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Towards Innovative Universal Health Coverage in Bangladesh

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COMMENTARY

Background

Universal health coverage (UHC) guarantees all people accessible, quality and affordable health services when they need it. It is fundamental to improving health, protecting individuals against financial risk, reducing inequity and promoting wider economic development.[1] In Bangladesh, 64% of healthcare spending is out-of-pocket (OOP; see *Figure 1*). Catastrophic health expenditure forces 5.7 million into poverty every year.[2,3] Existing healthcare financing methods do not allow provision of the necessary level of healthcare to the population.

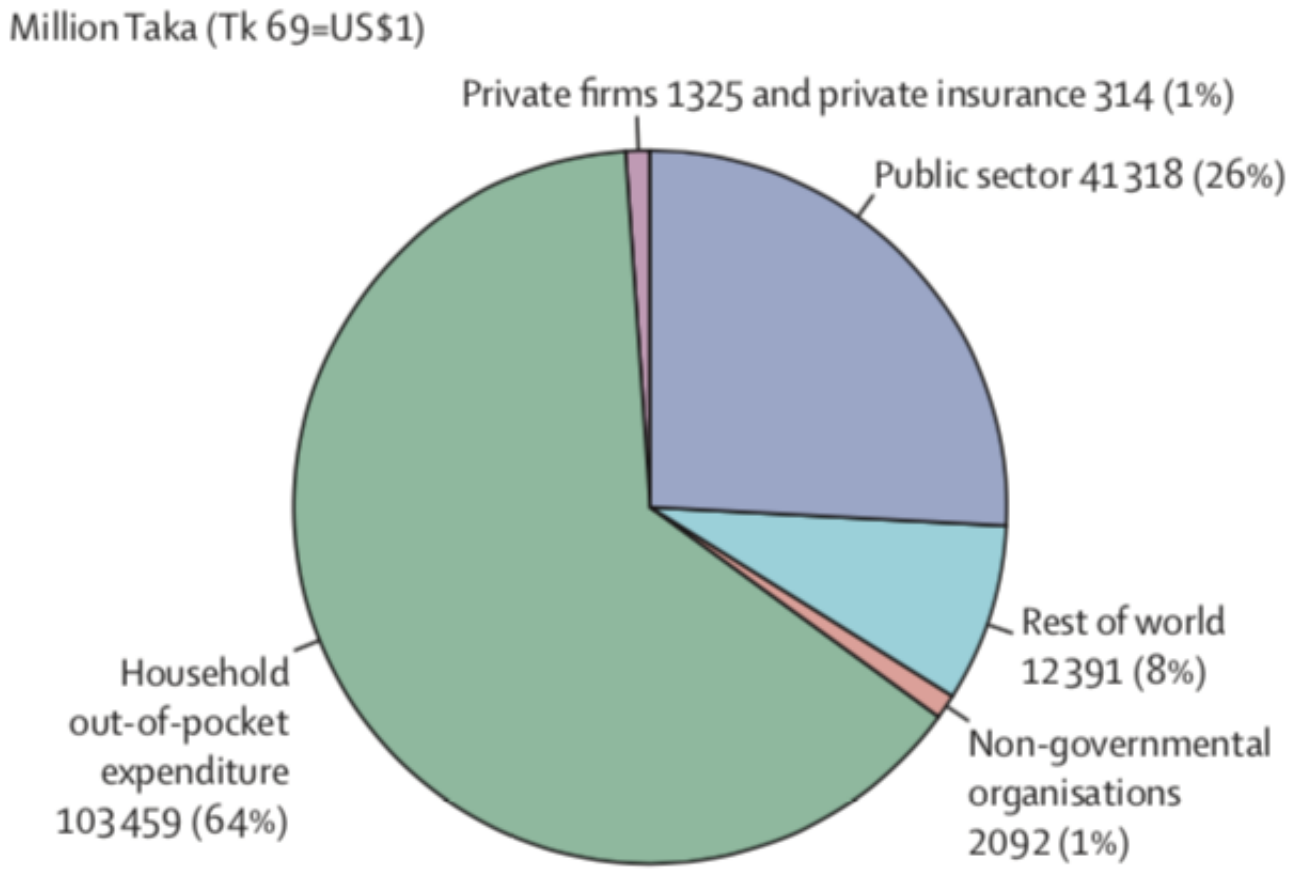

Figure 1. *Sources of financing for health expenditure in Bangladesh, 2006-07*[2]

