CHAPTER 2

BACKGROUND OF HOSPITAL SERVICES IN BANGLADESH

2.1 Description about Bangladesh

The People's Republic of Bangladesh became a sovereign state in 1971, following the war of liberation. The territory now constituting Bangladesh was under the Muslim rule for over five and half centuries from 1201 to 1757 AD. Subsequently, it was under the Subjugation of the British, after the defeat of Nowab Sirajuddowla at the battle of Palassy on the forceful day of June, 1757. The British ruled over the entire Indian sub-continent for nearly 190 years from 1757 to 1947. During the period Bangladesh was a part of the British Indian province of Bengal and Assam. With the termination of the British rule in August 1947, the sub-continent was partitioned into India and Pakistan. Bangladesh was then a part of Pakistan and was known as East Pakistan and remained so for about 24 years from August 14, 1947 to March 25, 1971.

Bangladesh is an independent country, having area of 147570 sq. km (56977 sq.miles), surrounded by India in the north and west, India and Myanmar in the east and Bay of Bengal in the south. The population is 113.2 million with 106 : 100 male and female ratio respectively, the density of population is 755 per sq. km. Average literacy rate is 32.4%. Main seasons are Winter (November-February), Summer (March-June), Monsoon (July-october). The average maximum temperature in winter is 29^{0} c and minimum 11^{0} c, in summer the average maximum temperature is 34^{0} c and minimum is 21^{0} c, in monsoon average rainfall is 1194 to 3454 mm.

2.2 Economic Status of Bangladesh

There are three measures of national income of a country; a) the sum of values of all final goods and services produced, b) the sum of all incomes, in cash and kind, according to factors of production in a year and c) the sum of consumers' expenditures and government expenditures on goods and services. It is remarkable that agriculture plays a vital role. The annual growth has decreased in 1992-93, in comparison with 1991-92. There is increasing trend in transport, storage and communication sector, public administration and defence is in decreasing trend. The population is increasing by 1.8 million every year and the annual per capita GDP in 1990-91 was 180 US $, in 1991-92 was 190 US $ and in 1992-93 was 200 US $, which is also in increasing trend. The health sector has no direct role in economic growth, as because the health sector directly do not make any profit, but it indirectly contributes for the economic growth of the country. If a person remains healthy he can work and contribute to the country and to the society, but if a person is sick he cannot contribute, after

treatment and recovery, as soon as possible he can contribute.

2.3 Importance of Economic Status- Why and How ?

Economic considerations play a key role in all aspects of life : in agriculture, housing, industry, trade and in health. In addition, the nature and level of a country's economic development can be shown to be a major determinant of its epidemiological profile, and is clearly associated with the level of health service and health - related activities a country can support. Its ideological commitment, economic philosophy, and organizational structure will then shape how much of, and where, such activities are provided. Health policy and its implementation is thus strongly influenced by macroeconomic considerations.

At the same time, the health of a population can itself influence economic progress. Health programs have therefore come to be seen as a part of a comprehensive strategy aimed at improving the social and economic welfare of populations. Such a strategy demands the selection of those programs which improve health most efficiently: health services, or the provision of other infrastructure such as water and sanitation.

The reappraisal of health policies in a number of developing countries has involved questioning the merit of any existing forms of care, and the past strategies and priorities. Choices on how best to improve health exist every where, but such choices in poor countries are both crucial and difficult. Efforts to widen the choices to be considered for delivering health services and for encouraging health-promoting activities are therefore, highly relevant.

They are particularly relevant in the economic context of poor countries. Health services absorb a significant proportion of both government expenditures and family budgets. They also demand scarce foreign exchange for drugs, equipment, and transport, and many countries are experiencing escalating medical costs. governments are actively seeking ways of containing costs and increasing efficiency (Lee and Mills,1992).

2.4 Economic Conditions of Bangladesh

The Finance Ministry's 'Economic Survey 1993-94', from July 1993 to March 1994 shows that progress of the development projects was only 9%. This is no exceptional example, in the last year of the 4th 5-year plan which will end in June 1995, most of the projects could not show any satisfactory progress. Like the previous 5-year plans, this one is also going to end with negligible success in implementing projects.

Development Scenario : Projects under a 5-year plan are implemented through the Annual Development Program (ADP). A picture of

the development scenario will unfold if the ADP of 1994-95 financial year is outlined showing the different fates of the various projects of that year. In the 94-95 ADP there were 652 projects. During the first months of the financial year, there was very little progress in 215 projects. Work on 194 projects is zero, and the implementation of 324 projects is at a snail's pace. This has been reported recently by the Planning Ministry's Implementation, Monitoring and Evaluation Division (IMED). (Dhaka Courier, Vol.11, Issue 30-31, 27 February 1995).

