the NDP and Drugs Ordinance of 1982 were partially relaxed in 1992. However, by and large, the NDP and the Drugs Ordinance of 1982 are still valid, and much of the benefits derived from them are still visible.

The implementation of drug legislations is better than that of many other health legislations because a whole Directorate is engaged full-time for administration and enforcement of these legislations. Empowerment of all the officers of DA as “Inspectors” for the purpose of the drug legislations has much strengthened the process and frequency of inspections of premises. The Drugs Act, 1940 and the rules there under are, by and large outdated.

5.4 The Pure Food Ordinance of 1959

The main concern of this law was the prevention of adulteration of fresh food. The law is out-dated, and is inadequate for the regulatory control of prepackaged or factory made food items which are now flooding the market. There is no authorized single agency responsible for inspection or prosecution under this law except the very low ranking sanitary inspectors. Local self-government authorities who were expected to administer and enforce the law are essentially weak and lack the expertise on the subject. The law is practically inoperative because of its cumbersome procedures and because
5.5 Abortion Law

Though non-therapeutic abortion is prohibited and treated as a criminal offence, every year a large number of such abortions take place in the country. Desperate women undergo 'illegal' abortion in the hands of unqualified abortionists who follow unsafe methods in unsanitary places. It is estimated that at least 10,000 women die every year in Bangladesh as a consequence of septic induced abortion and its complications. In many countries, mortality due to abortion is now very negligible after the liberalization of their abortion laws since the sixties. Menstrual Regulation (MR) which is a form of induced abortion in early pregnancy is officially tolerated and socially accepted. Though every year, hundreds of thousands of MRs are taking place in the country, as yet there is no legislation in respect of MR.

5.6 Registration of Births and Deaths and Legal Age of Marriage

Under the outdated laws, Chaukidars were required to report every birth and death but they exist no longer. The sanitary inspectors of public health services at one time maintained irregular records of birth and deaths. Chairmen of Paurashava, Mayors of Corporations and Chairmen of Union Parishads still enjoy *ex-officio* power as Registrars of Births and Deaths, and issue retrospectively effective "birth certificates". At different times, different agencies had been authorized for reporting or registration of births and death, but till now no agency maintains a regular up-to-date Register of Births or Deaths. There never had been a legally defined Central Registrar of Births and Deaths.

The legal minimum age of marriage for females was set as eighteen years in 1984 but the average age of marriage of rural women in many parts of the country is still 14 to 15 years. The legal age of marriage under *The Child Marriage Restraint (Amendment) Ordinance (1984)* cannot be enforced unless there is a full-proof regular system of birth registration.

6. Reforming the Regulatory Framework: Analysis and Recommendations

Many old and outdated health laws require to be updated and new laws require to be enacted to suit the emerging situation. At present health regulations are developed on an *ad hoc* basis when a crisis situation is encountered. Regulatory agencies are consulted but normally not the private sector. The process is generally not transparent. The major problem of the health regulatory framework at present is poor implementation and enforcement. Before the gigantic task of reforming the regulatory framework for the health sector is under-taken, two points must be made clear: (a) keeping health legislations relevant with changing health situation needs a permanent mechanism rather than *ad-hoc* efforts; and (b) a law on paper without a proper mechanism of implementing it is a futile effort. The need for setting up of a permanent Legal Cell in the MOHFW with appropriate experts and staffing is imperative.

**Regulation of Private Medical Practice, Clinics and Laboratories.** The system of licensing should be decentralized and simplified. Local committees or honest and competent individuals could be involved in inspecting, issuing of licenses and monitoring. If centralization continues, the responsibility of licensing and monitoring should be transferred to a full-time unit in the DGHS or to an autonomous unit under it. Some consumer groups could also be involved in monitoring. Whatever is done, it should be simple, efficient and transparent. Amendment of the law is needed to ensure appointment of qualified nurses. It is reported that GOB is considering amendments of the 1982 Ordinance and preparing a draft for this purpose.
BMA and BNA should be officially authorized to monitor minimum remunerations of junior doctors and nurses in private facilities. The patients also need protection against malpractice and improper use of resources from a profit motive. The DGH should set up a body with representation from professional associations and consumer protection groups to hear complaints against private physicians and other facilities. The price fixation part of the present regulation should be scrapped and new regulations adopted to increase fair competitiveness amongst the private actors. One sensitive issue that needs monitoring is the services of government employed physicians in private hospitals and clinics. Another sensitive issue is the malpractice of diagnostic laboratories providing commissions to prescribing doctors.

**Registration of Medical Practitioners.** The practices of unqualified medical practitioners (or quacks) should gradually be restricted and/or regulated. If this is not possible under the present *Medical and dental Council Act (1980)*, it should be amended or a new law should be enacted for this purpose. The current law also needs to be amended for activating the process of disciplinary actions against violators of medical ethics.