This brief provides highlights from the “first generation” of innovative health policies implemented in Bangladesh since its independence in 1971 and have led to “remarkable” progress in the country’s journey towards UHC.[4] Exemplary advances in child and maternal health, gender equity, communicable disease and other social indicators are attributed to a dynamic pluralistic health system, multiple stakeholder involvement in targeted health initiatives, a community-based approach, and emphasis on women’s empowerment. Countries across the world are implementing targeted policies as they too embark upon transforming their health systems to achieve universal coverage.[5] The brief goes on to explore these vibrant areas of discourse identifying contemporary and novel policy challenges in Bangladesh that are yet to be met. Commentators critique policies targeting vulnerable populations to achieve UHC, such as those implemented in Bangladesh, citing concerns around quality of care, fragmentation and lack of coverage for middle income groups.[6]

A picture of imbalanced health progress can be seen in Bangladesh which threatens its journey towards UHC. Despite improvements in survival rates, child and maternal malnutrition amongst poorer groups coexist with trends of rising obesity in the better off.[7] Communicable disease prevalence has been curbed but non-communicable and chronic disease such as diabetes, heart disease and metabolic syndrome are increasing.[4] Key policy challenges and health system barriers include a scarcity of trained health professionals, growth of an unregulated private health sector, and no government mechanism for financing UHC.[8]

A “second generation” of policy recommendations are proposed to enable policy makers to navigate the extensive evidence base, meet the challenges and advance Bangladesh’s journey towards UHC. Many of the challenges faced by Bangladesh are not unique to the country which is why there is no shortage of top-tier commentary both from within and outside Bangladesh (see *Further Information* section). Thus, policy recommendations in this brief are relevant in other development contexts.

“First Generation” Policies, Successes and Current Approach

A Pluralistic Healthcare System

Pluralism in health - the array of different stakeholders and agents involved in health, fulfilling varying important roles - has in many ways had a positive health effect on Bangladesh’s health outcomes (see *Figure 2*). This is due to the dynamic combinatory impact of traditional systems, enterprise of private sector actors, and a non-obstructive, weak regulatory atmosphere.