Implementation of the 4th 5-year plan began from October 1990. The major objectives of the 4th 5-year plan was to
a) accelerate economic growth b) alleviate poverty and generate employment through human resource development, and c) increase self-reliance. For poverty alleviation, the important strategies that have been emphasized are; i) the integration of group based planning with sector based planning ii) community participation in centrally executed projects whenever possible; and iii) decentralized participatory local level planning.In addition; improved inter-sectoral balance and management efficiency both in public and private sectors, are expected to promote higher rate of growth of GDP and greater self-reliance in domestic resource mobilization. Another major objective of the 4th 5-year plan was to attain self-sufficiency in food.

Sector wise allocation: According to the document of the 4th 5-year plan the total size of the plan has been estimated at Tk. 689300 million at 1989-90 prices of which Tk. 419300 million has been allocated to the public sector and Tk.270000 million to the private sector. Whereas in the last 5 ADPs in the public sector total allocation was Tk. 324680 million. No reliable current figure is known for the private sector investment. However, at a discussion meeting organized by Economic Reporters Forum the State Minister for Planning said the outstanding failure of the 4th 5-year plan is not being able to achieve the investment target for the private sector. Whatever investment has been made is not worth the mention. Another fact has to be noted here : in 1990 the value of Bangladesh currency was high. At that time (1989-90) according to the rate fixed by Bangladesh Bank one US$ against was Tk. 32.89, and now the rate is more than Tk. 40.00.

In the 4th 5-year plan in the public sector the allocation for rural development agriculture and water resource development was Tk. 110,210 million; in industrial sector Tk. 41,800 million, electricity, oil and gas Tk. 88,500 million;transport and Communication sector Tk. 74,730 million; physical planning housing and water supply sector Tk. 12,410 million; health Tk. 10,670 million; population control and family planning sector Tk.17,100 million; socio-economic infrastructure Tk. 5,850 million, manpower and labor TK. 760 million; public administration Tk.1,300 million and block allocation Tk. 31,200 million.

In 1990's 4th 5-year plan was prepared and launched. Subsequently in 1992 the plan was amended and the size of the plan was reduced. Amended 4th 5-year plan had a GDP target of 5%. Out of this in the agriculture sector 3.4%; industries 9%; electricity, oil and gas

9.2%; construction 5.9%; transport and communication 5.4%; trade and other service sectors 5%; housing 3.6% and public welfare sector 10.7%. But the GDP of the 1st, 2nd, and 3rd year of 4th 5-year plan instead of reaching the set annual target of 5%, could only attain 3.4, 4.2 and 4.5% respectively, claims government sources. Mentionable that the GDP in 1989-90 was 6.6%.

In most of the developed and the developing countries health care delivery system, specially the hospital services is divided in two major sectors a) Public and b) Private.

In public sector the services are of two types a) preventive health care for control of communicable disease, and b) curative health care, which is hospital based. In preventive care the government bears the expenses of drugs, vaccines, manpower. In curative health care most of the countries have introduced the system of payment for hospital services in different manner, such as, registration fee, cost for drugs, insurance etc. But in Bangladesh hospital services at the thana health complexes and the district hospitals are absolutely free in the sense that, the patient or the people are not to pay for the service in any form. Moreover, there is no health insurance scheme as yet. The government alone is to pay and run the hospital services and the health services as a whole.

In the developed and the developing countries the health sector is expanding by establishing private hospitals as an industry, which is absolutely on payment for the service. On the contrary in Bangladesh there are some private clinics or private hospitals which are growing very slowly.

Table 2.1 : Indicators of the National Accounts, Finance and Banking.

(Million Taka)

	1990-91	1991-92
GDP(Current)	834392	906502
GDP(Constant)	514442	536189
GNP(Current)	810835	882861
Per capita GDP (Current factor cost)	7156	7621
Per capita GDP at factor cost (constant 1984-85) Tk.	4412	4508
Total receipts	146548	160559
Tax (%)	9	11
Foreign aid (%)	42	38
Total Development Expenditure	52898	60240
Total Government Expenditure	125549	140222
Agriculture	7298	7439
Industry	9402	4494
Defence	11205	13029
Debt repayment	11316	12840
Govt. Gross Fixed Capital Formation	36303	38554

Source: Statistical Pocketbook,1993, BBS
Note : Taka is a currency of Bangladesh.

The above Table 2.1 indicates the national accounts, finance and banking based on GDP, GNP, tax, Percentage of foreign aids, Sector wise government expenditure in agriculture, industry and defence and capital formulation. It is remarkable that the per capita GDP, GNP is in increasing trend while the foreign aid is in decreasing trend.

Table 2.2: Gross National Products of Bangladesh at Current Market Prices.

(Million Taka)

Sector	1990-91	1991-92	1992-93
1. Agriculture	300596	312438	324804
2. Mining and quarring	112	134	141
3. Manufacturing	72801	82571	90759
4. Construction	47261	53590	56758
5. Power, Gas, Water & Sanitary services	11201	14011	16650
6. Transport , Storage and communication	96697	108672	113395
7. Trade services	68279	73766	78575
8. Housing services	73867	79055	85930
9. Public Administration and Defence	38191	43406	49020
10. Banking & Insurance	16229	17793	19295
11. Professional and Miscellaneous services	108088	121066	134865
12. GDP at current market price	834392	906502	970192
13. Indirect Tax, Net of Subsidies(-)	50070	57492	65078
14. GDP at current Factor cost	784322	849010	905114
15. Net factor income from rest of the world(+)	26513	33851	33851
16. GNP at current factor cost	810835	882861	938965
17. Net national products (income)	751975	818979	870389
Population (million)	109.6	111.4	113.2
Per capita GDP at factor cost (Tk)	7156	7621	7996
Per capita GNP at factor cost (Tk)	7398	7925	8295
Per capita NNP (National income)	6861	7352	7689

Source: Statistical Pocketbook, 1993, BBS
Note : Taka is a currency of Bangladesh.

