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Private Sector Assessment for Health, Nutrition and Population (HNP) in Bangladesh

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CURRENCY EQUIVALENTS

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ACRONYMS

AAA	Analytical and Advisory Assistance
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ALRI/ARI	Acute (Lower) Respiratory Infection
APP	Alternative Private Practitioner
BBS	Bangladesh Bureau of Statistics
BCC	Behavior Change Communication
BCG	Tuberculosis vaccine
BINP	Bangladesh Integrated Nutrition Project
BMA	Bangladesh Medical Association
BMDC	Bangladesh Medical and Dental Council
BMMS	Bangladesh Maternal Health Services and Mortality Survey
BNC	Bangladesh Nursing Council
BPCDOA	Bangladesh Private Clinic and Diagnostic Owners' Association
BPHC	Bangladesh Population and Health Consortium
BPMPA	Bangladesh Private Medical Practitioners' Association
BRAC	BRAC (formerly, Bangladesh Rural Advancement Committee)
CBR	Crude Birth Rate
CDR	Crude Death Rate
CIDA	Canadian International Development Agency
CIET	Community Information & Epidemiological Technologies
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
EC	European Commission
EIS	Epidemiological Information System
EOC	Essential Obstetric Care
EPI	Expanded Program on Immunization
ESP	Essential Services Package
GAVI	Global Alliance for Vaccination and Immunization
GDP	Gross Domestic Product
GOB	Government of Bangladesh
HA	Health Assistant
HDS	Health and Demographic Survey (BBS)
HEU	Health Economics Unit

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HEU	Health Economics Unit
HIU	Health Information Unit
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition, and Population
HPSP	Health and Population Sector Program
HRDU	Human Resources Development Unit
ICDDR,B	Center for Health and Population Research
IDD	Iodine Deficiency Disorder
IHE	Institute of Health Economics (Dhaka University)
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
I-PRSP	Interim Poverty Reduction Strategy Paper
MBBS	Bachelor of Medicine and Bachelor of Surgery
MCH	Maternal and Child Health
MDG	Millennium Development Goal(s)
MMR	Maternal Mortality Ratio (No. of maternal deaths/100,000 live births)
MOHFW	Ministry of Health & Family Welfare
NGO	Non Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PPP	Public-Private Partnership
PSA	Private Sector Assessment
PSB	Pharmaceutical Society of Bangladesh
QA	Quality Assurance
RTI	Reproductive Tract Infection
SD	Standard Deviation
SDS	Service Delivery Survey
Sida	Swedish International Development Cooperation Agency
SMC	Social Marketing Company
STD	Sexually Transmitted Disease(s)
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
THC	Thana/Upazila Health Complex
Tk	Taka
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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Executive Summary

Bangladesh has seen remarkable improvements 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 while the latest data suggest an IMR of 62. In a similar way under-five mortality has declined by two thirds in thirty years and now stands at 83. Life expectancy at birth is now estimated at 61 years.

Two-thirds of the deaths in children under five are due to acute respiratory infections (ARI, 27%), perinatal causes (24%) and diarrhea (16%). Neonatal mortality (i.e., deaths in the first month of life) currently accounts for about two thirds of infant deaths and almost half of under-five deaths. More than half the neonatal deaths occur in the first week, many on the first day of life. This points clearly to the vital importance of safe delivery and post-natal care to improve child survival. The data conceal significant socioeconomic disparities. For instance, in 1997, children in the poorest households suffered 83% higher mortality than children in the richest households. The maternal mortality rate (MMR) is still high by all standards, with recent estimates ranging from 320-400 deaths per 100,000 live births.

Malnutrition is an underlying cause of many childhood deaths. 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 faster among the richest quintile.

The number of women dying from causes related to pregnancy and delivery is around 17,000 each year. Thus 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.

Beyond childhood, a major cause of morbidity and mortality is tuberculosis. The number of deaths due to the disease was estimated at about 70,000 in 2000-01. HIV/AIDS is an emerging challenge, still largely limited to certain high risk groups, but with significant factors which threaten its spread to the general population. Among 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. Injuries are expected to increase their share from 9% to 11%. Communicable diseases are expected to decrease their contribution to mortality in the same time period from 51% to 30%. However, set-backs in the control of communicable diseases may occur if full vigilance is not maintained.

Thus far, the government's focus in the health sector has largely been on the establishment and operation of facilities and services in the public sector. A majority of contacts between people seeking health care and providers, however, takes place in the private sector[1]. It would seem

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[1] 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.

obvious that addressing the sector's problems requires the institution of appropriate public policies to enhance the effectiveness of the private sector's contribution to public health goals.

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.

The objectives of this Private Sector Assessment (PSA) are 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.

While the study analyzes private health care markets in general, 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 study, as the private HNP sector is too complex to be covered in full detail under one study. In particular, the study does 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.

The broader context of the Analytical and Advisory Assistance (AAA)

This PSA is just one of several studies initiated under the umbrella of the HNP Policy Options AAA work. Notable among the other closely related studies are: a Labor Market Assessment, a Study of Health Care Financing Options, a Decentralization Study, a Governance Study, a comparative analysis of efficiency among private and public providers, and a pilot design for pro-poor targeting. The AAA work is a collaborative venture, with the active involvement of the Government and various development partners, who are financing specific studies. Broad-based consultation has been an integral part of the AAA process.

It is hoped that this PSA would, along with other existing and new evidence, inform future public policy discussions in the HNP sector of Bangladesh, in the context of the Poverty Reduction Strategy, currently under development. It is also contributing to the preparation of the HNP Sector Program (HNPSP), to be implemented in the next three years. The AAA benefited from the divisional level consultations conducted for the preparation of HNPSP.

The AAA is particularly relevant to the new reform agenda being envisioned for the HNP sector by the Government, with a focus on areas such as public-private partnerships, rather than solely on the improvement of the publicly provided services.

Main Findings

The Provision of HNP Services in the Private Sector (Chapter 1)

- 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
- Lack of quality standards
- Inequitable distribution of health care
- Lack of competition between public and private providers

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 the main 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.

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 accompanied paradoxically by a significant problem of nurse unemployment because many private facilities make do with unqualified and unregistered nurses, which is a cause for concern in terms of quality.

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.

Findings indicate 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. 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.

Consumption of private HNP Services

The following bullet points capture the main demand-side issues, raised in chapter 2:

- 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

- 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 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 higher proportion of institutional deliveries in the public sector should be understood in the backdrop of the fact that overall proportion of institutional deliveries is only 8%. About 90% of medical care for children with acute respiratory infection (ARI) or diarrhea is obtained from 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.

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. 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.

Perceptions of provider's experience and familiarity with the provider are important reasons for selecting private health providers. Further studies are needed to examine what specific factors influence care-seeking behaviors in Bangladesh.

While expectedly the richest quintile spends more than the poorest quintile (by a factor of 6) on health care, the proportion of the spending that goes to the private sector is higher among the poor than among the rich. 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

Chapter 3 brings out the following findings:

- Weak regulatory framework; ineffective enforcement
- Several pilot initiatives include government-NGO partnerships, but most are donor-financed and have not 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.

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 of 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[2] level 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 reveal 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.

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[2] 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.

Key issues

Chapter 4 highlights the following conclusions:

- Public sector is not strategically using the scarce resources that are available in the private sector
- The low level of public expenditure on health care and the fact that all public spending on health goes to public providers leaves little head room for contracting with private providers
- Low level care provided by APPs 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 providers leads to inefficient use of resources
- Poor coordination between public and private sector, and lack of complementarity, which contributes to gaps in coverage

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 three broad areas would appear to deserve priority in government actions:

-Under-consumption of services by the poor and women
-Service quality and outcomes
-The knowledge base

Policy Options

The following policy options were discussed during stakeholder consultations in early May 2003, and at the policy retreat and dissemination workshop in July 2003. These consultations included government officials, private sector actors, civil society, 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.

- Develop a clear public policy towards the private sector 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 the service provider system by working with them in strengthening skills and increase the number of formally trained staff through training.

- 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 consumers, 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 financial incentives (i.e., fees for vaccinations) 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 (i.e. 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.

It is clear that the PSA has not covered the whole ground on the subject and further studies and analytical work are needed. **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.

The Way Forward

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), and has outlined a new reform agenda for the future, this study and the other related studies under the AAA work could meaningfully inform policy dialogue, taking a fresh perspective on sector reforms needed to achieve HNP outcomes as part of the MDGs.

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.
- Create the necessary fiscal space or "head room" in the public resource envelope.
- Capacity development in the MOHFW to enhance its engagement with the private health sector.
- Participatory policy-making and more inclusive planning and programming.
- Pilot activities to test the selected policy options.

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

Completion of other related studies (demand-side financing, governance, pro-poor targeting, comparative study of efficiency)	May 2004
Dissemination of existing evidence, multi-pronged communication exercise, consultations across the country	July to December 2003
Development of broad-based HNP Policy Options	July 2003 to June 2004
Initiation of Pilot Interventions (e.g., vouchers, micro-insurance, results-based contracting with private sector, demand-side subsidies, pro-poor targeting)	January 2004

Chapter 1. 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. There is little experience in Bangladesh with strategies to influence where or how private providers practice medicine. Not surprisingly, the largest 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.

1.1 Introduction

This chapter deals with the issues related to the supply side of private health services, specifically examining the health labor market[3] and private health infrastructure. We begin by examining the different types of private sector providers of health services. 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.

This chapter does not fully deal with the supply of health goods, notably the commodities such as contraceptives, bed-nets, oral re-hydration fluids, and infant formula and feeding supplements. Also, we do not examine other private key input markets such as those for manufacturers and distributors of pharmaceuticals, medical equipment, and construction of buildings.

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[3] Greater details on the labor market of HNP sector in Bangladesh can be found in the related study on the health labor market, which was financed by CIDA. This chapter's treatment of the labor market discusses key aspects about the supply of services.

1.2 The Actors

In this report, we categorize the health providers as qualified allopathic providers who 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" medicine), and providers without formal training and recognized qualifications in allopathic medicine, whom we have labeled as alternative private practitioners (APP); *dais or* traditional birth attendants (TBA) form a specialized type of APP, but we have treated them as a separate group of providers in view of the large numbers and the very limited scope of services they provide.

The main sub-categories of APPs include:

- Non-qualified allopathic providers, who have not received formal education to practice allopathic medicine.
- Pharmacists who supply allopathic or other medicines, but who do not have formal qualifications to diagnose illness or prescribe medicines.
- *Kabiraj,* who practice an ayurvedic system of 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. They may use allopathic medicines as well.
- Spiritual healers, who often rely on chants or sacred readings in their treatment.
- Homeopaths, who follow the homeopathic system of medicine, which involves treatment through minute quantities of the presumed cause of disease. In some cases, these providers have been formally trained and recognized in homeopathy.

The distinction between the public and private sector providers is not always clear. A considerable proportion of qualified allopathic doctors and other formal sector providers work entirely in the private sector (see below), but many of the public sector doctors also practice privately -- either by working at private clinics and hospitals after public hours, 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.

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 1.1). 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 1.1 – Visibility of Private Health Providers According to Selected Characteristics

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

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 shown in Table 1.2, it has been estimated that 50% of doctors, 42% of nurses, 65% of paramedics, and 100% of APPs and *dais* are in the private sector. The APPs outnumber qualified doctors by 12 to 1.

Table 1.2 – Estimated Numbers of Health Providers in Bangladesh

Type of Provider	Midrange Estimate of Number in 2001	Midrange Providers per 100,000 Population	Percent Private Sector	Low Estimate Providers per 100,000 Population	High Estimate Providers per 100,000 Population
Formal Allopathic Sector					
Doctors[4]	23,000	19	50%	11 (HRDU, 1997)	23 (HRDU, 2003)
Nurses[6]	13,000	11	42%	11 (CSIP, 1995)	15 (PRU, 2002)
Paramedicals	81,000	66	65%	--	--
Informal Sector					
Alternative private practitioners	284,000	231	100%	77 (Ali, 2001)	473 (Sarder & Chen, 1981)
Allopathic providers	110,000	90	100%	38 (Claquin, 1981)	145 (ORQ-Marg Quest, 2000)
Traditional providers	173,000	141	100%	50 (Claquin, 1981)	239 (Ali, 2001)
Dais (Traditional Birth Attendants)	119,000	96	100%	14 (Claquin, 1981)	549 (Sarder & Chen, 1981)

Sources: Midrange estimates derived from weighting provider/population ratios from Peters *et al*, 2003; Ali *et al*, 2001; ORQ-Marg Quest Ltd, 2000ab; BBS, 1998; Sarder and Chen, 1981; Claquin, 1981

[4] 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.

International comparisons on health personnel are fraught with difficulties, because of the differences in definitions, and the poor quality of data. Compared with other countries, there are fewer qualified physicians and nurses per capita in Bangladesh (Table 1.3). Another striking finding is that the physician to nurse ratio is very high in Bangladesh. The implications are that Bangladesh needs to consider ways of dealing with the shortage of physicians, but even more urgently the shortage of practicing nurses.

Table 1.3 – International Comparisons of Physician and Nurse to Population Ratios (Around 1998)

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

Source: WHO, 2003c and author's calculations

1.3 Physicians

There is no precise count of the physicians 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. But according to BMDC, until 2002 Bangladesh had 28,537 doctors (HRDU, 2003). However, a survey of their membership registered through the year 2000, returned only 9,988 responses (BMDC, 2003). In 1998 an HEU report made reference to a study, 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 report also cited a Bureau of Statistics Survey of Professional and Miscellaneous Services Personnel, which said that there should have been 22,356 doctors in 1993-1994 based upon the same 1993 census.

