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# Poor People's Access to Health Services in Bangladesh: Focusing on the Issues of Inequality

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## Poor People's Access to Health Services in Bangladesh: Focusing on the Issues of Inequality[1]

### 1. Introduction

Majority of the people being poor depend on government health structures for remedies from illness in Bangladesh. Like many developing countries, Bangladesh is also exposed to plethora of economic reforms that resulted in creating widespread inequalities in the society in terms of resource accumulation. Bangladesh since independence achieved much progress in public health domain, but the rich and the politically blessed can extract major services from the public health system. Although, there has been dramatic improvement in the private sector health system, but unfortunately, they are meant to serve the rich only. The issue of inequality in health is steadily widening. Inequality is characterized in terms of accessibility, affordability, gender, and geographical location. The rural poor have been more marginalized than the urban poor.

The direct contribution of health to human capital formation and socio-economic development is unquestionable and well recognized. The case for investing in health has been further strengthened by a growing body of evidence, which shows that better health contributes to greater economic security and growth. Good health also reduces the work loss and increases higher enrolment in schools for children. Health constitutes an important element in both Human Development Index (HDI) and Human Poverty Index (HPI). Being healthy is a valuable achievement in itself, and can be of direct importance to a person's effective freedom. The burden of income erosion as the major outcome of poor health further affects the poor disproportionately. Thus, broadly, better health reduces poverty and reduces poverty improves health- a virtuous circle indeed.

Therefore, the importance of health can be interpreted in three broad dimensions: (1) intrinsic dimension, (2) instrumental dimension, and (3) empowerment dimension. From intrinsic point of view, it is a direct measure of human well-being and is an achievement in itself. It is the fulfillment of life and a valuable achievement in itself. In the instrumental sense, better health is important because it has an economic rationale. Better health reduces medical cost, both of the government and of the households. In the case of children, better health leads to better attendance in school and higher levels of knowledge attainment. Better education and knowledge leads to better paid jobs and larger benefits to the future generation. For women and the poor, better health means empowerment because it also empowers them to participate in economic and public life. Indeed a pro-poor health strategy is central to establishing a harmonious society.

On the other hand, unhealthy people are usually poor because they cannot work to earn a living. They are usually malnourished and susceptible to diseases and therefore unable to work either in the fields in rural areas or work in factories in the cities, and are therefore unable to obtain food, shelter, and clothing. Thus, they become poor, and because they are poor and they cannot obtain adequate healthcare and become unhealthy and sick and eventually they become poorer. We can describe this as a vicious cycle.

Inequality in health in effect leads to fragmentation of the society between the rich and the poor. However, arresting the persistently growing inequality is a must to building a harmonious society. The paper aims primarily to focus on the major areas or issues that contribute to creating inequality in health service in Bangladesh. The paper also aims to deal with the following objectives:

- To present the overall health system of Bangladesh to illustrate the issues of accessibility and availability.
- To capture the pro-poor perspective in development agenda by analyzing the national health policy and the PRSP of Bangladesh.

[1] The article does not reflect the position of the organizations the writers are working with and necessarily is written based on the individual capacities of the writers.

- To shed light on the governance crisis of health services of Bangladesh.
- To focus on strategies for developing a pro-poor health system in Bangladesh.

## 2. The State of the Art of Health Sector in Bangladesh

After 34 years of independence, the health situation is still dismal in Bangladesh. Different statistics shows that child and mother malnutrition rate (70%) in Bangladesh remains highest in the world, and more severe than that of the most other developing countries, including Sub-Saharan Africa (WHO 2000; Asiatic Society of Bangladesh 2002). The survey report of National Institute Population Research and Training (NIPORT), Mitra and Associates and ORC Macro (2005) shows that 48 percent under five children of Bangladesh are underweight, 13 percent severely underweight. Titumir (2005) describes that malnutrition contributes to over one half of total child deaths, with low birth weight estimated to affect 30% to 50% infants. Again 34% of women were found to have chronically malnourished in Bangladesh since, a high proportion of women (16%) are below the critical height of 145 centimeters.