**Registration of Births and Deaths and Legal Age of Marriage.** A new law should be enacted for the registration of births and deaths. This law should provide among other things: (a) obligatory registration of all births; and (b) a Central Registrar, local registrars and reporters of all births and deaths. Marriage Registers should demand and be satisfied that those being married have actually attained the minimum legal age of marriage. The nature of evidence referred to above may be a birth certificate issued under the new law for registration of births and deaths. Registration of marriages should be compulsory, and the marriage registrar should be punishable for registering a marriage of a female below the minimum legal age for marriage.

**Food Safety.** *The Pure Food Ordinance (1959)* should be scraped and a new law should be enacted with provision of appropriate means for implementation. FAO and Either a new government agency should be set up for implementing the new law or the Directorate of Drug Administration should be suitably expanded for this purpose. All Civil Surgeons and Thana Health Administrators should be appointed as "Inspectors" for the purpose of the food safety legislations.

**Drug legislations.** Laws should be amended to provide for Rational Use of Drugs (RUD). The lists of essential drugs in the NDP should be revised. It has to be ensured that decisions regarding registration, evaluation and safety of medicinal products are left exclusively with technical experts and professionals, and not with bureaucrats or vested-interest groups. *The Narcotics Control Act (1990)* should be amended to emphasize the objectives of preventing drugs abuse and rehabilitating addicts.

**Other Recommendations.** *Sections 312-314 of the Penal Code, 1860* should be scraped and a new modern abortion law should be enacted, wherein a medical practitioner is authorized to terminate a pregnancy if he/she is convinced that it is in the best interest of the woman concerned for physical or psychological reason. MR should be brought under the purview of the new abortion law. A new laws should be enacted to ensure full EPI coverage, and for the control of emerging new infectious diseases. It should provide for notification of new cases of serious infectious diseases by all public and private sector health facilities and practitioners. Some legislation is needed for the protection and treatment of AIDS patients.
The Factories Act (1965) should be amended to provide full-time medical officers and registered nurses for factories employing more than 200 workers. The Workmen's Compensation Act (1923) should be amended to ensure quick trials and to cover occupational diseases. A new cosmetics law should be enacted for regulating the manufacture, quality control and trade of cosmetics. A new law should be enacted on the disposal of hazardous hospital wastes for both the public and private sectors. The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982 should also be amended for this purpose.

New legislations are needed for the restructuring the health care system to give effect to: (a) decentralized Regional Authorities; (b) converting the larger hospitals into autonomous institutions; (c) conversion of the private practice of public sector physicians into supervised institutional practice; (d) public funding of officially sponsored health insurance schemes especially for the poor and vulnerable groups; and (e) mobilization of local resources in the form of user fees for curative services provided in public hospitals and health centres.

7. Conclusion

The aim of legislations for regulating the private health sector should not be directed to control profit levels but wholly to improve the quality of services and to ensure a fair competitiveness among the service providers. In the complex market situation, quality can never be ensured by authoritative dictums or severe regulations. The best and cheapest way of ensuring quality is to provide the best field situation for fair competitiveness. The Government's first priority should be to establish a suitable regulatory framework with implementation mechanism for ensuring the standards and quality of services, and to ensure fair competitiveness among the service providers. The role of private sector health care providers could increase substantially when a proper Health Insurance system evolves, providing a new field for competition amongst them. Although self-regulation is the most preferred method, it is not clear how self-regulation could work in this early stage of private health sector development in Bangladesh.

A strong political will and commitment is needed to develop a fruitful partnership between the public and private sectors. A broad consensus on the principle that the poor and vulnerable groups have a right to access quality services at subsidized low cost or at public cost, could probably lead to a fruitful co-operation between the two sectors. When such a consensus develops, the modalities and cost-sharing between the public and private sectors can be worked out. As public/private partnership evolves, there will be great opportunities for GOB to purchase selected services for vulnerable population groups instead of trying to provide all the services to all the citizens, which is quite beyond its capacity and means.

Laws constitute the basic foundation of a civilized society, reflecting its needs, hopes and aspirations. Most of our legislations, including our health legislations were given to us by our erstwhile colonial masters. They formulated these laws essentially to serve their own interests and with the desire to perpetuate their system of rule. Those masters are gone now, and we carry a full burden of their laws, often not knowing what to do with them or how to change them to suit our own times and our own needs.