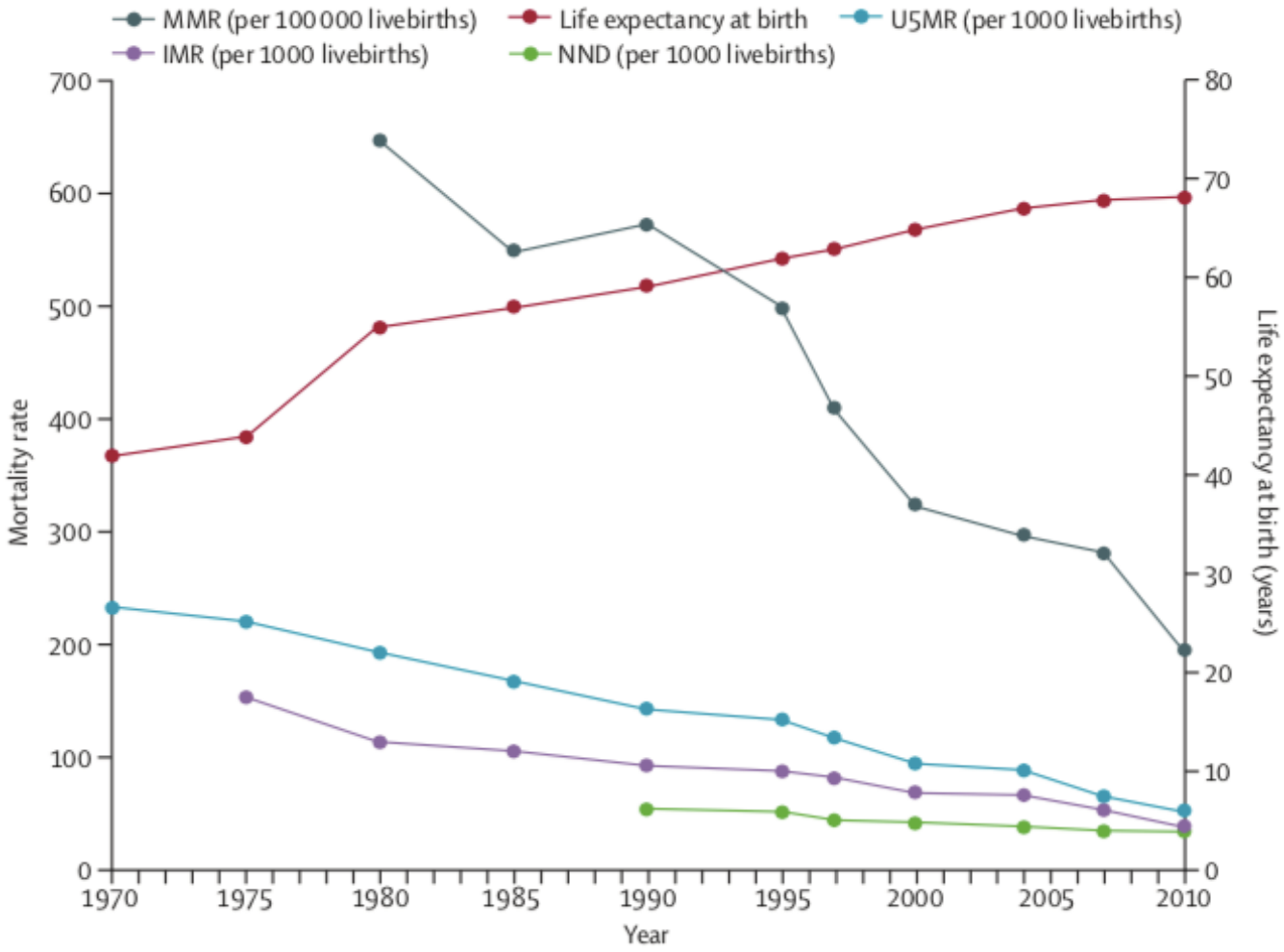

Figure 2. *Life expectancy and various mortality rates in Bangladesh, 1970-2010*[11] MMR=maternal mortality ratio; U5MR=under-5 mortality rate; IMR=infant mortality rate; NND=neonatal deaths

The Government of Bangladesh (GoB) has permitted various actors such as the for-profit private sector, non-profit non-Government Organisations (NGOs), donors and pharmaceutical companies the space to operate.[9] The National Drug Policy (NDP) adopted in 1982 moved Bangladesh away from dependence on foreign-made costly drugs to national production of essential drugs at an affordable price. This was achieved by creating favourable market conditions for rapid generic drug manufacture. For example, the NDP permitted Bangladeshi pharmaceutical companies to purchase raw materials from competitive global markets and allowed the retail of drugs to be governed by market forces instead of government regulation. Conversely, the expansion of tuberculosis treatment has followed a distinctly non-market driven approach but still owes its success to the cooperation of various actors. Bangladesh-based BRAC, the world's largest NGO, transformed the World Health Organisation's (WHO's) Directly Observed Treatment, Short course guidelines increasing treatment completion rates from under 50% to over 90%.[10] The success of this initiative led to the development of a national tuberculosis programme involving public, private, NGO and donor actors.

Community-based Partnerships

The large-scale utilisation of community health workers, by government and NGOs, began in the 1970s to address major shortages in human resource (*see Figure 3*). Since then, distinct models of

national expansion of community health worker initiatives have been deployed to meet growing needs. In this sphere, three general facets of healthcare delivery can be attributed to Bangladesh's community-based approach over the past four decades:[12]

1. Trialling and extensive implementation of large-scale community-based approaches with investment in community health workers at the doorstep level;
2. Experimentation with informal and contractual partnerships that take advantage of multiple actors and their distinct skills, such as NGOs and their ability to develop community trust, reach vulnerable populations and address gaps in public service provision; and
3. Early and swift adoption of context-specific innovative technologies and policies relevant to the development context.