Under-five mortality rate is 76 per 1,000 live births and in the case of infant mortality the rate is 53 per thousand. Maternal mortality rate is between 320 and 400 per 100,000 women, which is among the highest in the world and is still higher relative to many developing countries (Titumir 2005). A majority of infant deaths occur during the first month of life (neonatal mortality) (NIPORT, Mitra and Associates and ORC Macro 2005). Bangladesh ranks fourth on the list of the 22 highest TB burdened countries in the world. About 70,000 patients die of TB each year (Titumir 2005). The Sexually Transmitted Diseases' (STD) consciousness among people is very low as majority of the people are illiterates. Fertility rate in Bangladesh is 3.0 children per woman; compared to other Asian countries Bangladesh is lagging behind India (2.8), Indonesia (2.6), and Vietnam (1.9) (NIPORT, Mitra and Associates and ORC Macro 2005).

## 3. Health Administration in Bangladesh and the Issue of Accessibility

Total health system in Bangladesh is controlled by the Ministry of Health and Family Welfare (MOHFW), which is divided into two wings one concerned with Population and Family Planning and the other concerned with Health. Government healthcare service network is spread over the country from the capital to village level. The network service is provided through three approaches; such as primary care at upazila (sub-district) level; secondary care at district level; and tertiary care at division level.

Bangladesh has a surprisingly extensive health infrastructure throughout the country. The country has six administrative divisions and 64 districts while the districts are divided into upazilas (476 in number) and upazilas into unions (4,770). Each union consists of approximately 25,000 people and the unions are sub-divided into, in most cases, nine villages (Chowdhury 2004). While specialized hospitals are available at the divisional level, in some areas postgraduate hospitals exist and all districts have various types of hospitals (Siddiqui 2003). At the upazila level there are upazila health complexes (463), which are treated as the first referral centres for primary health care. These have been established to take the health service delivery system including the primary health care system to the doorsteps of the rural poor. Primary health care service is provided through four-tier systems i.e. upazila level, union level, ward level and community level. The standard set up for health services in an upazila consists of a health complex, union health & family welfare center (UHFWC) at union level (4062) and community clinics at village levels, however, the community clinics established under the Health and Population Sector Program (HPSP)- a donor driven mega program initiated a few years back, are not functioning now. The services at the upazila levels are divided into three units namely clinical services unit, support services unit and field services unit, all under the administration of upazila health and family planning officer (Siddiqui 2003). The total number of government hospitals in the country is 660 and the number of beds in government hospitals and dispensaries is 32,000 while the number of maternity and child welfare centers is 96. Each Union Health Centers has an available staff comprising of a Medical Assistant, trained for three years in disease prevention, health education, and basic first aid, and a Family Welfare Visitor, who receives 18 months of training in family

planning, reproductive health, and postnatal and prenatal care (Chowdhury: 2004). These health centers offer, other than general health services, minimal reproductive, maternal, and child health care services for the local people free of cost. The number of physicians and registered nurses relative to population is 241 and 136 respectively per million people while number of hospitals available for a million people is 10 and the availability of hospital beds is one for about 4000 people (Siddiqui 2003).

NGO and private sectors are also involved to provide reproductive health services. At present many NGOs have special program and facilities for providing antenatal care and safe delivery care. Beside this, there are private physicians and increasing number of service sites, especially in urban areas. There are innumerous private clinics spread throughout the country even at district and upazila levels to offer health service in privatized form. Although the private clinics are operated privately, many doctors of the public hospitals deliver services in those clinics in part time basis. These clinics are highly charged and work fully on commercial basis. Solvent people prefer private clinics for quality service, which they think is absent in the public hospitals. The private clinics are beyond accountability and control of the government in terms of service rates and health risks. Other than these, in the recent years a number of international level private hospitals have been established in Bangladesh, more specifically, in the capital city of Dhaka. Some of those are established with collaboration between the multinational companies and the local entrepreneurs. These hospitals have prevented some solvent patients from going abroad as they can receive the treatment of some foreign doctors and quality services equivalent to foreign hospitals there. But treatment costs in these hospitals are so high that common people don't dare go there.

Healthcare facilities in Bangladesh have made notable progress in the recent years. Over the last two decades, the number of hospitals and hospital beds has become more than double and the per capita availability of these facilities has been improved. The number of qualified physicians has also improved. Government statistics shows that physical facilities for provision of health care services have been improving throughout the country but the accessibility of the poor people to proper healthcare has not been improved.