A frustrating situation is presently prevailing in the public health care system in the country; the situation in the private sector is not much better. The regulatory mechanism is inadequate for ensuring a minimum standard or quality of the services. At the moment, there is much anarchy and violation of laws and ethics in the private health sector. In many ways, both
the public and the private sectors have failed to meet the essential health care needs of the people in terms of both access and quality. The mute question is: can the performance of the private sector be improved to meet the needs of the people and to provide the value for the money they spend for their health and medical needs?
Table 6.3 – Summary of Formal Regulatory Instruments

<table>
<thead>
<tr>
<th>Name of Instrument</th>
<th>Year</th>
<th>Type</th>
<th>Issued by</th>
<th>Implementing Agency</th>
<th>Objective</th>
<th>Regulates</th>
<th>Maximum Punishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Practice and Private Clincs and Laboratories (Regulation) Ordinance (Ord. IV of 1982)</td>
<td>1982</td>
<td>Ordinance</td>
<td>CMLA</td>
<td>Directorate-General of Health services (DGHS)</td>
<td>To regulate medical practice &amp; functioning of private clinics &amp; laboratories</td>
<td>Private medical practitioners, clinics and diagnostic laboratories</td>
<td>Practitioners: Fine Tk.5000; Labs: Fine Tk.5000 + forfeiture; clinics: imprisonment 6 m + fine Tk.5000 + forfeiture of property</td>
</tr>
<tr>
<td>Medical Practice and Private Clinics and Laboratories (Regulation) (Amendment) Ordinance (Ord. LXVIII of 1984)</td>
<td>1984</td>
<td>Ordinance</td>
<td>President</td>
<td>DGHS</td>
<td>To revoke maximum consultation fees of doctors under Sr. No. 1</td>
<td>Doctors’ consultation fees</td>
<td>Nothing mentioned</td>
</tr>
<tr>
<td>Medical and Dental Council Act (Act XVI of 1980)</td>
<td>1980</td>
<td>Law</td>
<td>Parliament</td>
<td>Bangladesh Medical &amp; Dental Council (BMDC)</td>
<td>Registration of Doctors and dentists</td>
<td>Medical and dental practice; approves degrees</td>
<td>(a) Suspension/Cancellation of Registration; (b) Imprisonment up to 1 yr or fine Tk.5000 or both.</td>
</tr>
<tr>
<td>Bangladesh Nursing Council Ordinance (Ord. LXI of 1983)</td>
<td>1983</td>
<td>Law</td>
<td>CMLA</td>
<td>Bangladesh Nursing Council (BNC)</td>
<td>To constitute a Nursing Council for registration of nurses &amp; midwives</td>
<td>Nursing practice; approves courses and degrees</td>
<td>(a) cancellation/suspension of Registration; (b) Imprisonment up to 1 yr or fine Tk.2000 or both.</td>
</tr>
<tr>
<td>The Pharmacy Ordinance (Ord. XIII of 1976)</td>
<td>1976</td>
<td>Ordinance</td>
<td>President</td>
<td>Pharmacy Council of Bangladesh (PCB)</td>
<td>To regulate the practice of pharmacy; approval of courses &amp; degrees</td>
<td>Graduate and diploma pharmacists</td>
<td>Imprisonment for 3 months or fine Tk.500 or both</td>
</tr>
<tr>
<td>Drugs Act (Act XXIII of 1940)</td>
<td>1940</td>
<td>Law</td>
<td>British India Government</td>
<td>Directorate of Drug Administration (DDA)</td>
<td>Control manufacture, import, QC, distribution &amp; sale of drugs.</td>
<td>Drug producers, traders and retail sellers</td>
<td>Imprisonment for three years or fine or both</td>
</tr>
<tr>
<td>Drug Rules</td>
<td>1945</td>
<td>Rules</td>
<td>British India Government</td>
<td>DDA</td>
<td>Supplements Drugs Act, 1940</td>
<td>Manufacture import, sale and testing of drugs</td>
<td>As under Drugs Act, 1940</td>
</tr>
<tr>
<td>Drug Rules</td>
<td>1946</td>
<td>Rules</td>
<td>Bengal Govt.</td>
<td>DDA</td>
<td>Supplements Drugs Act, 1940</td>
<td>Manufacture, trade and testing of drugs</td>
<td>As under Drugs Act, 1940</td>
</tr>
<tr>
<td>The Drugs (Control) Ordinance (Ord. VIII of 1982)</td>
<td>1982</td>
<td>Ordinance</td>
<td>CMLA</td>
<td>DDA</td>
<td>To control manufacture, import, distribution &amp; sale of drugs; registration of products</td>
<td>Pharmaceutical manufacturers, traders and retail pharmacists</td>
<td>Imprisonment up to ten years + fine up to Tk.200,000</td>
</tr>
<tr>
<td>The Drugs (Control) (Amendment) Ordinance (Ord. XXVIII of 1982)</td>
<td>1982</td>
<td>Ordinance</td>