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).

"Brain drain" is a serious problem for Bangladesh, with many physicians leaving the country to work elsewhere (See Box 1.1).

Box 1.1 – The Brain Drain in the Health Sector in Bangladesh

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 cannot be easily measured. However, the costs of medical education can be reasonably determined. There are currently 13 medical colleges in the public sector (of which five are new) 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 five established public medical colleges, it is estimated that Tk 250,000 (US$4,000) 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 five-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 per graduate estimated to be between Tk 800,000 and 1,000,000 (US$16,000-20,000) (HRDU, 2003).

1.3.1 Income/Incentives/Disincentives for Physicians

Estimates of income of physicians vary by type of practice and level of experience. In a survey of private health service establishments, 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).

Disincentives for private practice in the rural areas include lower purchasing power of patients, competition with alternative private providers, and a weak infrastructure. Another concern is harassment from local mafia-like structures (Gruen *et al*, 2002). Another difficulty with attracting doctors for rural areas is that most physicians come from urban backgrounds. They are reluctant to give up that life and do not want their children to be deprived of the opportunities available in cities (Chaudhury and Hammer, 2002). In this study of absenteeism, determinants of government physicians' likelihood of attending their rural postings included living in the same locality as that of the clinic, access to roads, and electrification.

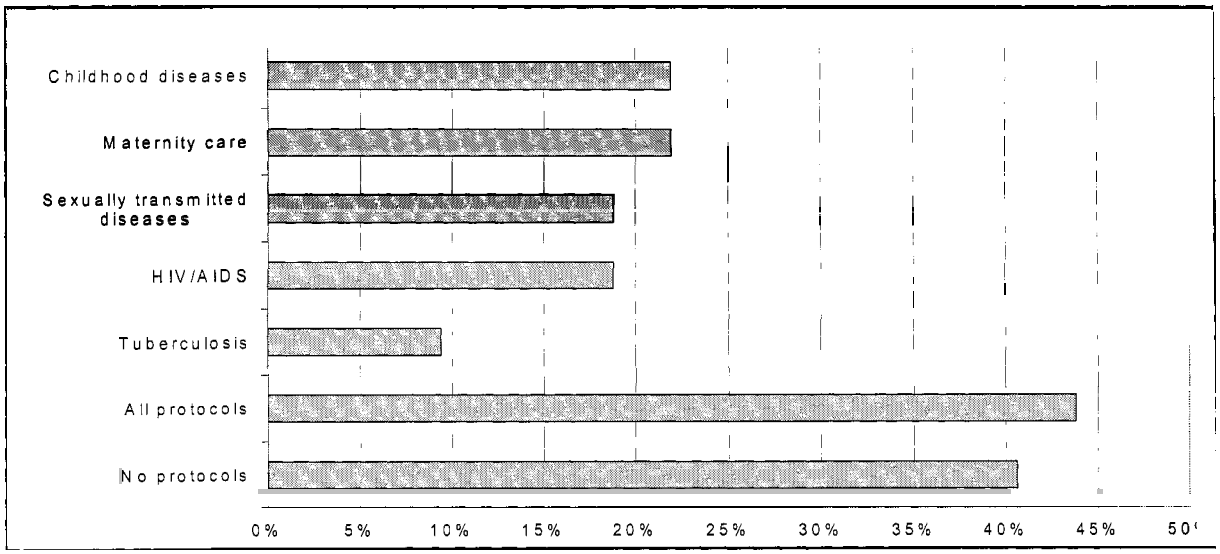
In an extensive survey done for the MOHFW on incentive schemes for public sector doctors and other health workers, the most frequently mentioned source of dissatisfaction was "lack of promotion", followed by "low salaries". Figure 1.3 shows reasons for discontent among medical practitioners: non-recognition of good work was also a cause of discontent, along with

inadequate residential and clinical facilities, lack of access to quality health care for the physicians and their families, and physical and social insecurity (SRGB, 2002).

1.3.2 Quality of Care Provided by Physicians

There is little assessment or reporting on the quality of physician care in Bangladesh, in the public as well as the private sector. A background study on private practitioners found that about 90% of private hospitals maintained patient records, and nearly 60% used standard treatment protocols (HEU/IHE/NIPORT, 2003) (Figure 1.1). Nearly all facilities claimed to use safe disposable syringes. Ninety-eight percent 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 2, quality of care is examined from the patient's perspective.

Figure 1.1 – Percentage of Private Hospitals using Medical Protocols to Treat Patients

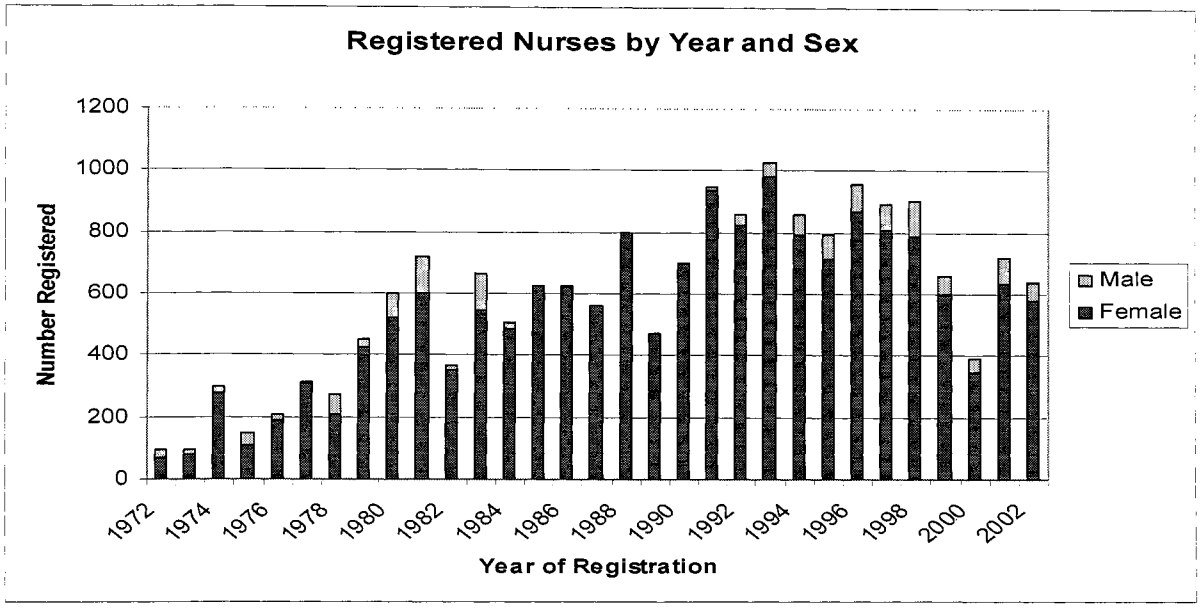


Source: HEU/IHE/NIPORT, 2003 [Study commissioned specifically for this PSA] and authors' calculations

1.4 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 and the number actually employed is even lower. 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 1.2. But based on a national census of professional services personnel, there were just over 12,000 nurses working in 1993-94, a ratio of about 11 nurses per 100,000 population (CSIP 1995). Ninety-five percent of the nurses work in hospitals and clinics in urban settings.

Figure 1.2 – Registration of Nurses by Year and Sex



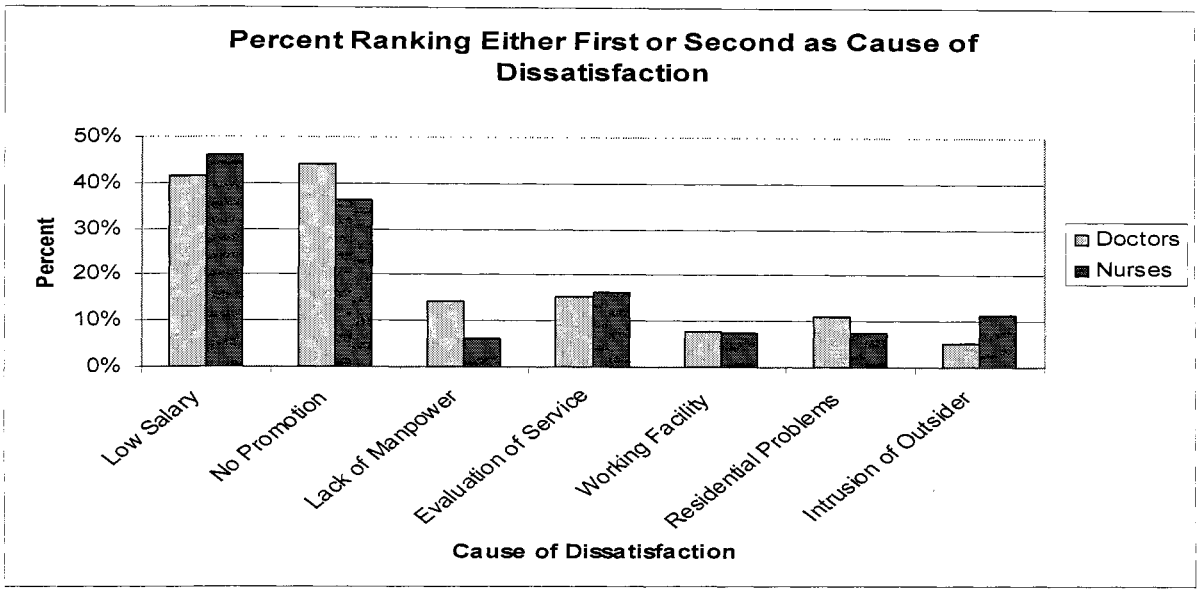
Source: Bangladesh Nursing Council, 2003

Data on immigration of nurses from Bangladesh into other countries are 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 will emigrate if employment opportunities remain poor in Bangladesh. However, nursing training facilities are in poor condition, and the vast majority of students and teachers are not proficient in English, which is 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 for 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 1.3).

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 1.3 – Causes of Dissatisfaction Among Doctors and Nurses in the Public Sector



Source: SGRB, 2002

1.5 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 1.4, 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.

There is very little information on paramedics. 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 the relative ease of selecting paramedical trainees 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 1.4 – Estimates of Health Workers in Bangladesh Other than Physicians and Nurses

Provider	Public Sector 2002	Private Sector 1996-97
Medical Assistant	5,598	45,603[5]
Pharmacists	7,622	1,789
Licensed pharmacists (without university or technology degree)	0	15,477
Laboratory Technicians	1,840	29,085
Radiographers	1,054	?
Health Inspectors	1,401	0
Family Planning Inspectors	4,110	0
Dentists (& Dental Surgeons)	1,740	1,247
Other trained paramedical[6]	3,574	?
Total	28,941	1,247

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, their 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 sustain them (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.

1.6 Alternative Private Practitioners

It has long been recognized that APPs provide the majority of health care in Bangladesh, particularly in rural areas (Claquin, 1981; Sarder and Chen, 1981). These providers are very well embedded into the culture and society of villages (Bhuiya, 1992; Feldman, 1983; Ashraf *et al*, 1982; Leslie, 1976). APPs are also becoming more organized, forming their own professional

[5] Probably includes many health providers who do not have a three-year Medical Assistant training

[6] Other trained paramedicals includes Physiotherapists, Family Planning Officers and related professionals

associations in local areas. 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.

1.6.1 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). However, the vast majority of APPs practicing in Bangladesh have not received formal education in their system of medicine, though a substantial proportion have received some semi-formal training. For example, in a study in Brahmanpura in 2000, 61% of APPs had some kind of certificate of health training (ORG-Marg Quest Ltd, 2000b). Most traditional providers have had training through apprenticeship (Feldman, 1983; Sarder and Chen, 1981). The general education levels among the APPs tend to be higher in the allopathic providers than in 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 has important consequences for women's access to health care, is described in Box 1.2.

Box 1.2 – Gender Distribution of Private Providers

With the exception of the traditional midwives, who are female, the APPs are largely male, 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 between male and female (Sarder and Chen, 1981). In the Brahmanpara study mentioned above, 98% of village doctors were male (ORG-Marg Quest Ltd, 2000b). 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 APPs. This issue is discussed further in Chapter 2 where the demand for and use of health services are considered.

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 tend 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).

1.6.2 Incentive and Disincentives of APPs

There are a few reports on the incomes and fees charged by APPs, 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 $0.25 at the time of the survey. However, payments from medicines could average 10 times this amount, with unqualified allopaths charging more than ayurvedics, followed by homeopaths and spiritual healers. In Brahmanpara, village doctors claimed to earn about Tk. 1,600 (US$ 32) per month from prescribing medicines to their patients, and another Tk. 2,200 (US$ 44) per month through other pharmacy sales (ORG-Marg Quest Ltd, 2000b).

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 (ORG-Marg Quest Ltd, 2000b). Although there have been a number of projects that attempted to train APPs, these are not well documented, and little is known about what strategies would be effective in improving their skills, preventing them from practicing illegally, or reducing the potential harm caused by poor quality services.