In spite of having an extensive health care infrastructure the government services are not client focused, needs based, of high quality and within the reach of the poorest. Only 8 percent, of the rural population are able to avail these amenities and only 2 percent of mothers seek care for their sick child from the nearest Union Health and Family Welfare Center (Chowdhury 2004). Most of the rural people prefer the services of a *palli chikitshak*, a local village doctor without any degree. It is reported that 57 percent of the rural populace are usually treated by doctors without a degree, whilst only 31 percent were treated in the same manner in urban areas. It is also noted that around 50 percent of the rural women are not aware of the existence of Satellite Clinics in their areas. Another national survey undertaken by USAID shows that not even one percent of those surveyed had utilized the services of a Union Health and Family Welfare Center (Chowdhury: 2004). In most cases these clinics are used by the people located within only the half-mile radius areas of the centers. The government clinics are blamed for lack of quality care and attention towards the patients. The clinics are ill managed with poorly staffed manpower that lack career prospects and motivation. Recent data show that the top five percent of population enjoy 30.66 percent of the national income while the share of the poorest five percent shrank to meagre 0.67 percent (The Daily New Age: 2005). Again eighty-two percent of the national poor live in rural areas, 10 percent in municipal areas (cities, apart from the four largest), and 8 percent in metropolitan slum areas in Dhaka, Chittagong, Rajshahi, and Khulna (Chowdhury: 2004). While 70 percent of the population reside in rural areas, but most of the specialized hospitals sited in the urban areas and healthcare facilities are offered in the urban areas. Statistics shows that only 44 percent of the major government facilities are rural based compared to 56 percent in the urban areas; 28 percent of private clinics are rural based, while 72 percent are based in urban areas (Chowdhury: 2004). Moreover, the government rural healthcare centers are located on the basis of government's administrative convenience rather than of actual accessibility criteria and that in effect makes the beneficiaries inaccessible to the services. It illustrates that the majority

people are victims to a disproportionately low level of healthcare facility. On the other hand, though the bulk of the population of Bangladesh lives in the rural areas, most doctors are based in cities and towns serving a meager number of populations. The poor economic condition of the people living in rural areas and the scarcity of civil amenities at rural areas are the major reasons for this.

The current healthcare policies, not only of the government but also of the private sector and of the NGO's, are biased against the poor. The private hospitals and clinics don't create wider access to the majority people of the country. The recently established international quality hospitals have established to arrest exclusively the high-income bracket of the population. Although they have some free beds for the poor people but the hard core poor and the common people are not able to reach their door for free bed service and there is lack of proper mechanism to create opportunity for these poor people to avail these offered facilities. Even the NGOs, which are by law supposed to be non-profit and purely welfare-oriented, are also using the criterion of convenience i.e. situated nearer to the urban centers ignoring the greatest need for the poor of rural areas. It is explored that NGOs have only 40 percent of their healthcare units in the rural areas, while 60 percent are in cities (Chowdhury: 2004).

## 4. Challenges of Health Care Service of Bangladesh

- *The Challenge of Population Growth*

Bangladesh with a limited area of 147,570 sq. km has a large population of 141.8 million causing the highest population density (more than 900 per sq. km.) in the world (except some island countries and city states). Population growth rate is still high and according to UNFPA Report 2005 population is expected to stabilize by 2050 at around 242.9 million, which will further aggravate the population density situation (The Daily Prothom-Alo: 2005). Moreover, the number of elderly population is increasing since the life expectancy has been increased; urban population are increasing and the size of slum dwellers is also increasing accordingly; early marriage of girls is still high. No doubt, the existing population size itself is very big one and it is not easy to ensure proper balancing between human numbers and their needs and the resources and providing proper medical facilities to this large number of population.

- *Poverty*

Since independence in 1971, Bangladesh is struggling to emerge from the realm of poverty and improve the standard of living of her population. But in spite of receiving large amount of foreign aid it has not been possible to achieve the goal and the rate of poverty reduction is still low. In the last five years the average rate of poverty reduction is about 0.52 percent per year, while the rate is only 0.32 percent per year for rural areas during 1999 - 2004 (Titumir 2005). The poor people are neither capable of bearing their health expenditure nor conscious of health, nutrition, and sanitation. Pervading poverty is, therefore, a major challenge for ensuring health care for the growing number of population.

