Open Peer Review on Qeios

Strengthening Healthcare in Bangladesh: Challenges and Pathways to Equity and Quality

Jabed Iqbal

Funding: No specific funding was received for this work.

Potential competing interests: No potential competing interests to declare.

Abstract

This manuscript examines the multifaceted healthcare system of Bangladesh, characterized by its decentralized and unregulated nature, with diverse control spanning for-profit entities, NGOs, the national government, and international welfare organizations. Despite substantial challenges, including inadequate public health facilities, a scarcity of skilled healthcare professionals, and significant healthcare inequity, Bangladesh has made commendable progress in health-related Millennium Development Goals. The COVID-19 pandemic underscored the system's shortcomings, notably in testing, national coordination, and treatment equity. This study explores these challenges in detail, alongside potential solutions aimed at improving healthcare financing, enhancing healthcare worker training, and promoting public-private partnerships. Recommendations for overcoming barriers include increasing government healthcare funding, improving rural healthcare facilities, and addressing healthcare inequity through a dynamic and visionary policy approach. This analysis seeks to contribute to the discourse on advancing healthcare in Bangladesh towards Universal Health Coverage.

Keywords: Bangladesh healthcare system, Healthcare challenges, Public-private partnerships, Healthcare equity, Policy recommendations.

Introduction

The Bangladeshi healthcare system, which is highly decentralised and unregulated, is controlled by a variety of organisations, including for-profit entities, NGOs, the national government, and international welfare organisations. In recent years, the Bangladesh government has prioritised healthcare as a key development area, aiming to improve healthcare infrastructure, expand services, and strengthen the overall healthcare system [1]. Despite facing many challenges, Bangladesh has made remarkable progress in achieving health and population indicators, particularly in achieving health-related Millennium Development Goals (MDGs), such as MDG 4 and MDG 5, concerned with improving infant survival and maternal health, respectively [2]. Efforts are being made to enhance healthcare financing, increase the number of healthcare professionals, and promote public-private partnerships to address the existing challenges.

As noted, the healthcare system of Bangladesh relies heavily on both the government and the public sector for financing and setting overall policies and service delivery mechanisms [3]. However, the healthcare sector in Bangladesh suffers from a range of problems, such as (a) a lack of public health facilities, (b) a shortage of skilled workers, (c) inadequate financial resource allocation, (d) a lack of accountability and established guidelines, and (e) healthcare inequity [4]. Political instability and the demise of ideal democratic practices are also significant contributing factors. As such, the COVID-19 pandemic provided a backdrop that brought greater attention to the fragmented synchronisation of relevant government bodies and legislative authorities. The lack of adequate testing centres, disconnect in national health coordination, and largely, treatment inequality, especially amongst the poorer demographic, cumulatively resulted in over 2 million cases and 29,445 deaths [5]. It must also be said, the absence of proactive and transformative stewardship that can design and enforce policies to further strengthen and enhance the overall health system is the most crucial challenge. While the limitations of this paper prevent an exhaustive examination of the ongoing causes behind our healthcare challenges, it is essential to recognize that the socio-cultural and financial deficiencies inherent at the macro level in developing countries, including Bangladesh, amalgamate to form the myriad obstacles encountered by individuals seeking medical assistance.

Challenges

a. The Bangladeshi government has set up many government-funded hospitals in rural areas to provide cheaper treatment for rural citizens. These hospitals are often poorly funded, understaffed, and crowded. These challenges are magnified by the unequal geographic distribution of individuals throughout the country, in which 60% of Bangladeshis are primarily concentrated in rural areas, while 40% are concentrated in urban areas [6]. Moreover, the current shared public and private healthcare systems, and non-governmental organisations are predominantly partial against rural demographics; therefore, providing unequal treatment between socioeconomic classes.
b. Enrollment in medical colleges and healthcare training facilities has increased, but the shortage of healthcare workers and clinical equipment is a significant issue, with most physicians and healthcare workers concentrating in urban areas, leaving rural areas with inadequate healthcare facilities. Moreover, in a study regarding career choices of Bangladeshi medical students, an overwhelming 90% of students chose major cities as practice locations; with 51% wanting to immigrate and practice abroad [7]. Without prompt intervention, these statistics allude to a collapsing future healthcare system, characterised by chronic shortages of competent personnel, especially in rural areas of highest demand. It is worth mentioning as well, lifestyle-related and preventative medicine were two of the least attractive specialties – a commentary on the requisite refashioning of the medical education to include community-based teaching and exposure to practicing in suburban and mostly rural settings quite early on [8].
c. Socioeconomic inequality affects healthcare in Bangladesh. Poorer citizens cannot afford certain treatments or services due to high out-of-pocket costs. Limited government funding has also led to high out-of-pocket payments, creating a significant financial burden for impoverished families. A recent study revealed that approximately 25% of individuals incurred catastrophic health expenditures, 14% of the population had forgone healthcare for various reasons, and nearly 69% of total health expenditures continue to be paid out-of-pocket by Bangladeshis [9]. Financial burden and forgone care were greater among households with older populations or chronic illness and those who used