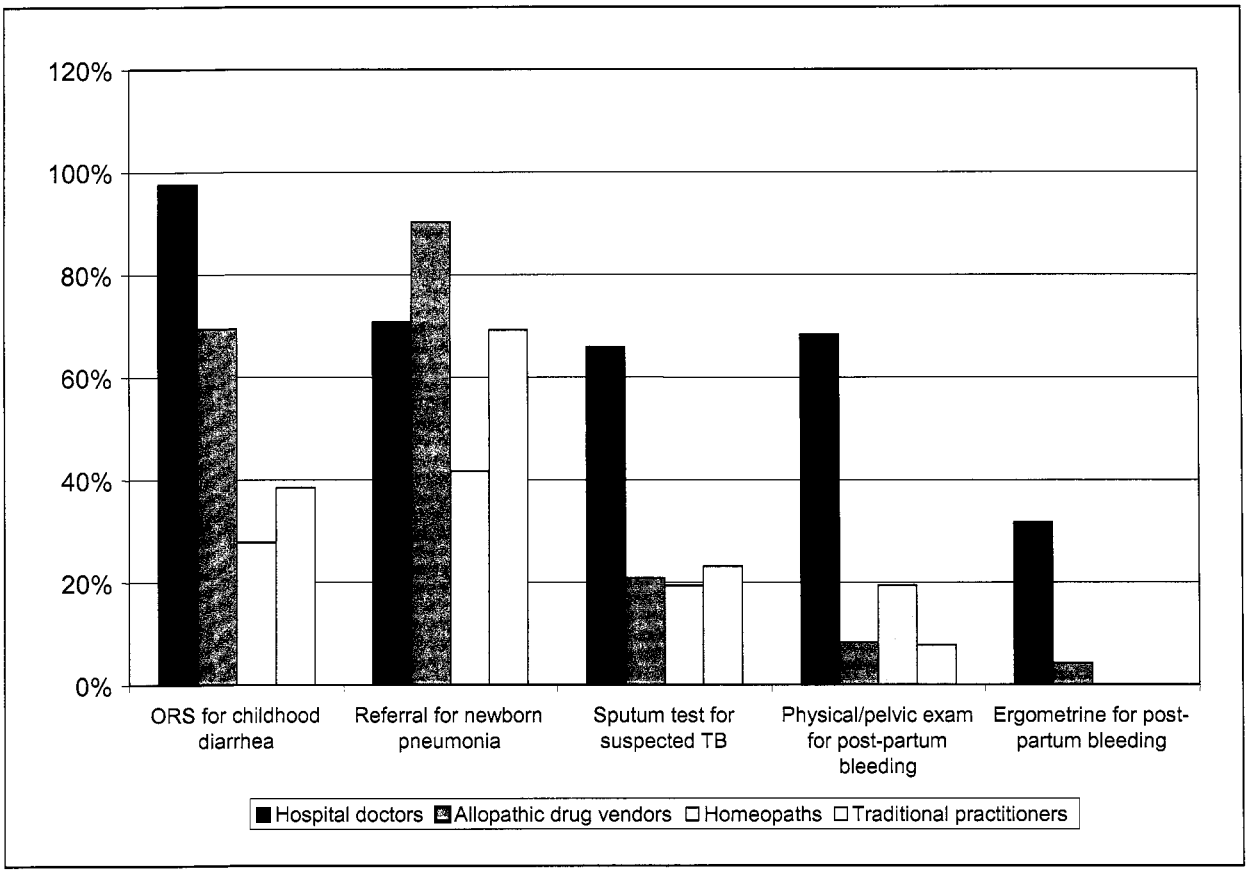
1.6.3 Quality of Services Provided by Alternative Private Practitioners

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 providers 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 providers were more likely to provide appropriate care for diarrhea than the traditional ones. In a similar vein, Ali and colleagues (2001) found that access to allopathic providers (both qualified and unqualified) was related to lower childhood deaths due to pneumonia, whereas access to traditional providers was related to higher mortality.

In a background survey for this study, different types of private health providers were asked about how they would handle specific medical conditions (Figure 1.4) (HEU/IHE/NIPORT, 2003). With one exception (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 correct medical care would include an affirmative answer to each of the responses shown at the bottom of the figure. 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 better than the homeopaths and traditional providers in cases of 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 1.4 – Percent of Different Types of Providers Offering Appropriate Medical Care for Specific Medical Conditions



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

1.7 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 1.5). 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 total number of private facilities: only 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.

Table 1.5 – Estimated Number of Government and Private Health Facilities in 1997-98

	Government	Private		
		Registered	Unregistered[7]	Total
Hospitals	645	126	32	158
Hospital beds	29,106	--	--	6,213
Nursing Homes[8]	0	314	140	455
Nursing Home beds	0	--	--	5,158
Total Inpatient facilities	645	440	172	613
Laboratories	NA	582	460	1,042

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 noted above, APPs 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.

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 estimated that average return to capital was 38%, suggesting that private hospitals were making profits much larger than would be available in other sectors. 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.

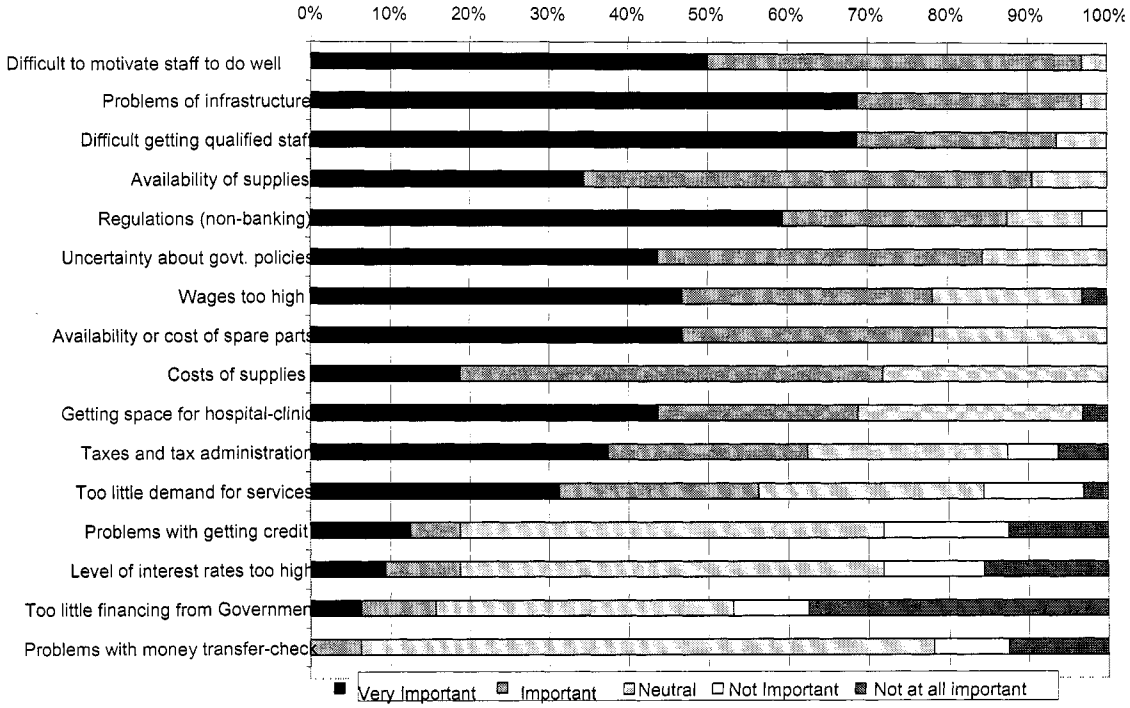
A background study of private hospital and clinic managers reported on some of their main constraints (HEU/IHE/NIPORT, 2003). As shown in Figure 1.5, their main concerns are with motivating and recruiting qualified staff, problems with infrastructure, ability to purchase supplies, and uncertainty over 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 of 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, allows the existing private hospitals to make substantial

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

[8] Nursing homes have inpatient services but no outpatient services

profits in spite of the relatively high number of beds unoccupied. Caution is needed in interpreting these findings, as the survey was conducted on existing facilities. If it were possible to study cases in which private hospitals were sought to be established by investors but failed to materialize, or had started but failed thereafter, the list of barriers to entry might be different.

Figure 1.5 – Private Hospital Managers' Opinions on the Business Environment



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

Turning to 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 margin. Given that the average laboratory on the average employs somewhat less than two laboratory technicians, there would be about 16,000 laboratories in Bangladesh, compared to the 1,042 identified in the 1998 survey (BBS, 1998).

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. It is possible that equipment costs and technical ability to operate the machines are creating the conditions where laboratories can charge high prices relative to their costs.

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 validity of most laboratory test results is unknown.

1.8 Other Private HNP Input Markets

Whereas a detailed assessment of the other input markets 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 licensed drug manufacturing units in 1997, 1,353 drug wholesale trading 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. About 40% of non-clinical family planning methods were distributed through private pharmacies in 1989 (BBS, 2002a). Spurious drugs are a serious problem.

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 (SMC, 2003). 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. In addition to providing ORS, SMC also provides training to APPs on diarrhea management. SMC is considering to market zinc as a supplementary dose to persons with diarrhea, and believes that there is social marketing potential for safe delivery kits (SMC, 2003).

Currently SMC is subsidized by the government, which provides the commodities free of charge for distribution, and SMC charges the consumer a nominal price. SMC is 40% self-financed.

Bed-nets, another important health commodity, are imported and sold in the private sector. However, the market for bed-nets is currently not very large. Soap is currently too expensive for the poor population, who mainly uses ash for hand washing (SMC, 2003).

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

1.9 Conclusions

There are clearly large information gaps concerning the supply of private health services in Bangladesh. However, enough is already known to conclude that the biggest portion of health providers is also the most neglected by public policy-makers.

For policy-makers, there are a number of key recurring themes that run through this analysis of the private health 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.

A number of strategies could be pursued to try to retain health professionals in the country. One relatively simple measure to reduce losses to emigration is to demand reimbursement or a bond covering the costs of medical expenses from physicians who obtain visas to work overseas.

Developing more nurses and paramedicals that could take on more of the primary care diagnostic and therapeutic responsibilities that physicians now assume is likely to be a more cost-effective strategy than focusing on training more physicians. This could be coupled with admission strategies that target rural communities. Engaging with the existing APPs also has potential to reduce the needs for new formally trained health personnel.

Finally, the question of private practice among public practitioners is a persistent and pervasive issue that affects the credibility of government health services. Partial approaches to this issue, such as formalizing private fees in government hospitals are likely to exacerbate the problem. 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 2. Demand for / 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 even more true for the poor in Bangladesh; the poorest quintile of Bangladeshi children have a higher dependence on the private sector for acute respiratory infection and diarrhea care than the richest quintile.

Poverty is a significant constraint to health care access and hence, use. The largest differences between the rich and the poor are for medically trained deliveries, antenatal care, treatment for acute respiratory infection, and immunization. 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 absolute 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.

The cost of health care often results in foregone medical treatment. 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 generally 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 on 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.

2.1 Introduction

This chapter addresses the issues related to the demand for health services. 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.

2.2 Health Service Consumption

Although data on overall outpatient clinic visits or hospital utilization are not available in Bangladesh, it is possible to use Demographic and Health Survey (DHS) data to compare selected services with other countries (Table 2.1). These 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 in 1996/97, 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 2.1 International Comparisons of Health Service Consumption

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

Source: World Bank, 2003; based on Demographic and Health Surveys in 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 2.1). The most recent DHS data show that the proportion of children of age 12-23 months fully vaccinated against tuberculosis, diphteria, pertussis, tetanus, 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 desirable levels; consumption would have to increase by 122% to reach the desired per capita consumption level. Two critical questions remain: (1) how can demand for the essential service package 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 should the much larger private sector be used?

2.3 Public/Private Shares of Services

Bangladeshis are much more likely to use private providers than public providers for most of their ambulatory 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). Private 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 1), 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.

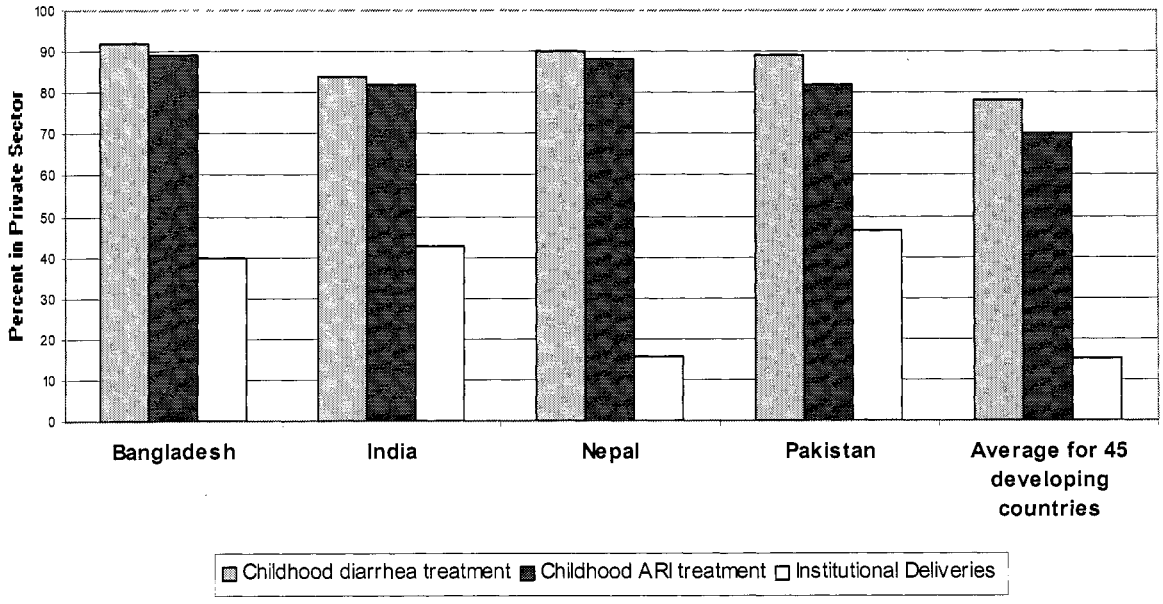
International comparisons of the distribution of the use of public and private health services are difficult to come by, but data from comparable DHS surveys provide some insights. These surveys show that Bangladesh stands out for its high level of dependence on the private sector for treatment of childhood diarrhea, ARI, and institutional deliveries (Figure 2.1). 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).