- *Changes in the Spectrum of Diseases*

The spectrum of health situation has also been changing in Bangladesh with the global scenario changes in health over time. The disease patterns have been shifted in the recent years. Bangladesh is experiencing the resurgence of malaria, *kalazar*, and other deadly diseases such as dengue, filariasis, tuberculosis etc. Sexually transmitted diseases like Human Immunodeficiency Virus (HIV) is creating threat to the whole humanity. Moreover, the cardiovascular disease, renal disorders, mental illness, cancer and conditions related to substance abuse, smoking and alcoholism are increasing throughout the country. Arsenic in sub-soil water in many areas is remaining as a potential threat to human health. Epidemiological transition and age-old infectious and emerging new diseases as well as metabolic disorders, malnutrition, tuberculosis, reproductive health, diarrhea, respiratory tract etc continue to influence the health status of the population. It is really a challenge for Bangladesh to overcome, with existing health system, the upcoming challenge regarding public health to the growing number of population. Modernization and renovation of the health sector for ensuring quality service and wider access to common people is, therefore, getting importance to all concerned.

- *Insufficient Budget Allocation*

Although the population of the country is increasing rapidly, the expansion of health facilities and allocation for health is not increasing with the same pace. The percentage of health budget to GDP is quite negligible (only 1.5%). Study report, conducted by the health economics unit of the Ministry of Health and Family Welfare, shows that the public sector finance was only 34 per cent of health expenditure while the household fiancé 64 per cent and the NGOs only 2 per cent. The annual allocation to the hospitals per bed is negligible in Bangladesh. The hospitals attached to the medical colleges receive annual allocation of Tk. 25000 per bed while the district level hospitals receive Tk. 18,000 and the upazila health complexes receive Tk. 10,500 per bed (Asiatic Society of Bangladesh: 2002).

Although the public hospitals offer free services and the government policy include free distribution of medicine to the patients, the reality is different. The provided medicine is far less than the requirement. The allocation for the urban dispensaries of each hospital amounts Tk. 70,000 per year and the amount is Tk. 40,000 for the union health and family welfare centers (Asiatic Society of Bangladesh: 2002). Moreover, corruption and malpractice are prevailing in the hospitals and health centers; the provided medicine is sold privately by the corrupt officials. This is why poor patient don't find any necessity to go to the public hospitals and prefer to go to the *palli chikitshaks* for immediate prescription and medicine.

- *Poor Health Knowledge*

Another setback in the public health care system is that most of the projects and programs are based on curative measures, which is much expensive and more complicated. Practices of healthy lifestyles and nutrition habits; health education and health research; prevention programs etc. are negligible and, in many areas, absent in Bangladesh. We see that most of the treatment and equipment facilities prevailing in our hospitals are based on western types of diseases and the indigenous disease-based treatment facilities are underdeveloped in our hospitals. While the medical practitioner remaining unnecessarily biased to west centric treatment system ignoring our local ethos, the poor people also do not know their rights.

5. **Governance Crisis in Health Care Services**

- *Administrative Mismanagement*

There are also administrative mismanagement and deficiency of medicine and medical facilities for the majority of people living at the rural areas. In the recent years physical facilities have deteriorated in most Upazila Health Complexes. Modern technologies are not available in those hospitals and in some cases existing high-tech equipments are ruined due to non-operation in short of technicians. Training opportunities for nurses, laboratory x-ray and other health sectors technicians are very much limited. Bangladesh has the scarcity of health personnel with only 246 physicians and 136 nurses per one million people. Poor staff practices is a major problem in many Upazila and Union Health and Family Planning Complexes with high levels of absenteeism, informal user-charging, unwilling to work, regarding postings as 'punishment' etc. Moreover, wrong treatment, negligence towards patients, non-attentiveness, irresponsibility, absence from duty, and unwillingness of doctors to stay at rural areas and small towns are the other problems in the public health sector of Bangladesh. There are also problems related to supplies, equipment, beds, ambulance services, proper referral services etc.