either public or private health facilities. Finally, paralysed by mismanagement, high population density, and corruption, to secure treatment by reputable healthcare professionals, patients usually must rely on external connections; a luxury that, unfortunately, most of the general population is unable to exploit [10].

d. Quality of care in both public and private services has been consistently poor due to the unfortunate (i) lack of assessments and monitoring of provider care quality, (ii) widespread suboptimal professional knowledge, and (iii) lack of proper established guidelines in clinical practice.
e. Enhancing primary health care (PHC) through the strengthening of health systems is crucial for the progression towards Universal Health Coverage (UHC) in low-income nations like Bangladesh. However, corruption poses a significant obstacle, undermining the UHC objectives of equity, quality, and system responsiveness, leading to devastating increases in health care costs. More so, it constitutes a deliberate disregard of duty and hence loss of public trust; ultimately resulting in adverse effects on health outcomes, particularly for the impoverished and disadvantaged. For instance, according to the corruption perception index by Transparency International, corruption is estimated to cause 140,000 annual deaths globally among children under five [11][12].

Possible Solutions

To ensure access to health services for all, Bangladesh needs to undertake dynamic and visionary steps to implement several policies:

1. Increased government funding for healthcare: The allocation of resources to the health sector in Bangladesh has historically been limited. Despite recent increases, the health budget remains insufficient to address critical shortages of trained personnel, medical equipment, and supplies. Consequently, Bangladesh's healthcare system relies heavily on out-of-pocket payments, which creates a significant financial burden for impoverished families. Increasing government funding for healthcare can reduce the financial burden on individuals and attempt to ensure that everyone has access to affordable healthcare.
2. Train and educate more healthcare workers: Bangladesh has a shortage of physicians, specialists, and clinical equipment, particularly in rural areas. Increasing the number of healthcare workers, including traditional healthcare providers, by providing training and education facilities can help address this shortage and ensure that everyone has access to healthcare services. Healthcare providers should receive ongoing training and support to maintain high standards of care.
3. The development of a comprehensive national healthcare quality strategy should include a clear vision for improving healthcare quality, specific goals, aims, and action plans for achieving those goals [9]. The strategy should prioritise patient-centred care, evidence-based practice, and continuous quality improvement. Strengthening governance and leadership structures: effective governance and leadership are critical for creating a culture of quality and accountability within healthcare organisations. This includes establishing clear roles and responsibilities for quality management, developing quality standards and guidelines, and building capacity for quality improvement.
4. Improving healthcare facilities in rural areas: Most physicians and healthcare workers are concentrated in urban areas,

leaving rural areas with inadequate healthcare facilities. The government can establish more government-funded hospitals in rural areas and provide better funding, staffing, and equipment to ensure that rural citizens have access to quality healthcare. Healthcare systems and infrastructure should be strengthened to support quality improvement initiatives.

5. Improving healthcare inequity and inequality: the simplest measure is to compare the health status of the lowest socioeconomic stratum with that of the highest stratum. To reduce health inequity in Bangladesh, additional measures can be taken (a) Enhance health literacy and awareness, targeting vulnerable populations through comprehensive health education programs. (b) Address gender disparities by promoting equality and eliminating barriers to women's healthcare access by providing specialised services for women. (c) Improve data collection systems and invest in studies on determinants and disparities (d) Engage communities in decision-making and involve them in healthcare program planning, implementation, and evaluation. (e) Utilise technology and innovation like telemedicine and mobile health applications to improve access, especially in remote areas, with the help of community workers.
6. In Bangladesh, challenges such as low GDP, limited education, weak democratic values, and patriarchal norms hinder efforts to reduce corruption. To address this, a two-pronged approach is recommended: (i) addressing socioeconomic and cultural barriers and (ii) testing community-based interventions such as public hearings and healthcare monitoring. This can benefit frontline workers and those in power by improving community health and generating goodwill. Further research is needed to refine these interventions and explore new methods for addressing corruption. The accountability of healthcare providers, raising awareness of service entitlements, and comprehensive multisectoral efforts are essential. By engaging and empowering the community, corruption mitigation can be part of broader health system reforms for universal health coverage.