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 the1999-2000 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).

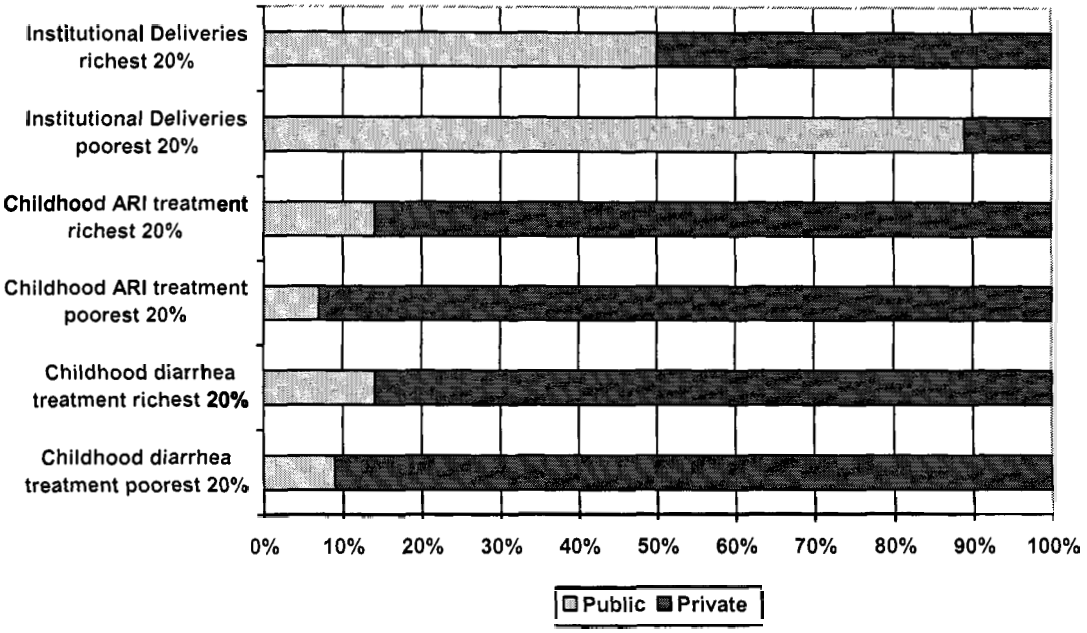
The use of private providers is not restricted to the rich, as the poor also have a high dependence on private providers for childhood curative care (Figure 2.2). However, as noted above, there may be differences in the type of private provider used, with the poor more likely to rely on unqualified practitioners, and the better off able to afford qualified physicians.

Figure 2.1 – International Comparison of the Share of Medical Care Used in the Private Sector For Selected Services



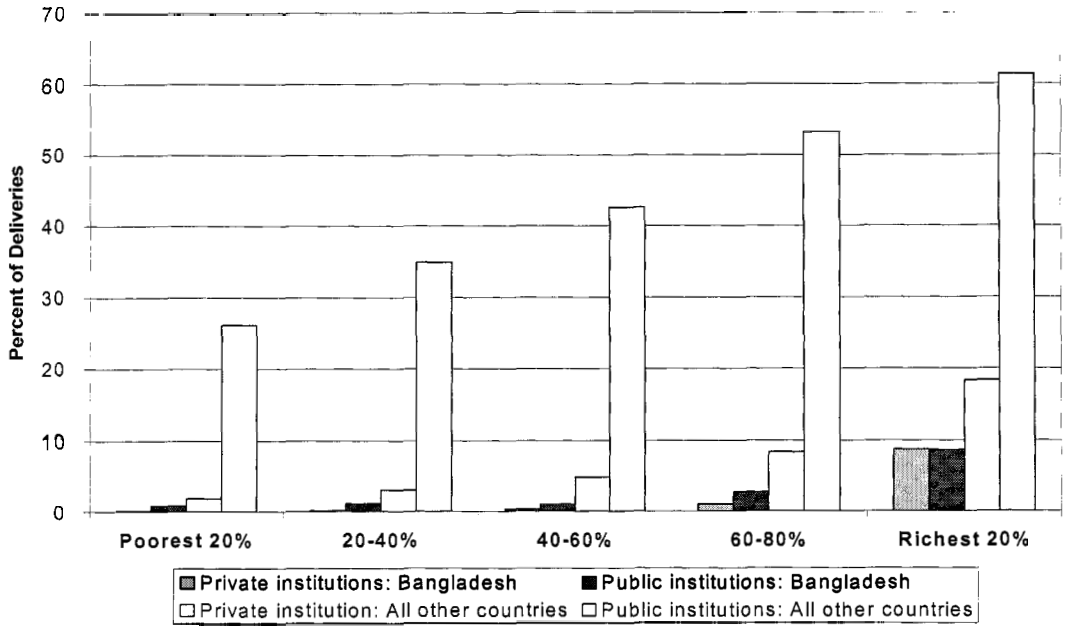
Source: World Bank, 2003; based on DHS in the 1990s (1996/97 for Bangladesh)

Figure 2.2 – Proportion of Richest and Poorest Quintiles Using Public and Private Health Services



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

Figure 2.3 – Institutional Deliveries in Private and Public Facilities in Bangladesh and 44 Other Developing Countries According to Level of Wealth



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

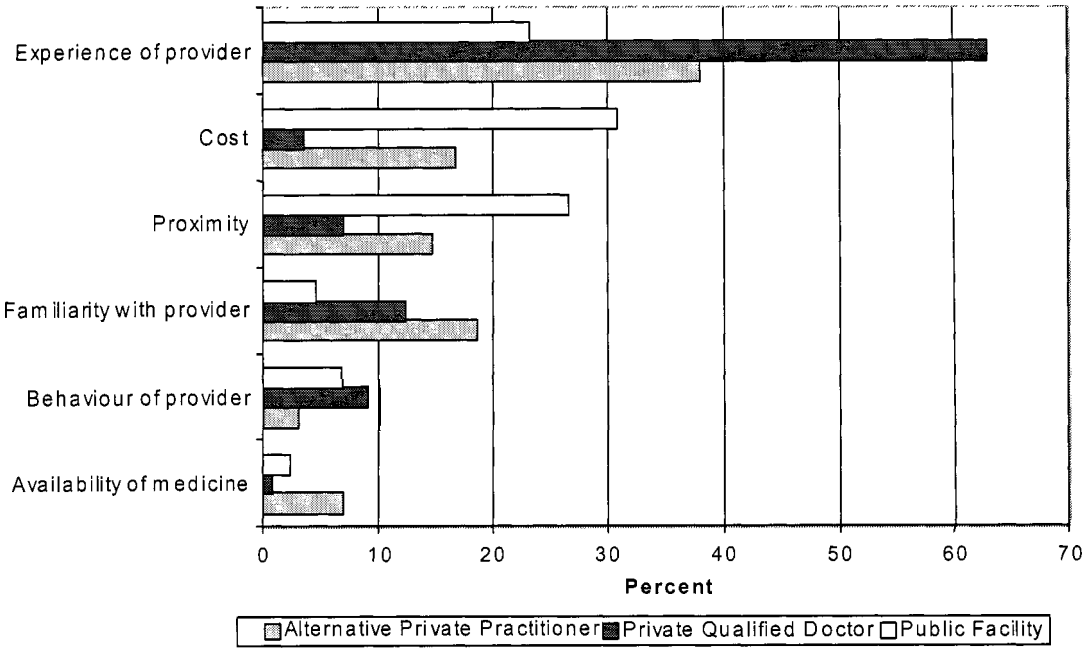
Figure 2.3 shows that there are enormous differences in the use of private institutional deliveries between the richest quintile (8.7% of deliveries) and poorest quintile (0.1% of deliveries) in Bangladesh; a rich/poor ratio of 87. Of all countries with comparable data, Bangladesh has the greatest inequality in 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.

2.4 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.

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 2.4. 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. The provider's behavior, and the availability of medicines were less frequent reasons for selecting a particular provider.

Figure 2.4 – Main Reason for Choosing a Specific Provider for Treatment of the Most Recent Child Illness



Source: HEU/IHE/NIPORT, 2003

2.4.1 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 minute 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 an advantage over other providers in the public and private sectors.

2.4.2 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 a high proportion of health care is financed privately, and without any type of financial risk protection from health insurance. In Bangladesh, 60% of total health expenditure in 2000 was in the form of out-of-pocket payments by individuals (64% of total health expenditure was from private sources), so that households' 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.

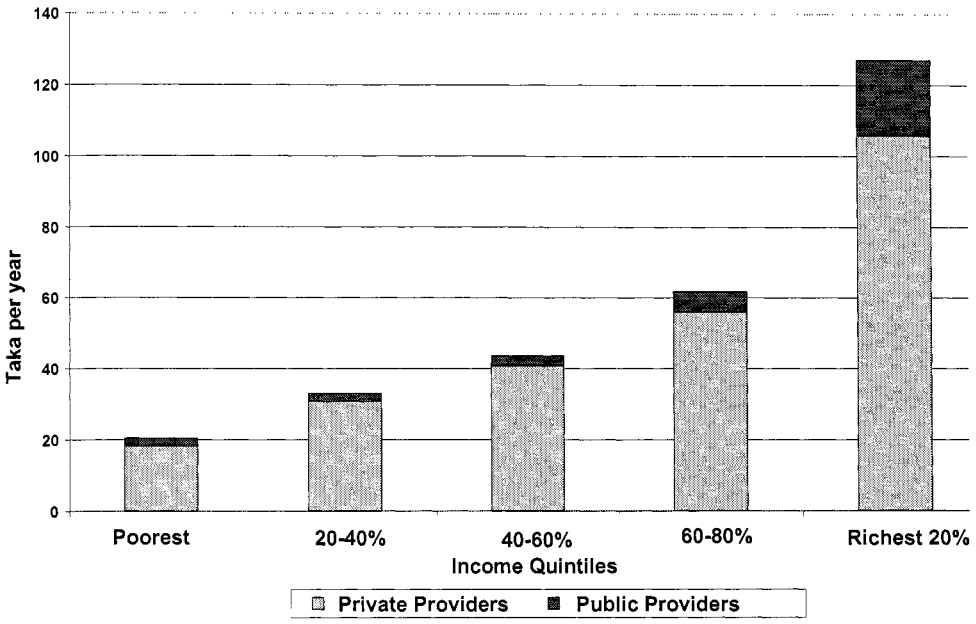
Different types of cost items can be barriers to the use of health care. Health care costs can be divided among direct medical costs (e.g. medicines and service fees), direct non-medical costs (e.g. transportation costs) and indirect costs (e.g. traveling and waiting time, lost earnings). In the SDS, 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). 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.

A background study analyzing the Bangladesh Household Income Expenditure Survey (Peters *et al*, 2003), not surprisingly, found that 88% of private health expenditures are for services from

private providers, and that the rich pay far more for medical care than the poor (the richest/poorest quintile ratio was 6.2) (Figure 2.5). As a proportion of total income, health spending by households was found to comprise 6.8% of their total income overall, with the richer groups spending a slightly higher proportion than poorer groups.

It is 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.

Figure 2.5 – Household Per Capita Payments to Private and Public Health Providers in Bangladesh by Income Quintile



Source: BBS, 2001 and authors' calculations

Total household payments to health providers is estimated according to the results of the HIES (2000) in 1.5 billion dollars which includes fees, hospitalization expenses, medicines, laboratory and tests, transportation costs, tips and others charges.

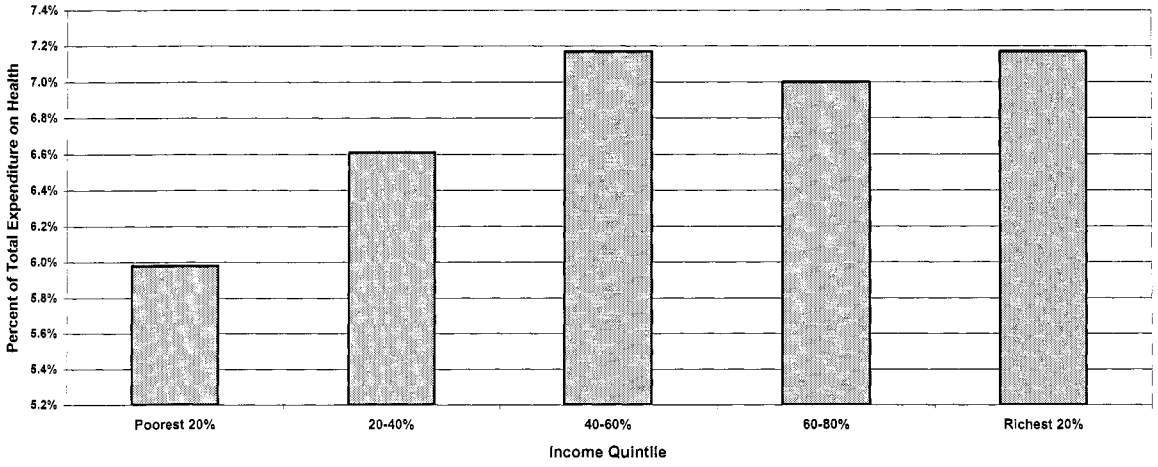
Gwatkin *et al* (2000) disaggregated the Bangladesh 1996-97 DHS data by wealth quintiles based on assets of the household, and then reported the use of health services (Table 2.2). The largest differences between rich and poor were found for medically trained deliveries, antenatal care, treatment for 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. This may be due to the fact that 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.