Hospital management is said to be very poor in Bangladesh. There is little scope for training courses for the health administrator and on the contrary the trained officers are not posted in the respective places. Qualified doctors are not posted in the right place and in most cases posting is influenced, and sometimes, decided by BMA (Bangladesh Medical Association), the highly politicized professional organization of the physicians. The professional organization is also blamed for influencing health administration and working against people's interest. Professional regulation in medicine, nursing and dentistry is much little in Bangladesh and mechanism to bring

the service provider under accountability is also very poor here. As a result these hospitals and health centers no longer enjoy public confidence and are underused.

- *Crisis in Personnel System*

The low level salaries offered to the doctors have led them to private practice. Lack of promotion prospects reduces their motivation and working inspiration. There are instances that doctors are taking retirement as medical officers, the same post they have joined in nearly three decades ago. For all these reasons a recent study showed that 76% of doctors do not remain at their posting places (Chowdhury: 2004). They don't receive further training and their medical knowledge is not up-to-date to treat the modern diseases with changing methods of treatment. Doctors are allowed to private practice, which leads them towards more income and diverts them from their hospital duties. Doctors of the public hospitals are blamed for referring patients to paid treatment or paid operation in their own private clinics or even receive illegal charge for treating privately during hospital hours and within hospital premises. With all these things there prevails a vicious circle whereby their vested interests keep public sector service quality relatively low (Pearson: 1999).

- *Monitoring and Accountability*

The public hospitals lack proper monitoring mechanism and system of accountability. Absence of strong local government system has made the public hospitals and health centers guardian-less. Practice of trade unionism by the lower employees, illegal and unethical practices by the contractors (food and other commodity suppliers etc.), organized pressure from the nurses community, irritation created by the medical representatives (sale agents of the pharmaceutical companies) and the *dalals* (agents) of the private clinics have made the hospital environment polluted where the interests of the patients is meagerly protected. The doctors are also blamed for prescribing unnecessary examination and diagnosis suggestion to the patients since they get commission from the diagnosis centers. There is currently neither monitoring mechanism for seeking redress against the violation of right to health, nor for holding the violators to accountable. The doctors and the other service providers, therefore, get immunity of their negligence, inefficiency or wrong treatment causing health hazards and sufferings to the patients.

- *Policy Incoherence*

Policy incoherence is another major problem in Bangladesh political culture and it is also evident in the health sector. In the former HPSP project there were plans to have a 'community clinic' in every village. But after construction of huge number of community clinics the project has been abandoned leaving both a huge amount of spent money and large area of occupied land unutilized. Bifurcation of health and family planning sector and further reunification and again bifurcation is another typical instances of policy incoherence. Donor orchestrated reforms failed to earn public confidence and provide appropriate approach.

- *Lack of Coordination*

The Ministry of health & family welfare is responsible for health and family planning activities in Bangladesh. Health services and family planning services are run by two entirely separate arms of the Ministry of Health and Family Welfare (MOHFW). Other than government agencies some NGOs also run health and family planning activities throughout the country. But the government agencies lack coordination among themselves and also with the NGOs. There are duplication of programs, which cause misuse of resources and facilities; on the other hand, a large number of potential beneficiaries are remaining out of reach. Lack of coordination among the government agencies cause mismanagement and sufferings to the service seekers. Vaccination program conducted by different agencies is a typical instance of duplication.

- *Corruption*

The health sector of Bangladesh is not out of ubiquitous corruption prevailing in the country. The government policy provides that all citizens will get free services in all government facilities but informal and unofficial charging is widely practiced. The Baseline Service Delivery Survey for HPSP conducted in 1999 found that 22% of people make an extra payment to the workers when

they visit government health services and 27% pay an unofficial registration fee. However, over half of people surveyed responded that they are willing to pay for improved government health services (WHO: 2000). Corruption also prevails in the field of purchasing health materials, supplying food to the hospitals, distribution of medicine, use of ambulance, transfer and posting of health personnel etc.