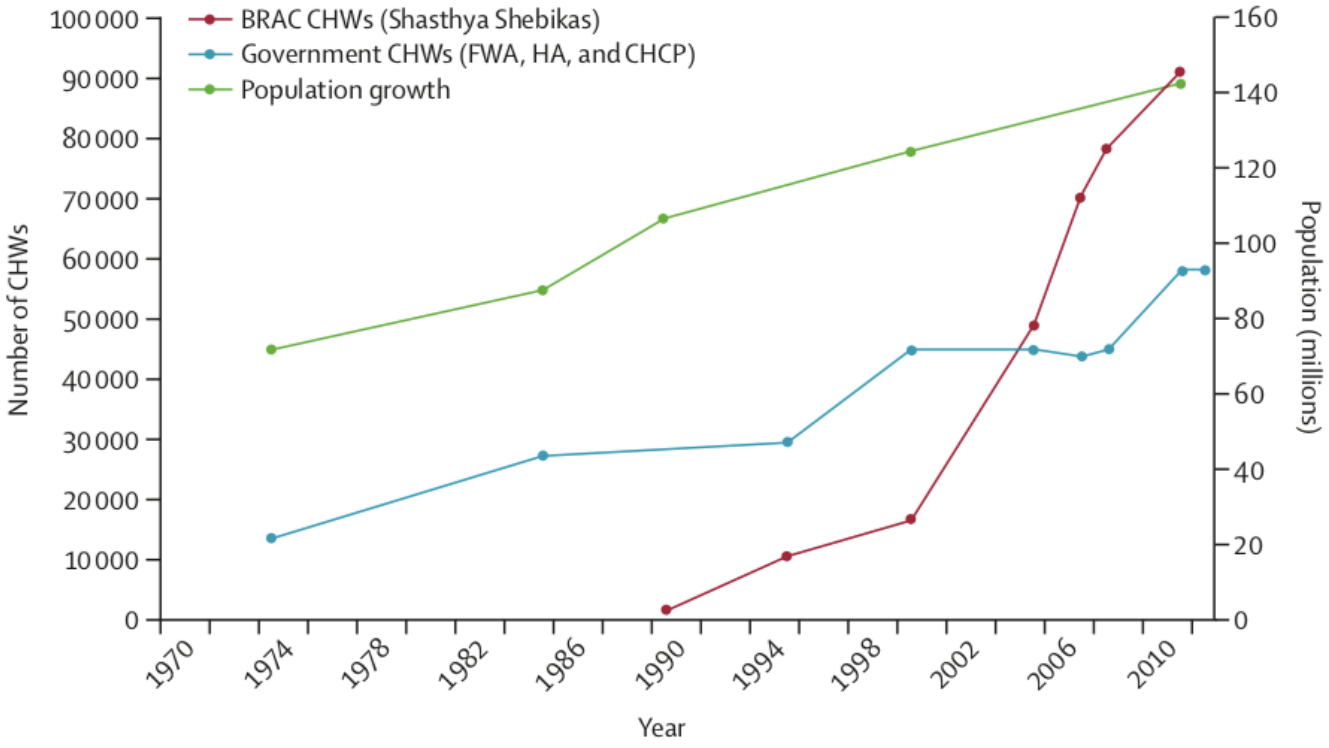

Figure 3. *Expansion of government and BRAC community health workers (CHWs) in Bangladesh relative to population growth, 1974-2012* (Source: BRAC 2011, Ministry of Health/GoB data 2011)

The Bangladesh Family Planning Programme implemented on the doorsteps of the community has been the most crucial innovation behind contraceptive uptake, and fertility reduction. Between 1978 and 1997, 85% of oral contraceptives were provided by community health workers and via doorstep delivery.[13] The oral rehydration therapy programme in Bangladesh was once the largest in the world.[12] BRAC-trained community health workers visited every rural home in the country to teach mothers how to prepare oral rehydration solutions. The success of this initiative in increasing the ability to treat children's diarrhoea in the household instead of a medical setting led to the development of further community-based approaches, such as, oral antibiotics for childhood pneumonia.[14]

Female Empowerment

Policies promoting family planning and normalising use of oral contraceptives in a traditionally