Table 2.2 – Wealth Differences in Health Service Consumption

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

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

Figure 2.6 – Proportion of Household Expenditure Spent on Health by Income Quintiles



Source: BBS, 2001 and authors' calculations

Figure 2.7. Household payments to health providers.

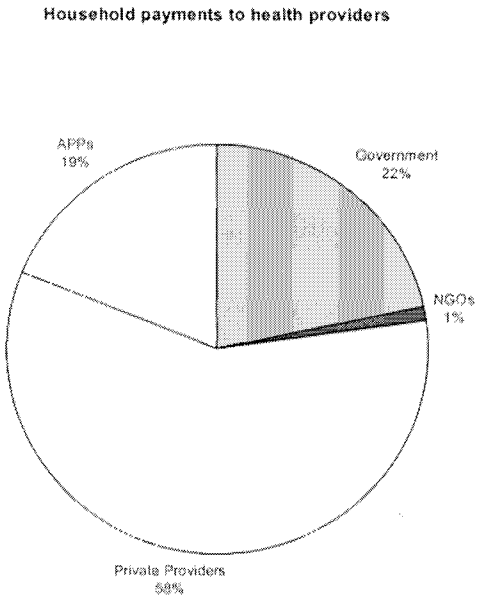


Figure 2.8 Health services by private and public providers.

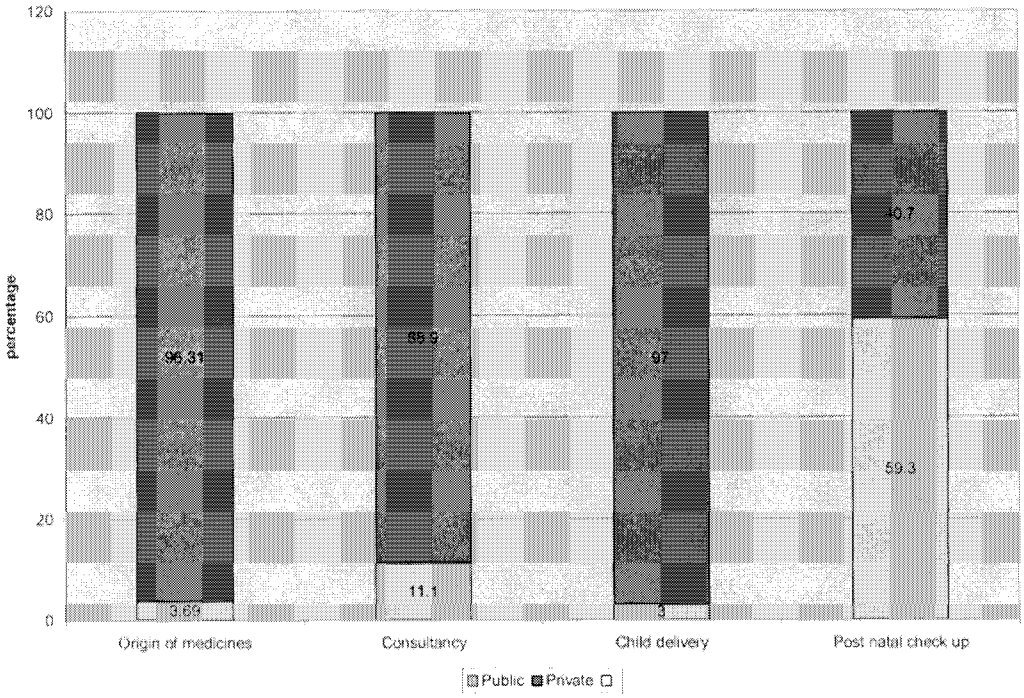


Figure 2.9. Health consumption of the poorest the quintile of income.

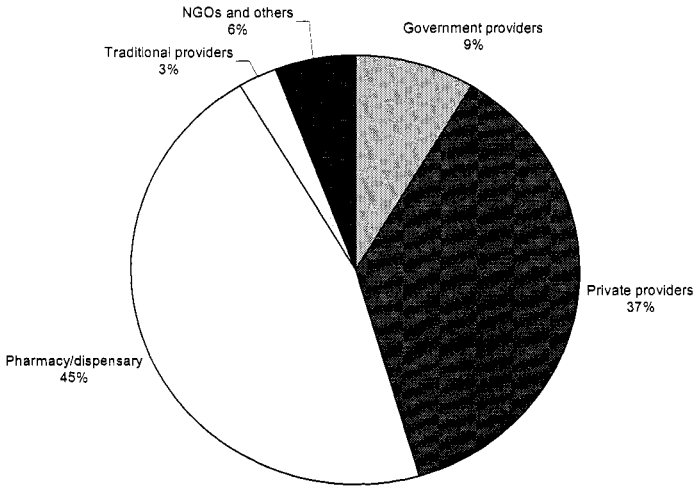


Figure 2.10. Health Consumption of the richest quintile of income.

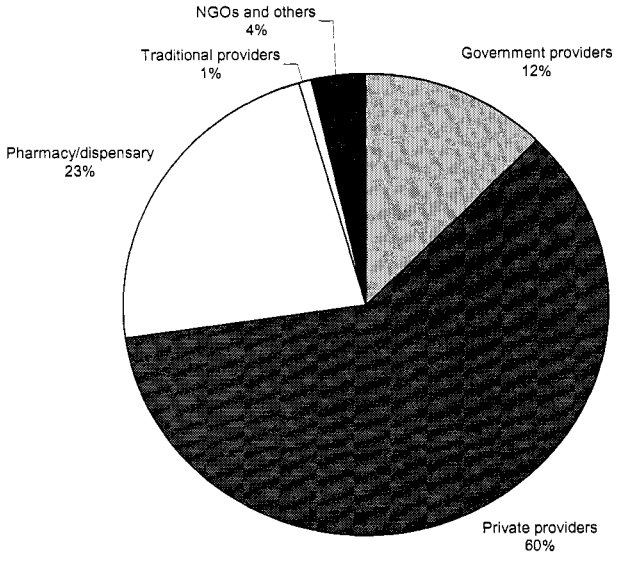


Table 2.3 Total household payments to health providers in Bangladesh by income quintiles

Quintiles	Fees	Hospitalization	Medicines	Lab. And test	Transport	Tips	Other charges	TOTAL Monthly total household payments (millions tks and percentage).
Poorest quintile	5.9%	2.5%	9.4%	3.6%	5.2%	4.0%	4.7%	562 (7.5%)
Second	10.4%	2.1%	16.0%	5.5%	9.7%	22.2%	8.1%	958 (12.8)
Third	13.2%	7.8%	19.3%	14.1%	18.3%	5.3%	14.2%	1,274 (17%)
Fourth	23.3%	9.8%	22.2%	16.3%	24.1%	26.8%	17.3%	1,550 (20.7%)
Richest quintile	47.2%	77.7%	33.1%	60.5%	42.7%	41.7%	55.6%	3,126 (41.9%)
Total Monthly total household payments (millions tks and percentage).	680 (100%)	524 (100%)	4,712 (100%)	681 (100%)	419 (100%)	50 (100%)	405 (100%)	7,476 (100%)

HIE 2000. Author's computations

2.4.3 Social and Cultural Context – Gender

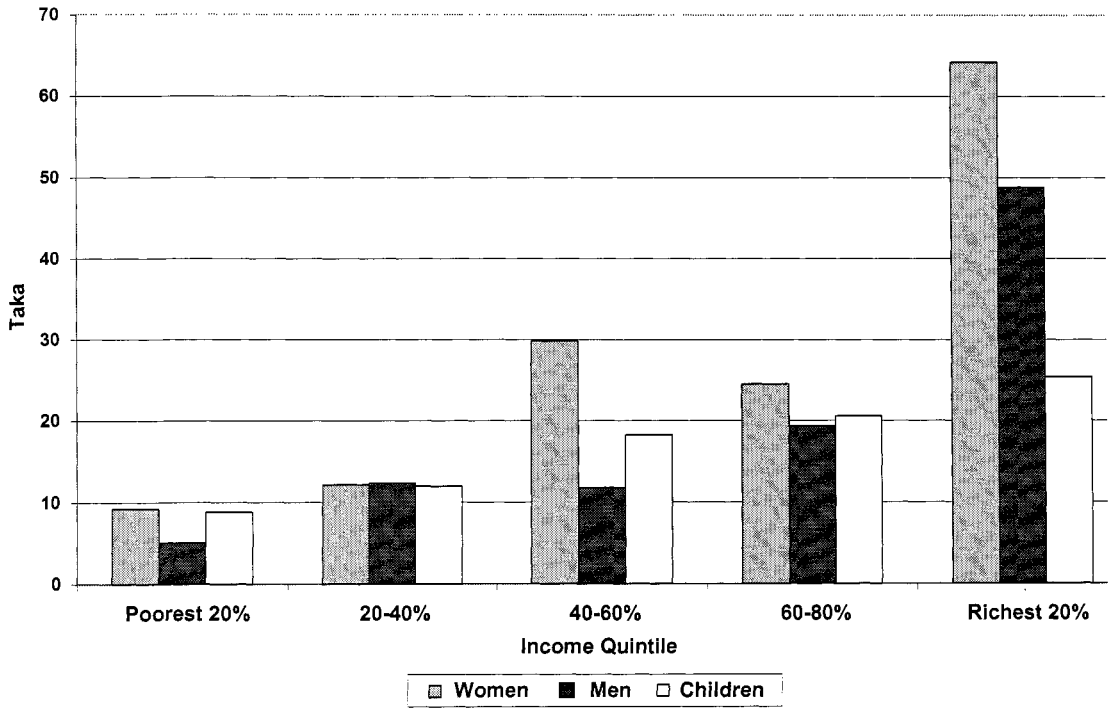
The social and cultural context has an important impact on the patterns of health service use in Bangladesh. Social and cultural factors particularly affect the role of gender and the distribution of household decision-making. The mobility of women in Bangladesh is improving, but is still limited (Levin *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 1) 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 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 tuberculosis, polio, and measles, and to be taken to a health facility if sick with acute respiratory infection or diarrhea (NIPORT *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 in most cases for boys (80%), whereas non-

qualified allopathic providers and homeopaths provided most of the health services for female children (Bhardwaj and Paul, 1986).

The information on 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 *et al*, 2002). However, analysis of the Bangladesh HIES (Peters *et al*, 2003) shows that in nearly all income quintiles, spending on women is greater than on men or children (Figure 2.11).

Figure 2.11 – Average Annual Amount (in Taka) of Private Out Of Pocket Spending on the Health of Women, Men, and Children According to Income Quintile, Bangladesh, 2000



Source: BBS, 2001 and authors' calculations

2.4.4 Patient Perceptions of Providers

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 2.4 summarizes the main reasons for dissatisfaction with public or private health and family planning services (CIET Canada and MOHFW, 2001). Poor staff attitudes and problems with the lack of medicines or their quality were the biggest problems with the public sector. while costly medicines, and lack of doctors/nurses were cited in the private sector.

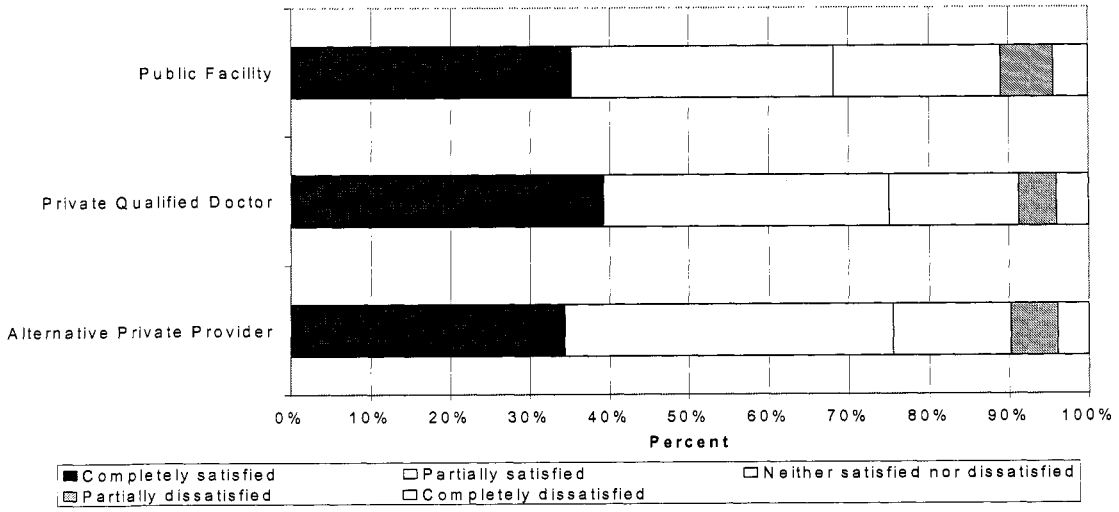
Table 2.4 – Commonly Identified Problems in Public and Private Services