### 6. National Health Policy of Bangladesh and the PRSP

The government of Bangladesh has adopted National Health Policy in 2000. This is a strategic directive and indicator to the mechanism of exploiting available resources to realize the Government's vision for addressing the health issue of the country. Prior to this, public health policies had been guided by the five-year plans of the government. The fifth-five year plan was coincided by the Health and Population Sector Program (HPSP) launched in July 1998 by the donors to guide reforms in the health and population sector. The five-year health and population sector program (HPSP) based on the Health and Population Sector Strategy (HPSS) called for setting up one community clinic for each local population group of 6,000 where all elements of the essential service package (ESP) are to be made available through "one-stop service" at health centers throughout the country. It was envisaged that the policy would facilitate decentralization of services and introduction of an "inclusive process" which would seek out the participation of the local population and local government institutions. The program also included community based healthcare scheme for the entire population at four different levels of delivery. The levels are: community out-reach, health and family welfare centers, rural dispensaries, upazila health complexes as first referral system and district hospital as second referral system (WHO: 2000). Under this program a huge number of community clinics had been set up in different parts of the country to provide primary health care facilities. The unification of two departments of healthcare service i.e., the health and family planning was another distinctive feature of this program.

With the change of political regime the subsequent government has abandoned the HPSP program and, has undertaken another framework namely Health, Nutrition and Population Sector Program (HNPSP) for the period July 2003-June 2006 (CPD 2003). This document was envisaged to redefine the direction of GOB in the HNP sector for the next three years. The major shift in this program was to abandon the concept of community clinic and bifurcation of the health and family planning departments, which were unified in the HPSP period.

In the recent years the government of Bangladesh, as aid conditionality from the donor agencies, especially from the World Bank, has formulated Poverty Reduction Strategy Paper (PRSP) as its strategic guideline for development activities of the country. It has replaced the former five-year planning and works as an indicator to all the government programs and policies and as the 'road map' for overcoming the poverty situation with the positive values of participation from all walks of people and national ownership (Siddiqui: 2003). Since the PRSP is now working as the only strategic guideline paper for the government for the following years, it was expected that the paper would incorporate all the burning issues including the health issue and its crises. But unfortunately, the PRSP did not take government's primary responsibility in addressing major public health problems and did not give due attention to addressing these problems. It didn't maintain policy coherence since it has ignored majority of the objectives of the National Health Policy (Siddiqui: 2003). We didn't find any initiative in the PRSP to address the overall governance crises of the public sector including health sector. The strengthening of local government institutions and increasing coordination among the government machineries are also absent in the paper. We also don't find any major thrust to emphasize on health research and considering the heath issue at the top of government priority list. The PRSP has also ignored the inequality issue and no measure is found to minimize the rural urban gap and equitable distribution of resources and amenities among the people. Considering the overall situation Siddiqui (2003) has rightly commented that the right to health has totally been ignored by the PRSP in the sense that it does not have specific solutions to the questions of availability, accessibility, acceptability, monitoring and accountability.

## 7. Recommendations

It is now evident that problems are prevailing in the health sector regarding health policy, health budget, health personnel, health infrastructure, extension of health service, health administration, peoples' participation, medicine supply, the issue of accessibility etc. The problems related to the physicians include inadequate number of physicians, wrong treatment, negligence towards patients, non-attentiveness, irresponsibility, absence from duty, lack of professional ethics, and unwillingness to stay at rural areas and small towns. The other problems are related to supplies of medicine and ambulance, equipment, beds, proper referral services etc. There are also significant problems related to health bureaucrats, employees and nurses.

In response to the prevailing problems and changing health situation of the country, reforms in the health sector, particularly in the areas of management structure, service delivery mechanisms, accessibility of the common people and utilization of both public and private sector resources are called for urgent solutions. Bangladesh requires a need-based, pro-poor and feasible program for the health sector, which will be formulated through a completely participatory approach with the opinions of the stakeholders. Bottom up policy planning system should be introduced in the public policy formulation. Donor driven top-down and incoherent policies and programs will not create any positive impact on the situation.

Overall government administrative system requires renovation and reformation for proper functioning of the organs of the government. The government machinery should be decentralized by giving proper authority and autonomy. Central monitoring and evaluation system should be strengthened to bring the service providing agencies into accountable so that no violation of rights go with impunity. The local government system should be strengthened and given the responsibility of proper functioning of rural health care service system. With the help of local government institutions (LGIs) decentralized service delivery will be possible through satellite clinics and EPI for out reach and grass root level people. Government may empower the LGIs by vesting the responsibility of the public health centers for local level planning and better implementation of programs. Community Based Organizations (CBOs) may also, under direct supervision of and joint collaboration with the LGIs, experimentally manage some rural health centers. The NGOs working in the remotest areas of the country may also cooperate the government institutions by extending health network in those areas. Scholars also suggest to establish community-based health financing system and health insurance and health credit programs for the poor people of Bangladesh (Siddiqui: 2003). The extensive network of the NGOs can also help government to increase the consciousness regarding health, sanitation and family planning among the poor and rural people.