Islamic context have played a significant role in empowering women and promoting cultural and religious attitude changes. Front-line community health workers recruited, trained and deployed were predominantly female. In a culturally conservative country, this was a radical step taken by the government. Post-2000, the share of women obtaining contraceptives directly from pharmacies has overtaken the amount delivered by government community health workers. This marks a shift in attitudes, destigmatised behaviour, and a sustained demand for family planning led by females.[12] Teaching mothers how to manage children's diarrhoea at home also empowered women and led to demedicalisation. Other pro-gender equity policies include female education subsidies. Bangladesh has a 92% female enrolment in primary school which is significantly better than its South Asian neighbours.[11]

"First Generation" Policy Limitations; Current and Future Challenges

Pluralistic Health System Challenges

Despite numerous benefits to the pluralistic health system in place in Bangladesh, there exists no formal policy or vision relating to effective utilisation of the various stakeholders. This is particularly prevalent as not all actions of stakeholders in a pluralistic health system are welcome. Though there have been health and social benefits to the deregulation of the national pharmaceutical industry, there exist issues such as non-compliance with good manufacturing practice (GMP) in pharmaceutical manufacture leading to lower efficacy and poorer quality products. In addition, there are widespread reports of overuse and misuse of drugs.[8] For example, over-prescription of antibiotics, painkillers and other medication by healthcare providers.[9] The pluralistic environment has also facilitated the fast growth of a private sector that aims to maximise profit through exclusive services for the rich. Emergence of for-profit diagnostic clinics and hospitals staffed with public sector employees and catering for patients from higher socioeconomic groups is widespread.[15] This highlights the dual job-holding nature of health professionals in Bangladesh and is driven largely by market forces. This duality reaches into the public sector where informal payments for, what should be, free or affordable services can add up to around 80% of what is spent in private facilities.[15] This leads to a fusion of organisational structures, with significant overlap between public and private elements, causing challenges to patients and governance bodies.

Challenges Arising from Evolving Determinants of Health

A crucial point of consideration in the progress towards UHC is the changing determinants of health. Demographic and epidemiological transitions such as progressive population ageing; a shift from infectious to chronic disease; and changing causes of death present vastly different challenges which will dictate the "second generation" of national health policy in Bangladesh. Recent statistics from the Bangladesh Demographic and Health Survey[16] reveal 60% of women and 46% of men over the age of 35 years have high blood pressure. Over a third of the population has glucose intolerance and therefore fall under the classification of either diabetic or prediabetic.

Rapid urbanisation and its associated health risks must also be considered. In the next couple of decades, more than 50% of the population of Bangladesh is expected to live in cities, most typically concentrated in urban slums that are already home to 30% of the population.[17] The ability of GoB to plan, regulate or provide basic services in urban settings is not in tune with this population shift. 22% of poor urban dwellings have no or insufficient access to drinking water, 25% have no toilet facilities, 57% have no drains, and 79% have no waste collection service.[18]

Health services are also in disorder. There is inadequate primary care provision and a bourgeoning formal and informal private sector filling the void.[8] Problems with cost and quality are common, particularly in relation to the informal private sector which include unregulated pharmacies, drug

sellers, and traditional healers. This cohort represents the predominant source of care for the urban poor (*see Figure 4*).