Problem	Proportion of Respondents Reporting as a Problem in:		Public/Private Ratio
	Public	Private	
Lack of, and poor quality of, medicines	58%	18%	3.2
Bad service	40%	33%	1.2
Bad staff attitude	25%	6%	4.2
Difficult to reach	19%	8%	2.4
Have to pay for medicines, expensive medicines	17%	41%	0.4
Lack of doctors, nurses, specialists	14%	32%	0.4
Lack of different services	14%	24%	0.6
Dirty and poor equipment and facility	13%	8%	1.6
Doctors not available	13%	No data	--
Extra payments to doctors and other workers	12%	11%	1.1
Too few beds, lack of facilities	7%	7%	1.0

Source: CIET Canada and MOHFW, 2001

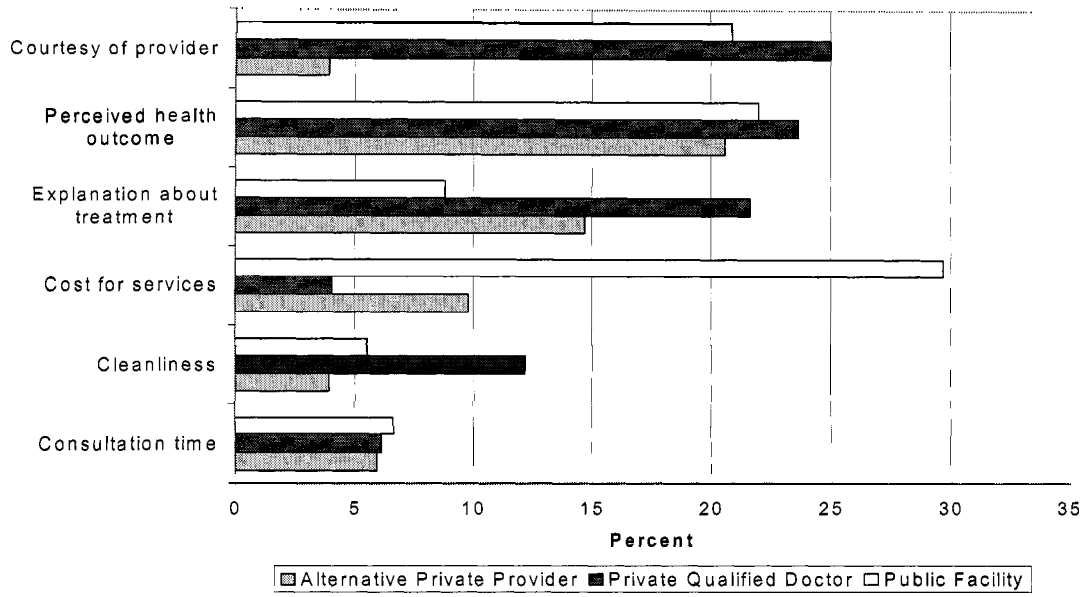
In the background study on household use of health services, satisfaction with child health services was also assessed for 342 children who were treated for an illness outside the home (HEU/IHE/NIPORT, 2003). As shown in Figure 2.12, there was little difference in overall levels of satisfaction between users of different types of providers.

Figure 2.12 Levels of Satisfaction with Child Health Services, by Type of Provider



Source: HEU/IHE/NIPORT, 2003

Figure 2.13 Satisfaction with Child Health Services: Most Important Factor 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).

2.5 Conclusions

This chapter confirmed that Bangladeshis overwhelmingly use the private sector for their health care, though much of this care is obtained from unqualified providers and other APPs. In the case of maternal health services, there are remarkably low levels of access, particularly for delivery and antenatal care.

The data also show that there are considerable gaps in information concerning the demand for health care that policy makers need to be aware for the design and implementation of policy options. There is little experience in how to influence demand for higher quality of health services. Family planning and use of oral rehydration therapy, 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 foregone 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 a challenge in 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 implement actions that take advantage of the existing private sector to address basic public health goals of improving quality, access, and affordability of health services. The identification of activities where the private sector has comparative advantage for the delivery of health services is crucial to scale-up the process of purchasing private services with public funds.

Chapter 3. 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 presence serving the poor. 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, where the public sector has partnered with private, mostly non-profit, health service providers -- e.g. in nutrition, TB/leprosy, family planning, urban primary health care and immunizations. In addition, the involvement of 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 provider 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 maternal and child health 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, there is a need 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.

3.1 Introduction

The previous chapters described the size and characteristics of the private heath 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.

3.2 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.

3.2.1 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. 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 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 under the Director General of Health Services, 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.

3.2.2 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 3.1). 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 government does involve representatives from these organizations in some policy initiatives, for instance consultation on proposed legislation. However, it generally does not involve professional or provider organizations in implementation of policies. The degree of governmental support and oversight for self-regulation by professional or provider bodies is likewise low.

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, 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).

Box 3.1 – 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 functions more or less as a trade organization.

Source: Hye, 2003

3.2.3 Planning

In mixed-delivery health systems, government 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 service 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 3.1). However, information about private capacity appears not to be taken into account in government facility and investment plans.

Table 3.1 – Public/Private Sector Interaction by Type of Provider

	Non-allopathic providers N=62	Pharmacists Drug vendors N=72	Hospital/Clinics	
			Clinicians N=41	Managers N=32
Currently not involved with government activities	100%	90.3%	N/A	43.8%
Receives information on health sector planning	0%	5.6%	11 (26.8%)	40.6%
No monitoring visits in last 3 months	74.0%	58.3%	N/A	34.4%
Uncertainty about government policies "Important" or "Very Important" constraint to operations	51.6%	68.0%	N/A	87.5%

Source: HEU/IHE/NIPORT, 2003 and authors' calculations.[9]

3.2.4 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 3.1).

3.2.5 Information Dissemination

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.

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[9] The percentages were calculated among the private actors who provided an answer to the question.

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 proportion 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 3.1 above). With regard to information dissemination activities to consumers, though very little information 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.

3.2.6 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 3.2).

Box 3.2 – 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. NGOs' resources are channeled to the provision of standardized TB services, to rural and less accessible areas, through the use of community health workers. 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 the government, the use 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.

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

Source: Barkat *et al*, 2003

3.2.7 Contracting

Engaging in long-term purchasing arrangements with private providers is the most influential instrument used to guide independent service providers in mixed–delivery health systems. The interest of private providers in a predictable revenue flow yields the government purchaser strong leverage over their operation. Health services contracts are typically longer-term (relative to other public services), and subject to on-going consultation and coordination. Therefore, health services contracting both requires and generates frequent communication and interaction with private providers, and, as such constitutes an important component of a government's overall interaction with the private sector (Taylor, 2003).

In Bangladesh, a number of pilots have been initiated to engage NGO providers via contracting to provide health care services. These experiences constitute a rich resource for evaluating and improving the interaction between the GOB and private service providers. To date, most of these public-private partnership initiatives have been implemented in conjunction with donor-supported initiatives. Recently, the MOHFW has declared its intention to contract out NGOs in 350 unions to provide essential service delivery.

3.2.8 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 3.3). As with contracting however, these experiences are taking place mainly in connection with donor supported programs and pilot activities.

Box 3.3 – 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. Most NGOs deliver diverse and integrated programs to their communities, of which health is one component. Some NGOs have the capacity to provide the full range of Essential Services Package 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 essential 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.

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

Source: Barkat *et al*, 2003

3.3 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 -- those directly in charge of implementation of health sector policies -- were interviewed to obtain an understanding of their views on private provision (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. 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.

3.4 Perceptions of the Private Sector

As part of the policy-makers interviews, four private health care providers were also 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 that there was 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 3.2).

While there was a surprisingly large amount of interest in working with the Government, private sector representatives expressed some 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 3.2 – Public/Private Sector Interaction: the Perception by Type of Provider

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

Source: HEU/IHE/NIPORT, 2003 and calculations by authors.[10]

3.5 Conclusions

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 it is a fairly low priority.

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.

3.5.1 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 the past 10 years, a number of pilot initiatives have been undertaken to work with private, mostly non-profit, service providers to provide

[10] The percentages were calculated among the private actors who provided an answer to the question.

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. Encouragingly, recent statements by the GOB indicate increasing awareness of and openness to working with the private sector and in particular with NGOs to provide service delivery at the union level.

3.5.2 Public-Private Engagement Excludes 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. 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. While there are multiple factors that contribute to this situation, a stakeholder analysis of the relevant political economy may be helpful to identify resistance points and develop appropriate solutions.

3.5.3 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.
- The policy-makers' interviews revealed that there is a limited understanding, indeed, even misunderstanding of the private sector size and role in provision of health 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 private 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 different from their traditional ones related to administration of public facilities. There is currently very little capacity to operate such instruments in the MOHFW or in local government bodies.

The bulk of health services are provided by alternative private practitioners. 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 segment is particularly challenging.

Chapter 4. Main messages and policy options

4.1 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.

(b) The poor are far more likely to forego medical treatment (30% of poor sick people are not treated), 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 despite the fact that females show a greater disease burden than males. HIES 2000 indicates that 58% of curative services are utilized by men.

(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 mainly to the tertiary care needs of richer populations.

(e) The poor also use private curative health care services and pay for those services with higher proportion of their income than the richest households. However, both the poor and the rich choose private providers in similar proportion. In the poorest households, 81% of the health care services are provided by the private sector, and 88% in the richest households. Also 40% of total out-of-pocket expenditures are made by the 40% bottom poorest households.

(f) 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.

(g) 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, APPs*) do not have formal training and recognized qualifications in allopathic medicine. The poor, especially, make heavy use of these APPs. Implementing training programs to drugs shop workers and birth attendants is needed to improve quality of services to the poor.

(h) 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.

(i) 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.

(j) 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.

(k) 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 know how and resources of the private sector more systematically to achieve 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 evaluated and be applied to HNP program.

(l) 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 there is no wide 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. Near half of the users of the publicly financed essential service package are non-poor people. The relevant question is whether the performance of the private sector can be improved to meet the needs of the people and to provide the value for the money they spend for their health care.

4.2 Policy Formulation: A new paradigm

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 included in the government's December 2002 interim PRSP. Given the lack of resources and capacity constraints in the public sector, there is a need to shift the role of the Government from provision of health care services to the purchase of health services. This new paradigm is justified by the current dominant place held by the private sector 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 to strength the implementation of the next Health, Nutrition and Population Program.

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

The fact that many patients have a preference for private providers 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 unlikely to reach the poor. The gender distribution of the providers poses an additional disincentive for women.

4.2.2 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 means to obtain 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.

4.2.3 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, and also to help users to make informed decisions related to the utilization of health providers.

4.3 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 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 different measures such as contracting with private providers and subsidizing care for the poor.
- Bring Alternative Private Practitioners (APPs) into to service provider system by working with them in strengthening skills and increase the number of formally trained staff through training.
- In addition to traditional regulatory and quality assurance techniques, it is necessary to promote health services standards, performance based competitive pressures, and incentives to attract private practitioners to work in low coverage areas

Consumption

- Make information about the quality and price of private providers readily available to consumers, 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

Public private interaction

- Increase competition between public and private sector through competitive and selective contracting and performance benchmarking and service standards.
- 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

The options described below are initial ideas to address the three 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.

4.3.1 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 commitment 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. The contracting and the monitoring should be performed by an independent body such as an NGO or private company. Health services should initially be focused on child and maternal services. Contracting arrangements should be performance-based. Contracts fees should be linked to agreed outputs and health outcomes. Box 4.1 provides some pointers on "contracting in" and "contracting out", based on experiences in other countries.

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 bed nets and soap, which is known to have a positive impact on the health of the poor.

Box 4.1: Contracting-In and Contracting-Out to Improve Health Services Utilization and Quality in Cambodia

In response to poor health outcomes and a public infrastructure ravaged by a quarter-century of conflict, Cambodia has recently undertaken innovative approaches to collaborating with the private sector for health services delivery. The Ministry of Health is currently piloting health financing reforms in selected districts, through its Accelerated District Development (ADD) program. With the assistance of the Asian Development Bank (ADB), Cambodia has piloted two models of contracting for primary health care services in an eight-district intervention covering a total of one million people: 1) contracting-out, where contractors (typically NGOs) have full responsibility for service delivery and directly employ their staff; and 2) contracting-in, where contractors provide only management support to civil service health staff. The contracting model was intended to address one of the primary causes of poor health system performance: poor staff morale and inadequate management.

Preliminary results show that those districts with contracting models outperformed control districts on several health service coverage indicators, with the contracting-out model yielding the greatest gains. For example, districts with contracting out increased annual per-capita health care contacts among the population to 1.7, compared with 1.2 for contracting-in districts and 0.8 for control districts, with lower recurrent costs (Bhushan et al., 2002). Contracting-out also proved equitable, as utilization of government-financed services increased disproportionately among the poor, whose out-of-pocket payments were also reduced, up to 70% in contracting-out districts and 40% in contracting-in districts.

Several factors of the Cambodian contracting experience have contributed toward its success, including: establishment of contract management capacity in the Project Coordinating Unit (PCU) of the MOH; a transparent competitive bidding process; and an agreed-upon monitoring process. With assistance from ABD, the Ministry of Health specified objectives and solicited contract bids from for-profit and not-for-profit international agencies, and subsequently monitored awarded contracts through the PCU.

For more details on the contracting-in model, please refer to an in-depth case study of the Pereang District in: Soeters, R, and Griffiths, F. 2003. "Improving Government Health Services Through Contract Management: a Case from Cambodia." *Health Policy and Planning*, 18: 74-83.