It is evident that health budget, in Bangladesh, remains extremely low ($4 per capita) and should be enhanced. Unless the public spending in health is enhanced it is not possible to ensure healthcare for the growing number of and poverty-ridden people of Bangladesh. The health budget should be at least 2% of GDP (Now 1.3%) in line with other South Asian average (2.51%) (Siddiqui: 2003). Since the access of people to public health centers is low, and the private health practitioners and arrangements like private clinics and hospitals are the major service providers in Bangladesh, government attention should also be given to these private clinics and hospitals. Government may give subsidy to the private health care centers or tax relaxation so that the poor can get care in lower price. Proper and regular training should be provided to the *palli chikitshak* (Village doctors) in rural areas so that they can ensure primary healthcare to the rural people. Regular training should also be provided to the doctors as well as the nurses and health technicians working in the public sector.

Lifestyle of our people including health and nutritional behavior, food behavior, sanitation behavior should be amended for protecting their health. Preventive programs and consciousness building programs is inevitable for this. Community leaders and the religious leaders can play active role in increasing consciousness of people. Mass media are also important agent to creating consciousness regarding healthcare services and rights of people. Health related social

research is necessary to explore the health behavior of our people and accordingly to undertake suitable policies and programs for them.

## 8. **Conclusion**

Health care is a fundamental human right and ensuring healthcare service is a constitutional obligation of the government. There prevails an inter-linkage between health and poverty that poor people are victim to ill health and people with ill health are more prone to poverty. Study conducted by Health and Demographic Survey shows that 41 percent of rural people who were sick lost an average of 10 days of work. Per capita annual treatment cost is around Tk. 900 in urban areas and Tk. 600 in the rural areas (Asiatic Society of Bangladesh 2002). The attainment of sustainable poverty-reducing programs requires achieving basic thresholds in several key areas among which health is the most important one. It is well accepted that the target of MDGs will not be possible to achieve within the stipulated time until and unless the health status of the people is ensured. A healthy nation is necessary for poverty reduction, economic development, social harmony, national integrity, and national dignity. And attainment of health target accessibility of the common people to the existing system should be ensured first. Other than government, the NGOs, the civil society organization, mass media, the academicians and the donors can play role for attaining this target.

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**Annexure: A**

**Table 1: Health Statistics of Bangladesh**

| Indicator | Number / Rate / Ratio |
|---|---|
| Total Population | 141.8 million |
| Population density (Per Sq. Km.) | 900 persons. |
| Population Growth Rate | 1.4% |
| Total Fertility Rate (TFR) | 3.0 |
| Maternal Mortality Rate (MMR) | 320-400 per 100,000 |
| Infant Mortality Rate (IMR) | 53 per 1000 live births |
| Under 5 Mortality | 76 per 1000 live births |
| Life Expectancy at Birth | 61 years |
| Male | 61 years |
| Female | 61 years |
| Medical university | 1 |
| Medical college and hospital | 13 |
| National institute | 5 |
| Infectious diseases hospital | 6 |
| TB hospital | 4 |
| Chest hospital | 45 |
| Leprosy hospital | 3 |
| Mental hospital | 2 |
| Paramedic institute | 1 |
| Dental college hospital | 2 |
| Rural Health Center | 13500 |
| Union Health and Family Welfare Center (UHFWC) | 4062 |
| Upazila Health Complex | 463 |
| Government District Hospital (at secondary level) | 80 |
| Post Graduate Hospital (at tertiary level) | 6 |
| Specialized Hospital (at tertiary level) | 25 |
| Doctors | 246 per 1 million people |
| Nurses | 136 per 1 million people |
| Total number of Registered Doctors | 33573 |
| Total number of Registered Nurses | 17233 |

***Source***: *(WHO 2000; CPD 2001; Asiatic Society of Bangladesh 2002; Siddiqui 2003; Titumir 2005; NIPORT, Mitra and Associates and ORC Macro 2005; The Daily Prothom-alo 13-10-2005)*