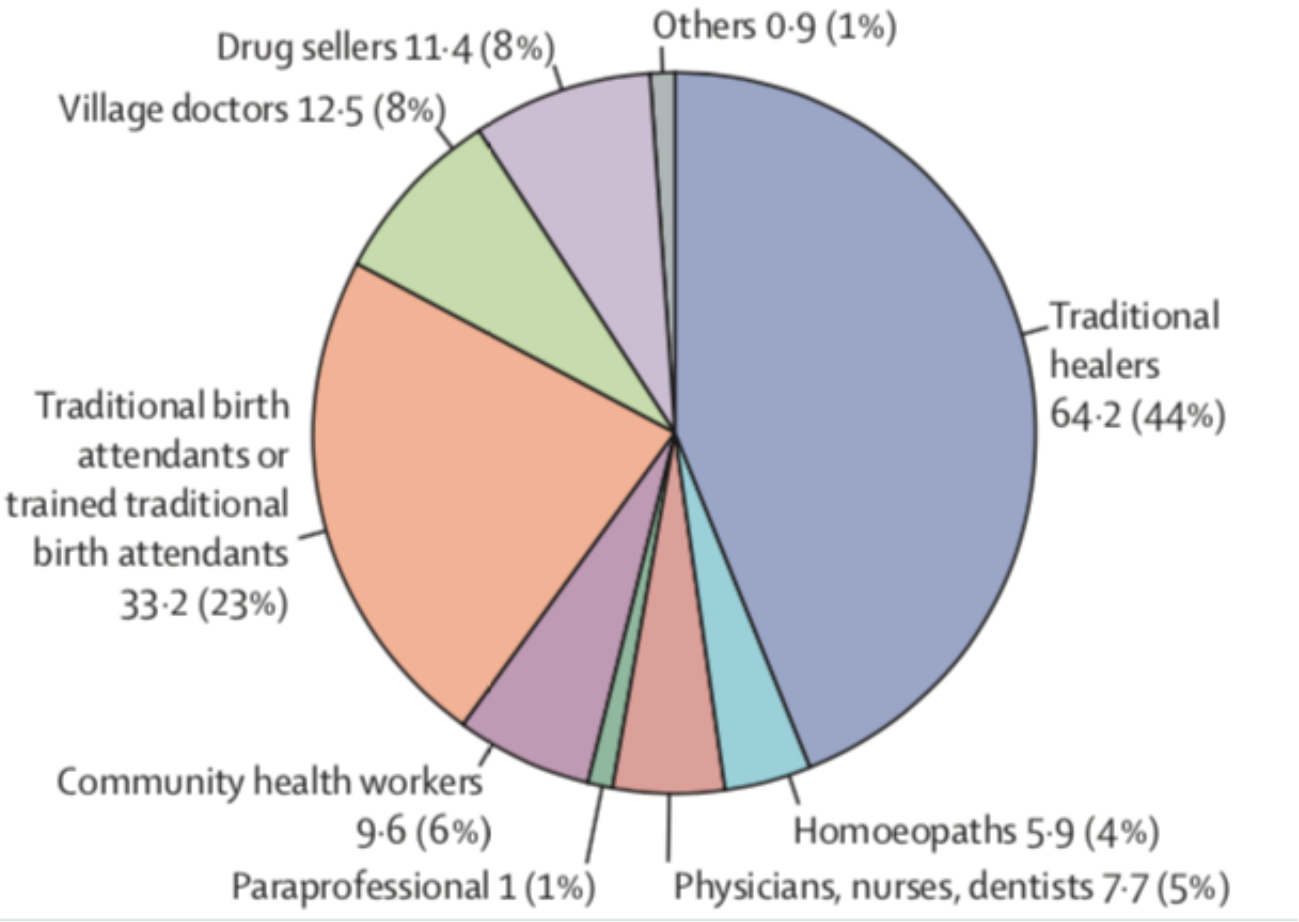

Figure 4. *Density of different health-care providers per 10,000 population*[3]

Bangladesh's growing role in the global economy signifies another challenge for health progress. It is ranked the second largest apparel exporter in the world. A large proportion of gross national product is supplied by migrant remittances. Thus, the country is subject to fluctuations in global markets. In addition, it has faced international criticism due to the health and safety, and human rights of its workers. In combination with political instability and poor governance, these evolving determinants of health significantly test the country's health and economic progress, and therefore journey towards UHC.

Human Resource Challenges

The health workforce in Bangladesh is significantly smaller than in other countries at 0.58 per 1000 population. It falls below the WHO's recommended threshold of 2.28 per 1000 population and designates the country as one of serious shortage of human resources for health.[19] In addition, growth in health human resource has been slow in the last decade and the scarcity in Bangladesh is more prominent than any other South or South-East Asian country.[12] Forecasts predict population growth in Bangladesh for years to come which means the health workforce gap will continue to widen as the country fails to produce and retain sufficient numbers of trained health professionals, especially nurses, midwives and paramedics.[19]