<td>CMLA</td>
<td>DDA</td>
<td>To relax certain provisions of Sr. No. 6</td>
<td>Registration of medicinal products</td>
<td>As under the Drugs (Control) Ordinance, 1982</td>
</tr>
<tr>
<td>The Drugs (Control) Rules</td>
<td>1990</td>
<td>Rules</td>
<td>MOHFW</td>
<td>DDA</td>
<td>Composition of DCC; registration guideline; documents relating to manufacture &amp; QC, etc.</td>
<td>Pharmaceutical manufacturers, traders and retail pharmacists</td>
<td>As under the Drugs (Control) Ordinance, 1982</td>
</tr>
<tr>
<td>The Pure Food Ordinance (Ord. LXVIII of 1959)</td>
<td>1959</td>
<td>Ordinance</td>
<td>Governor of East Pakistan</td>
<td>DGHS and local-government bodies with sanitary inspectors</td>
<td>To check adulteration &amp; ensure quality of foods like milk, butter, fish, meat, etc.</td>
<td>Producers and sellers of food items; hotels</td>
<td>Imprisonment for up to one year or fine of Tk.4000 or both + forfeiture of tools &amp; implements</td>
</tr>
<tr>
<td>Breast-milk Substitutes</td>
<td>1984</td>
<td>Ordinance</td>
<td>President</td>
<td>DGHS</td>
<td>To promote breast feeding; marketing and</td>
<td></td>
<td>Imprisonment for up to two years,</td>
</tr>
<tr>
<td>Name of Instrument</td>
<td>Year</td>
<td>Type</td>
<td>Issued by</td>
<td>Implementing Agency</td>
<td>Objective</td>
<td>Regulates</td>
<td>Maximum Punishment</td>
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<tr>
<td>(Regulation of Marketing) Ordinance (Ord. XXXIII of 1984)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>registration of breast-milk substitutes</td>
<td>advertisements of breast-milk substitutes</td>
<td>or fine up to Tk.5000, or both</td>
</tr>
<tr>
<td>Control of Iodine Deficiency Disorders Act (Act X of 1989)</td>
<td>1989</td>
<td>Act</td>
<td>Parliament</td>
<td>M of Health; M of Industries; Salt Committee</td>
<td>Universal iodization of edible salt to prevent iodine deficiency disorders</td>
<td>Manufacturers, importers and sellers of edible common salt</td>
<td>Imprisonment up to three years or fine up to Tk.5000, or both</td>
</tr>
<tr>
<td>Control of Iodine Deficiency Disorders Rules 1994</td>
<td>Rules</td>
<td>MOHFW</td>
<td>M of Health; M of Industries; Salt Committee</td>
<td>Supplements control of Iodine Deficiency Disorders Act 1989</td>
<td>Manufacturers, importers and sellers of salt</td>
<td>Cancellation of registration of salt manufacturers</td>
<td></td>
</tr>
<tr>
<td>The Epidemic Diseases Act (Act III of 1897)</td>
<td>1897</td>
<td>Act</td>
<td>British India Government</td>
<td>DGHS</td>
<td>Allowing Govt. to take emergency measures during epidemics to prevent spread</td>
<td>Movement of people; sale of food items</td>
<td>Imprisonment up to one month, or fine up to Tk.200, or both</td>
</tr>
<tr>
<td>The Vaccination Act (Bengal Act V of 1880)</td>
<td>1880</td>
<td>Act</td>
<td>British India Government</td>
<td>DGHS</td>
<td>To make small-pox vaccination compulsory</td>
<td>giving of small-pox vaccinations</td>
<td>For guardians: Fine of Tk.100 &amp; subsequently Tk.25 per day to a max. of Tk.1000</td>
</tr>
<tr>
<td>Narcotic Control Act (Act XX of 1990)</td>
<td>1990</td>
<td>Act</td>
<td>Parliament</td>
<td>Department of Narcotics Control</td>
<td>Control of narcotic and psychotropic drugs and alcoholic beverages</td>
<td>manufacturers, traders, doctors/hospitals using narcotic drugs and pharmacies,</td>
<td>Death sentence or imprisonment for life (for possessing more than 25 g of heroin, cocaine or coca derivatives)</td>
</tr>
<tr>
<td>The Medical Degrees Act (Act VII of 1916)</td>
<td>1916</td>
<td>Act</td>
<td>British India Government</td>
<td>Department of Health</td>
<td>To regulate the grant of titles implying qualifications in Western/ Allopathic medicine</td>
<td>private medical practitioners</td>
<td>First offence: fine up to Tk.250; subsequently: Tk.500.</td>
</tr>
<tr>
<td>Bangladesh College of Physicians and Surgeons Order</td>
<td>1972</td>
<td>President's Order</td>
<td>President</td>
<td>Bangladesh Coll. of Physicians and Surgeons (BCPS)</td>
<td>To establish BCPS for training medical/ surgical specialists</td>
<td>Courses/examination s of medical/ surgical spec.</td>
<td>None</td>
</tr>
</tbody>
</table>