Conclusion

The existing laws and policies that address healthcare services in Bangladesh have several limitations that need to be addressed to ensure quality healthcare for all people. Due to flawed regulatory frameworks, loose accountability and transparency, widespread corruption, poor monitoring systems, inadequate health financing, inequity between rural and urban populations in accessing healthcare services, and a lack of effective grievance procedures, people in Bangladesh are being deprived of their right to proper medical service and healthcare, which the Constitution has guaranteed as a fundamental right.

A dynamic and proactive stewardship approach that can formulate and enforce policies to strengthen and enhance the overall health system could lead to meaningful and effective health system reform. These policies are built upon the values of social equity and accountability and work for the betterment of the health of the people of Bangladesh.

References

1. ^*Bryce, J., Black, R.E. & Victora, C.G. Millennium Development Goals 4 and 5: progress and challenges. BMC Med*

11, 225 (2013). https://doi.org/10.1186/1741-7015-11-225

2. ^*Chowdhury S, Banu LA, Chowdhury TA, Rubayet S, Khatoon S. Achieving Millennium Development Goals 4 and 5 in Bangladesh. BJOG. 2011 Sep;118 Suppl 2:36-46. doi: 10.1111/j.1471-0528.2011*
3. ^*Kabir, A., Karim, M.N. & Billah, B. The capacity of primary healthcare facilities in Bangladesh to prevent and control noncommunicable diseases. BMC Prim. Care 24, 60 (2023). https://doi.org/10.1186/s12875-023-02016-6*
4. ^*Murshid, Munzur-E; Haque, Mainul. Hits and misses of Bangladesh National Health Policy 2011. Journal of Pharmacy and Bioallied Sciences 12(2):p 83-93, Apr–Jun 2020. | DOI: 10.4103/jpbs. JPBS_236_19*
5. ^*https://coronavirus.jhu.edu/region/bangladesh*
6. ^*Afzal Hossain Sakil (2018) ICT, youth and urban governance in developing countries: Bangladesh perspective, International Journal of Adolescence and Youth, 23:2, 219-234, DOI: 10.1080/02673843.2017.1330697*
7. ^*Ahmed SM, Majumdar MA, Karim R, Rahman S, Rahman N. Career choices among medical students in Bangladesh. Adv Med Educ Pract. 2011 Feb 14;2:51-8. doi: 10.2147/AMEP.S13451. PMID: 23745076; PMCID: PMC3661246.*
8. ^*Amin, Zubair & Merrylees, Neil & Hanif, Abdul & Talukder, Md. (2008). Medical education in Bangladesh. Medical teacher. 30. 243-7. 10.1080/01421590801947010.*
9. [a, b]*Rahman MM, Islam MR, Rahman MS, Hossain F, Alam A, Rahman MO, Jung J, Akter S. Forgone healthcare and financial burden due to out-of-pocket payments in Bangladesh: a multilevel analysis. Health Econ Rev. 2022 Jan 10;12(1):5. doi: 10.1186/s13561-021-00348-6. PMID: 35006416; PMCID: PMC8751265.*
10. ^*Al-Zaman MS. Healthcare Crisis in Bangladesh during the COVID-19 Pandemic. Am J Trop Med Hyg. 2020 Oct;103(4):1357-1359. doi: 10.4269/ajtmh.20-0826. PMID: 32828138; PMCID: PMC7543838.*
11. ^*Naher, N., Hoque, R., Hassan, M.S. et al. Influence of corruption and governance in the delivery of frontline health care services in the public sector: a scoping review of current and future prospects in low and middle-income countries of south and south–east Asia. BMC Public Health 20, 880 (2020). https://doi.org/10.1186/s12889-020-08975-0*
12. ^*Hanf M, Van-Melle A, Fraisse F, Roger A, Carme B, Nacher M. Corruption kills: estimating the global impact of corruption on children deaths. PLoS One. 2011;6(11):e26990.*