Sources: Bhushan, I., Keller, S., and Schwartz, B. March 2002. "Achieving the Twin Objectives of Efficiency and Equity: Contracting Health Services in Cambodia." Asian Development Bank. ERD Policy Brief No. 8; Loevinsohn, B. "Contracting for the Delivery of Primary Health Care in Cambodia: Design and Initial Experience of a Large Pilot-Test." The World Bank; Soeters, R, and Griffiths, F. 2003. "Improving Government Health Services Through Contract Management: a Case from Cambodia." *Health Policy and Planning*, 18: 74-83.

Explore insurance / risk-pooling and prepayment mechanisms: Since people are paying for private sector HNP services from their pock*ets*, well-designed community insurance schemes could provide a feasible option for better delivering of a benefit package with acceptable quality. 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 such as Grameen Bank's schemes for their members may prove to be helpful in designing locally appropriate community insurance mechanisms. Box 4.2 provides a brief account of the Grameen Insurance system. 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, 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.

Box 4.2 Grameen Kallyan (a community health insurance scheme)

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 setbacks emerging from natural calamities as well as from personal or family-based misfortunes 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 medical care being one of the lowest, Grameen Bank thought of introducing microfinancing coupled with quality health care services toward improved health status of the rural poor.

The goal of Grameen Kallyan is to provide sustainable quality primary health care services. The existing interventions of Grameen Kallyan spread 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: collecting 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 health care services. Grameen Kallyan, from time to time, also arranges for health care camps especially in the area of care for cataract. angladesh.

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. Strategic planning of the Government would guide the private sector in the provision of public information campaigns on individual and household behaviors, with attention to be paid to changing health-care seeking behaviors, especially of mothers with children. Bangladesh does have some successful experience in modifying health-seeking behaviors through information campaigns, e.g., family planning, immunizations and oral rehydration therapy. Areas where information campaigns could have been more effective include the use of iodized salt, maternal health care, and tuberculosis control programs. Clearly thought out communication strategies, based on formative research which study not only health-seeking behaviors but also their socio-cultural

determinants are a key pre-requisite for successful information campaigns. Other conditions for success would be effective leadership and political will to carry out such campaigns, backed up by high quality services that the population can rely on. An example of information campaigns not backed up by appropriate services might be found in the manner that Bangladesh has been dealing with the problem of arsenic contamination of drinking water; while information campaigns warned people not to drink contaminated water, no viable alternatives have **yet been** made available in an affordable and acceptable manner.

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 capacity for identifying the potential beneficiaries, and 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., mechanisms for identification of the poor and accreditation systems .

4.3.2 To Improve Service Quality and Outcomes in the Private Sector

A recurring theme of this study is how to improve the quality of health care services. 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. Weak performance of the civil service and persistent governance problem underpin the need to design and implement adequate legal and economic incentives and to establish autonomous regulatory agencies financially and administratively independent of the MOHFW. Such agencies must ensure, promote and disseminate best practices in quality services. Quality of services will only be achieved as result of consistent set of actions. 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 will be necessary 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 4.1). The different strategies for addressing quality involve different actors, have complementary objectives, and have their own limitations and timeframes.

Tble 4.1 Quality Improvement Strategies Relevant to Bangladesh: Multiple Fronts

Strategy	Examples	Objectives	Limitations
Top-down	Licensing, egistration accreditation	Set minimum standards	Limited impact in informal sector; effectiveness linked to good governance
Bottom-up	(i) Consumer education & advocacy (ii) Pilot quality improvement projects in leading organizations	(i) Raise demand and expectations for quality (ii) Strengthen capacity for quality	(i) Long run solution, but limited experience in countries where education levels are low, modest successes have been achieve in specific areas (ii) Limited scale
Leading edge	Collaborative professional learning networks	Improve performance and change patterns of practice	Little experience in low-income countries
Driving force	Financing incentive mechanisms linked to clinical practices	Influence provider behavior to improve quality	Medium to long term solution; requires group purchasing of health services through insurance or pre-payment

The top-down strategies usually involve government agencies setting standards of care, most often with an objective of demanding a minimum level of quality and safety. In Bangladesh, most standards in health care concern the qualifications of staff and physical inputs at health facilities, rather than quality assurance processes, such as clinical guidelines, standard diagnosis, treatment guidelines and continuing medical education linked to certification and accreditation . 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 the quality of care 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. 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 levels of education 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 priorities for services, 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.

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. One limitation with these strategies in Bangladesh is that people make most health care payments individually from out-of-pocket, so that the ability to use the power of group purchasing to influence provider behavior is lacking. These payments are essentially in the nature of "fee for service", and there is little scope to use other mechanisms of compensating the provider (e.g., capitation payments for general practice), as levers to influence provider behavior. Risk-pooling mechanisms, e.g., community health insurance schemes, might help develop different kinds of incentive mechanisms for providers and consumers alike and could help improve quality of health services in Bangladesh. In the short to medium term, pursuing public sector contracting for non-public health services would help to build up experience with financing strategies.

Whatever sets of strategies are chosen to improve quality, leadership and consensus building will form important components 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 the clinical aspects to be 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 health care is to support research and assessments of quality of health care. 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 targeted at both the formal sector, i.e., the qualified allopathic providers and facilities and 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.

Creation of a National accreditation agency: Both public and private providers and facilities should be accredited, by a established independent body with a reliable system of regular monitoring and maintenance of standards, and legal capacity to provide incentives and enforce sanctions. This agency would provide information to consumers for judging the quality of services. The work of this agency should be linked to direct information campaigns to households.

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. Professional/provider associations need to be identified and their capacity to play the role of a self-regulatory body needs to be strengthened.

To promote the dissemination of 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 provide credit and management support to providers and staff and a sense of belonging and pride

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. Such strategy could initially be targeted to the poorest districts and the poor areas of selected urban cities.

Promote the formation of one or more 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 organizations can also play a role in the monitoring and improving of quality of care in the private sector.

Promoting 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. Special focus should be given to the training of local midwives, birth attendants and drug shop workers through the provision of scholarships to be trained and further monitoring of performance.

.4.3.3. *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. Policy decisions must have a solid evidence-base. 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) factors market (pharmaceuticals, medical equipment, consumables, etc); (b) labor market dynamics; (c) capital markets; and (d) potential for insurance markets. A broadening of the knowledge base is also necessary in 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, 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, level of training of providers, types of medicine practiced. Such a follow-on survey and training should include all types of alternative providers as well, particularly traditional birth attendants, and drug store managers; 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-elasticity, income elasticity, 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.
- Good research and development programs (such as those developed by HMOs in the US) might contribute significantly to policy options aimed at improving quality of services.

Based on a thorough analysis of the various markets relevant to HNP services, it is essential to 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 disease burden but also in private sector resources (practitioners, infrastructure, equipment etc.).

Information sharing: Such efforts would aim at disseminating information to policy-makers, managers, and other key actors in the public sector to enhance their understanding of the

private sector and vice versa. Key data to be shared are: public budgets and resource allocation across districts, health indicators, consumer preferences on health, market analysis on health, best management practices on health provision etc.

4.3.3 Promoting private investment in health

The scaling-up of private health care providers requires in the long term of additional resources from local and foreign investors. Investment will provide financial and physical resources, "known how" and best practices that can be rapidly spread across existing private and public providers with a positive impact in quality and unit cost. The Government should initiate an aggressive policy to encourage private investment in the curative health care sector. Some specific actions are suggested as follows:

To install a Special Task-Force Unit in the Office of the Primer Minister to help local and foreign investors to seek potential business in the health sector in Bangladesh. This unit would have to define goals in terms of the value of the investment, and will coordinate all needed public actions to accomplish those objectives. The Unit will have to develop the appropriate legal conditions and to monitor the dissemination of lease management, concessions as options to contract agreements and also to evaluate the transfer of ownership of public health facilities to the private sector.

Bonuses to NGOs or private providers that serve in underserved areas.

To encourage alliances between the MOHFW and the private sector to achieve specific public health goals such as immunization, tuberculosis and malaria control etc. Creation of Health Management Organizations

Implementing social insurance for civil servants and private employees. This implies a mandatory earnings contribution (about 4% of total earnings) that could go either to the Ministry of Health and Family Welfare providing a right to receive medical attention without fees or to a health maintenance organizations (HMO). **This strategy may allow to obtain not less than 200 million dollars a year into the health sector to strengthen the development of a competitive market with "incentive schemes" and "minimum standards" in the search of better quality and coverage**. This option requires the design of a new legislation that promotes the formation of HMO.

The accreditation of activities and health plans offered by these HMO will be under the responsibility of the NAAH. The Health observatory/Consumer alliance will inform consumers about the best choices and disseminate user's rights.

4.4 The Way Forward

This section provides some options on **how** the above policy options might be realized into action. The original intention of the authors was not to be prescriptive about the solutions for the issues emerging from their study. However since the Government is preparing its new Health, Nutrition and Population Sector Program (HNPSP), the findings of this study and the suggested policy options presented here - both the "what" and the "how"- could serve as a useful vehicle for policy dialogue in Bangladesh and also as starting point for the design and implementation of the sector reforms required to achieve the desired HNP outcomes as specified in the MDGs, in the context of a choice competitive model. The following are **possible next steps**:

- Set up a Public-Private Task Force in the MOHFW to provide a focal point for developing 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).

- 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 such as negotiation, social marketing, monitoring performance based on results etc. 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 input for the for national policy debate, involving stakeholders at all levels. Private sector actors should be included in such process and a full consideration given to strengthen private sector capacity in service and facility planning. Participatory policy debate should take advantage of the preparation of the full PRSP from the I-PRSP.
- Establishment of an Accreditation System

An Accreditation body would work with consumers, health care purchasers, legislators and the providers in developing standards for both public and private providers in Bangladesh. Participation in accreditation and certification programs would be voluntary. This would create incentives to good providers to distinguish themselves from bad providers.

The NAAH should evaluate health care in three different ways;

a. Through accreditation (a rigorous on –site assessment of key clinical and administrative processes)
b. Through health plan employer data if they exist.
c. Through a comprehensive user's and provider's surveys.

Since regulation is usually costly and often ineffective, **accreditation is recommended to "protect a minimal set of standards on health service provision". Non-regulatory interventions or incentives would also be essential for improving private sector activity**.

The NAAH may use **several factors** for the elaboration of the ranking of providers such as:

a. Access and service

-Are there enough doctors and specialists to serve the number of patients?

-Which are the services of the health facility?

-What is the access to training of the health workers and practitioners in the health facility?

-Sufficient and adequate resources: human (health personnel), equipment, and infrastructure of health facilities.

-Availability of diagnostic tests and drugs

Qualifications of providers

-Ensuring each doctor is licensed and trained to practice medicine and that the users are satisfied with the services received by practitioners.

-How do the providers rate their own doctors?

-How do the providers deal with bad practices and complaints against their practitioners or health workers?

-Which is the level of cleanliness of the health facility?

-Which is the level of access to water, electricity and other services in the health facility?

-What is the quality of the food provided by the health facility?

-What is the ratio of practitioners/administrative workers in the health facility?

-What is the status of financial procedures?

-Does the hospital have clear and written standards and protocols for treatment and diagnosis?

-What is the average waiting time of a patient before he/she receives treatment?

b. Health outcomes

-Are the health activities of the provider helping people to stay healthy?

-Are preventive health activities appropriate?

-Evaluate whether people recover effectively from illness.

c. User's satisfaction

Measure by the level of comfort, promptness of service, waiting time to receive the medical attention, treatment by the doctors and health workers, privacy, availability of services and food received by the patient.

To be eligibly for accreditation, a health provider would need to be in operation for a minimum of three years. The ranking of providers should be simple and easy to understand for the public such as: excellent, good, satisfactory, below average, fail.

The NAAH will use two options for accrediting health care providers:

a. Do the inspections directly with own personnel.

b. Contracting inspectors from other NGOs and private institutions.

Both options will demand special training of personnel.

- **Creation of a Health observatory/Consumer Coalition**

The main activities of the Health Observatory/Consumer Coalition would be the following:

a. Advocacy

Help to educate, assist and protect the rights of individuals through consumer information, consumer participation, consumer advocacy programs, data collection and independent quality oversight. Draft model policies or legislation on the areas of interest. Help consumers know about options of coverage, provision and treatment.

b. Grassroots organizing

Broaden coalitions by creating worker/consumers partnerships at the local and national level. Implement a quality watch-line (toll free number) which collects individual experiences of poor quality of care services from consumers or health workers in the country. These would be real life stories very useful for the design of pro-consumer strategies in the health sector.

c. Participation in quality measurement

Ensure that the consumer voice is listened to in all forums and work groups related to legislation or decisions on the health sector.

d. Accountability

The observatory should be independent of providers and financers of health care and free of conflict of interests. The agency should collect and disseminate information to strengthen the national data system.

- **A National Contracting Agency**

The formulation of a strategy framework for purchasing services from NGOs and other non-public providers should be defined clearly. The themes for further definition and work are:

a. The services to be purchased.
b. Criteria for choosing the geographical areas of interventions. The proposal is to start in the unions were there are already NGOs delivering health services.
c. The procedures to monitor and to supervise the performance of the NGOs.
d. The establishment of the contract agreements and bidding process.
e. Types of partnership between the GOB and NGOs.
f. The payment mechanisms to providers. One option is to initiate the process with a simple per capita allocation.
g. To give the contracted NGOs the possibility of retention of user fees.
h. Accreditation should be managed by an independent agency.