Selective vs. Comprehensive Coverage

As countries journey towards UHC, they must decide how to expand coverage to their populations. They broadly pursue one of two broad strategies: prioritisation of specific population groups (selective) or extend coverage to the whole population often with a limited priority package of services. In a low-resource setting, commentators and many major health agencies advocate for a selective approach focussing on providing free health services for women and children at the point of use and expanding coverage as more resources become available.[20] Further examples of policies used to determine coverage include targeting by employment status or geographic location.[21] An advantage of this selective approach is that those that require healthcare and financial protection the most may receive it sooner. A major challenge facing several countries who have gone down this route is a "coverage wall". For example, coverage rates steadfastly remain at 70% in Indonesia, the Philippines, and Vietnam. They are much less in Ghana, 35%, and Nigeria, 5%, regardless of expansion efforts toward universality.[6] Further challenges related to a targeted policy approach include quality of care concerns, lack of coverage to those employed in the informal sector and middle-income groups, and fragmented healthcare delivery overall. Nicholson and colleagues (2015)[6] therefore propound comprehensive (full population) coverage with a priority service package from the outset. They argue full coverage improves equity and efficiency due to being delivered to and perceived by everybody. Notable country examples in this category include Brazil, Malaysia, Sri Lanka and Thailand all of which have higher rates of coverage, and reduced health-related financial hardship at household level in comparison to countries that have adopted a selective approach.[22] Bangladesh, like many other countries has begun its journey towards UHC by offering selective services to targeted subsets of the population. For example, in children and mothers; immunisation; tuberculosis and oral rehydration therapy. The expansion of these services has been large-scale, rapid and, to an extent, relatively successful. Evidence supportive of this is seen in improvements in survival but should be evaluated in the wider context of challenges the country faces (*see Figure 2*).

Financing Challenges

The key issues around financing of Bangladesh's health system are that existing financing methods do not cover the whole population, and available resources are not sufficiently pooled to provide protection against variance in individual or household expenditures. There has been little progress in increasing the coverage of healthcare financing mechanisms. Government spending in healthcare was 36% of total health expenditure, and OOP household spending was 57% in 1997. In 2007, government spending as a percentage reduced to 26% and OOP household spending increased to 64%.[2] Forecasting data shows that total healthcare expenditure is increasing and will continue to do so at a faster rate than public spending.[2] There is clearly a financing gap between what is needed and what is spent on health by the public sector.

"Second Generation" Policy Recommendations

Establish a national insurance system to provide financial protection and tackle evolving determinants of health

Direct tax collection or public compulsory financing should be enforced making the tax system pro-poor and progressive. A single national risk pool should be created to protect all groups from catastrophic financial expenditure. A strong regulatory body for health insurance independent of the Ministry of Health and Family Welfare that also acts as a purchaser of health services should be established. Regulations that enable the public-sector to compete with the private-sector should be developed. An independent body for mandatory licensing and accreditation of all facilities in the public, NGO, and private sectors (including diagnostic centres and retail pharmacies) should be created.

Invest to strengthen the capacity of the public sector in the context of a pluralistic health system and changing determinants of health

Public spending on health should be increased and the capacity of the GoB, specifically, the Ministry of Health and Family Welfare, should be radically strengthened to:

1. Oversee the shift from selective to comprehensive primary health-care service provision at scale; and
2. Safeguard standards for all health-care services and particularly the for-profit private sector.

During this transition to comprehensive primary care, there should be sensitivity and responsiveness to the evolving determinants of health. The right balance must be struck between patient-centredness and Cross-Ministry service provision to ensure optimal and healthy living conditions. The new national health package should include high quality and cost-effective interventions. Quality, accountability and coordination can be ensured by coverage of facility services with pay-for-performance systems and establishing regulatory mechanisms.

Introduce a national human resource for health policy

Investment in training institutes, particularly for non-physician healthcare roles such as nurses, midwives and paramedics, is a priority. Task shifting from physicians to other healthcare workers may also lead to cost-savings, efficiency and service coverage. Existing community health workers' roles could be expanded and utilised in the provision of health promotion and prevention initiatives including services for chronic diseases such as diabetes and heart disease. The emerging complex set of health-related challenges requires healthcare workers to be trained in public health management and educated on the importance of determinants of health out with the biomedical and medicalised realm.

Build an interconnected electronic health records system

Electronic and mobile health platforms provide innovative opportunities to increase the quality, coverage and responsiveness of health services. Universal mobile phone coverage and rapid improvements in internet speeds and coverage provide a productive environment for potentially revolutionary and transformative health applications. Current efforts using biometric identifiers such as fingerprints or retinal scans should be used in the health sector to record patient information across public, private and NGO providers, and ensure coverage and accessibility of services.

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