A private institution (The National Contracting Agency) would be contracted by the GOB to manage the bidding process, and the supervision and monitoring of performance, together with the training of health workers in the NGOs.

A permanent GOB-Civil Society committee lead by the MOHFW would guide and provide inputs to the National Contracting Agency on the national goals of targeting the poor. The National Contracting Agency would be responsible for:

1. The decision of what to contract out.
2. The decision of from whom to purchase services.
3. The definition of the contract payment option.
4. To negotiate the terms of the contract with the selected provider.
5. To supervise and to monitor the performance of the contracted provider.
6. To modify contracts base on performance.
7. To promote the formation of public and private health networks at the union level.

The NCA will need also to develop indicators to measure contracting outcomes such as:

- Improvements in average health indicators with significant reduction in disparities between the rich and the poor, between male and female.
- Infant Mortality Rates reduced to a target rate with a significant decrease in rich/ poor , male/female ratios.
- Under-5 Mortality Rates reduced to a target rate with a significant decrease in rich/poor, male/female ratios.
- Maternal Mortality Ratio (or suitable proxy) reduced to a target rate with a significant decrease in rich/poor ratio.
- Percentage of fully immunized children against 6 diseases within the first year of life increased to x %.
- Proportion of women with obstetric complications treated at facilities increased to x %.
- Use of curative essential services by women, children and the poor increased to x %.
- Discontinuation rate of contraception reduced to x %.
- Proportion of women who receive antenatal care.
- Proportion of women who receive post-natal care.
- Fertility rates.

- Pilot activities to test the selected policy options. Selected policy options 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 available about public-private partnerships such as demand-side financing, micro-insurance schemes, and contracting with results-based financing.

- A summary of issues and suggested policy options is given in table 4.2.

A **preliminary timeline** for the next steps is suggested subject to previous agreement with the Government:

Completion of other related studies: - Governance issues in the health sector. - Pro-poor targeting mechanisms. - NGO contracting evaluation. - Comparative study of cost-effectiveness among public and private health care providers.	Between August 2003 and May 2004
Dissemination of existing evidence, multi-pronged communication exercise, consultations across the country	From July to December 2003
Development of broad-based HNP Policy Options dialogue	May 2004
Initiation of Pilot Interventions (e.g., vouchers, micro-insurance, methods for contracting-out non-public providers, demand-side subsidies such as cash transfers to the poor)	Starting January 2004

Table 4.2 Summary of Issues and Suggested Policy Options

Issue to Address	Strategies [Policy Options]	Who are involved [Targeted Private Actors]	What to do [Actions]	Where did it work? [Global Examples]	Expected risks
Under-consumption of services	Insurance/risk-pooling	Health insurance companies / NGOs Health Care Service providers	Develop appropriate health care benefit packages for risk pooling, at the community level; cost the package based on a minimum acceptable quality of care – to be obtained from private providers. Determine appropriate premiums, public subsidy to cover the poor, criteria for targeting the poor, co-payment tariffs, etc. Pilot a community health insurance scheme to cover essential reproductive health care package, and catastrophic illness coverage. Implementing social insurance for civil servants and private employees through a mandatory earnings contribution (about 4% of total earnings). To formulate legislation that promotes the formation of HMOs to encourage private sector participation in the health sector. The accreditation process of the activities and health plans offered by these HMOs would be conducted by NAAH. The Health Observatory would play a key role to inform consumers about the best choices and to disseminate user's rights.	Bolivia[11]	Institutional constraints to collect all necessary data to design a cost-effective health benefit package. Moral hazards. Adverse selection Political difficulties to allow the implementation of cost recovery schemes. Institutional limitations to supervise the performance of HMOs.

[11] Dmytraczenko *et al*, 1999a; 1999b

Issue to Address	Strategies [Policy Options]	Who are involved [Targeted Private Actors]	What to do [Actions]	Where did it work? [Global Examples]	Expected risks
	Social marketing	Service providers Suppliers The media The users	Organize social marketing schemes in order to improve means of prevention and to help users identify quality services Allocate at least half of the marketing resources to reach the 20% bottom poorest districts.	Central America[12] Indonesia[13] Tanzania[14]	Reluctance of health workers to implement social marketing actions . Insufficient coordination across Ministries and GOB agencies.
	Contracting in. Contracting out.	Health Service providers (private sector for profit, NGOs)	Determine goals and explicit contracts arrangements with measurable indicators. (estimated cost: $50,000) Provide legal autonomy to public hospitals for contracting "in" and "out" to improve quantity and quality of health services. Moving to capitation-allocation of budget across districts using health and poverty indicators. Increase in supply and coverage of health services based on contract arrangements that provide performance incentives to health providers that achieve goals on time. To scale up the contracting if there is evidence of declining unit cost and/or increasing health impact.	Senegal/Madagascar[15] Cambodia[16] Haiti[17] Peru, Colombia,India, Mali and Senegal[18]	Choice of inefficient providers (possible due to corruption) and political barriers to punish poor performance of contracted providers.

[12] Saade *et al*, 2001
[13] Alisjahbana *et al*, 1995
[14] Schellenberg *et al*, 1999; 2001
[15] Marek *et al*, 1999
[16] Bhushan *et al*, 2002; Loevinsohn, 2000
[17] Nieves *et al*, 2000
[18] Rosen, J. (2000)

Issue to Address	Strategies [Policy Options]	Who are involved [Targeted Private Actors]	What to do [Actions]	Where did it work? [Global Examples]	Expected risks
	Demand-side subsidies	Accredited private providers	Public subsidies are given to targeted vulnerable populations, giving them a choice of providers from whom to buy care Increase supply of health goods and services though transferring purchasing power directly to users of specific services in urban areas (vouchers for maternal and child health, and TB services): Design and implementation of voucher system in maternal and child services, TB, contraceptives and reproductive health services in selected urban areas.	Dominic Republic Cambodia Nicaragua	Lack of a cost-effective system to identify the poor. Poor institutional capacity to implement targeting schemes at the community level. Political use of the financing options.
Quality of services and health outcomes in the private sector	Information campaigns to consumers	Users	Disseminate standard treatment guidelines and quality standards to health providers. Disseminate chart of consumer rights in all public and private facilities and through radio. Disseminate information on quality of services of public and private providers to the public opinion.		Lack of political willingness to enforce the laws. Not enough interest from poor consumers. Rejection from medical associations and other professional bodies. Non collaborative response from Government officials in the health facilities

Issue to Address	Strategies [Policy Options]	Who are involved [Targeted Private Actors]	What to do [Actions]	Where did it work? [Global Examples]	Expected risks
	Promoting training of private providers	Service providers (Allopathic, APPs)	Design and implement a training project for accreditation of APPs, focusing on APPs who are currently serving the poor: Traditional and unskilled birth attendants and drug shop workers (estimated cost: $10 million). This project would have three key components: (Training). Scholarships to APPs who participate in training programs subject to evaluation and accreditation by a private institution. The program will monitor the health care practices of participants according to quality standards and will provide rewards and cash transfers for the accomplishment of objectives. (referrals, user's satisfaction, good practices, etc.). (To strength local health network). To promote joint work with public facilities and NGOs contracted by the Government in the area. (Communication). To inform consumers on the risks and disadvantages of being treated by APPs who are not qualified by the Accreditation Program of APPS.	India[19] Pakistan[20] Guatemala[21] Pakistan[22] Gambia[23]	Opposition from Doctors and nurse associations. Lack of interest from public facilities and doctors to interact with APPs. Designed incentives to promote participation of APPs in the project are not good enough

[19] Chakraborty *et al*, 2000
[20] Luby *et al*, 2002
[21] O'Rourke, 1994
[22] Miller *et al*, 1995
[23] Greenwood *et al*, 1990

Issue to Address	Strategies [Policy Options]	Who are involved [Targeted Private Actors]	What to do [Actions]	Where did it work? [Global Examples]	Expected risks
	Promote the formation of consumer organizations in health	Consumers Providers Academic institutions. Government Officials	To finance the formation of the Bangladeshi Health Observatory/Consumer Alliance. This entity will monitor the performance of the health system, and will advocate for quality of health services and health equity outcomes. The Observatory will disseminate to the public opinion the policies implemented by the Government and will focus on. a. Advocacy Help to educate, assist and protect the rights of individuals through consumer information, consumer participation, consumer advocacy programs, data collection and independent quality oversight. Draft model policies or legislation on the areas of interest. b. Grassroots organizing Broaden coalitions by creating worker/consumers partnerships at the local and national level. Operate a quality watch-line (toll free number) which collects individual experiences of poor quality of care services from consumers or health workers in the country. These are real life stories very useful for the design of pro-consumer strategies in the health sector. c. Participation in quality measurement Ensure that the consumer voice is heard in all forums and work groups related to legislation or decisions on the health sector. d. Prepare and implement a Consumer Protection Act. The dissemination should be done though the public schools, health facilities and working places, and also by radio and television. The main goal is to establish legal arrangements that protect users from bad practices and abuses of providers.		Opposition of Professionals associations and private sector providers. Dominance of interest groups. Lack of financial resources and independence of Government policies.

Issue to Address	Strategies [Policy Options]	Who are involved [Targeted Private Actors]	What to do [Actions]	Where did it work? [Global Examples]	Expected risks
	Upgrade the regulatory framework	Service providers (Allopathic, APPs)	- Implementation of private supervision of contracts on behalf of the Government. - An autonomous and private agency would be responsible for monitoring and supervising the contracts on behalf of the Government in each division or set of districts. - Implementation of new forms of contract agreements - To create a legal institution to help users to complain legally or to present cases to the court in cases of abuses or negligence of health providers.	Lao P.D.R.[24]	Focus in provision of legal interventions instead of developing incentives to providers. Inappropriate arrangements for the supervision of contracts and spread of corruption and lack of accountability. System is used to make difficult the entry of competitive providers

[24] Stenson *et al*, 2001a; 2001b

Issue to Address	Strategies [Policy Options]	Who are involved [Targeted Private Actors]	What to do [Actions]	Where did it work? [Global Examples]	Expected risks
	Promote self-regulation	Doctor's association, pharmaceutics groups etc.	- Encourage professional associations to set standards for their practitioners, establish mechanisms for monitoring quality of services through periodic "audits" by peers / colleagues - Develop systems of recognition / awards for better performing practitioners - Make membership of associations contingent on continuing medical education (or corresponding in-service training for non-medical professionals)		Lack of informed users and legal enforcement gives insufficient incentives to change behavior mainly in small business in the health sector.
	To disseminate and encourage franchising	Health providers Health workers	- Provide incentives to providers that participate in franchising especially in family planning and maternal and child health services that can be standardized. - Give them preferential treatment in the contracting of services related to other providers. - Assign a special fund for training of personal working for providers under franchise.	Kenya (1995), Pakistan (1995) and Philippines (1997)[25]	Inability to reach the poorest population groups. Difficulty of franchising in training professionals in needed numbers. Limited possibility for standardization of a large number of health services.

[25] Ruster J, et al (2002).

Issue to Address	Strategies [Policy Options]	Who are involved [Targeted Private Actors]	What to do [Actions]	Where did it work? [Global Examples]	Expected risks
	Creation of a National Accreditation Agency for Health (NAAH). Objective: to monitor quality of health service delivery based on standards, and providing information to the public on quality and pricing of health care providers.	Consumers Health Care Providers	- The National Accreditation Agency for Health (NAAH) would act as an independent body to qualify and to supervise the quality of services of health providers in particular those under government's contracts. The NAAH would have legal power to enforce sanctions. Participation in accreditation and certification programs would be voluntary . - The Board of this agency could be formed by a mix of 5 representatives of civil society (Universities, Unions, Doctor's associations, private clinics, and private health insurances.) and 4 Government representatives appointed by the Prime Minister. This agency would operate with a mandatory contribution of the private sector (0.5% of their total revenues) and the Ministry of Health and Family Welfare (0.5% of the total revenue budget). The NAAH should evaluate health care in three different ways; a. Through accreditation (a rigorous on –site inspection of key clinical and administrative processes) b. Through employer health plandata if they exist. c. Through comprehensive user's and provider's surveys - Proposed annual Cost: Starting investment of $2.5 million for infrastructure, training and technical assistance. Self-financial sustainability would be guaranteed by established legal contribution.	Taiwan[26] Tanzania[27]	Stakeholders rejection to the plan and low political willingness to pass the bill in the Congress. Private sector contributions may prove to be very difficult to collect. The NAAH and the MOHFW may duplicate efforts in inspection of facilities and some conflict may arise. The initial cost of training and formation of the inspectors teams may be high Increased attempts to buy or influence decisions of inspectors.

Issue to Address	Strategies [Policy Options]	Who are involved [Targeted Private Actors]	What to do [Actions]	Where did it work? [Global Examples]	Expected risks
Promoting private investment in health	Designing and implementing incentive schemes for private for-profit health providers	National for profit health sector.	- To create a Unit in the Prime Minister's Office to endorse and to promote private investment in the health sector. This unit would coordinate all necessary actions for that purpose. International technical assistance may be required to build institutional and operative capacities. - To sponsor lease agreements and concessions of public health facilities to private providers. - Bonuses to NGOs or private providers that serve underserved areas. - Encouraging alliances between the Ministry of Health and the private sector to achieve specific public health goals such as immunization, tuberculosis and malaria control etc.		Administrative barriers to pass appropriate legal laws. National for-profit health sector is small. It may requires strong links with foreign investors and experiences to learn from best practices. Political sensitivity to encourage private sector

[26] Huang. P (1995)

[27] Newbrander W. (1999).

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