Above Table 2.2 indicates the sector wise, year wise, gross national products at current market price, are in increasing trend in all the sectors, which reflects the economic growth. The growth in health sector is not mentioned in the above table separately but included in the professional and miscellaneous services shows in No. 11 includes the growth of health sector.

Table 2.3 Annual Growth of GDP by Sectors.

(Percentage)

Sector	1990-91	1991-92	1992-93
1. Agriculture	1.6	2.2	2.1
i) Crops	1.2	1.7	1.3
ii) Forestry	2.1	2.4	2.6
iii) Livestock	2.2	3.6	4.9
iv) Fisheries	5.8	6.5	6.6
2. Mining and Quarrying	21.2	17.5	1.1
3. Manufacturing	2.4	7.3	7.7
i) Large Scale	2.0	10.5	11.0
ii) Small Scale	2.9	2.9	2.9
4. Construction	4.5	4.4	4.2
5. Power, Gas, Water, and Sanitary	20.5	17.5	12.4
6. Transport, Storage, and Communication	3.1	4.1	4.3
7. Trade Services	3.9	4.0	4.9
8. Housing Services	3.4	3.4	3.5
9. Public Administration and Defence	9.7	8.3	8.6
10.Banking and Insurance	2.4	2.5	2.6
11.Professional and miscellaneous services	6.2	6.4	6.4
12.GDP at Market Price	3.4	4.2	4.3

Source: Statistical Pocketbook, 1993, BBS.

This Table 2.3 is about sector wise annual growth of GDP from 1990-93. In almost all the sectors, the growth is in increasing trend, while mining and quarrying, construction, power, gas, water and sanitary services are in decreasing trend. Professional and miscellaneous services which includes the growth in health sector care remains constant during the last two years (1991-92 and 1992-93).

Table 2.4 Annual Health Expenditure by the Government.

(Taka in million)

Year	Expenditure	GDP deflator	Real health expenditure
1989-90	3356.24	1.41	2380.31
1990-91	3943.57	1.48	2664.57
1991-92	4017.55	1.62	2479.97
1992-93	4968.87	1.69	2940.16
1993-94	5995.79	1.73	3465.77

Source: Budget Book, 1989-90 to 1993-94, Ministry of Finance, Government of Bangladesh.

The above Table 2.4 indicates that the annual health expenditure is increased every year since 1989-90 in real term until 1993-94, but in the year 1991-92, health expenditure decreased remarkably.

Health Policy :

The government is committed constitutionally to provide health services for every citizen of the Peoples' Republic of Bangladesh; in view of this the government is trying to bring the health services to the door step of the common people, but there is no approved health policy as yet. In 1990 the government formed a high powered committee to formulate a health policy. The committee has formulated a policy and submitted to the government. Subsequently it could not approve and materialized. Now, it is an immense need to formulate and approve a health policy with the consensus of opinion of the government, provider and the consumer containing the peoples' expectation, how much provider can contribute and how much the resources the government can allocate for health.

2.5 Structure of Hospital Services

Bangladesh is a country having 113.2 Million population, out of which 85% of them are residing in rural areas and depends on agriculture. Administratively the country has been divided into 6(six) Divisions, 64 (sixty four) Districts, 460 (four hundred and sixty) Thanas and 4451 (four thousand four hundred and fifty one) Unions.

There are teaching hospitals, General hospital and Specialized hospitals at the national level, at the Division level there are teaching hospital ranging from 650-1050 bed facilities. Each District headquarter has 50-250 bed hospital which depends on the area, population size, density of population, importance of the district with respect to road and railway communication systems,but most of the districts have 100 bed hospitals. There are 460 Thanas, out of which 63

are in urban areas and 397 in rural areas. Each of these 397 thana has 31 bedded hospitals,which is known as "Thana health complex" but physical infrastructure in 359 Thana health complex has been constructed, and functioning uniformly throughout the rural areas of the country, having full strength of manpower consisting of 8 Doctors including 3 specialists. The rest of the Thana health complexes are under construction. There are 4451 Unions; out of these, only 2800 have health centers which are known as "Union health center",established and functioning with only Out patient department (OPD) facilities. These are the primary level health institutions. Countries hospital bed position is 0.3 per 1000 population.

There are five types of hospitals in Bangladesh . The number of each type of hospitals are summarized in Table 2.5, and a brief characteristics of each type of hospitals are described below.

The following paragraphs describe the characteristics of these types of hospitals.

Table 2.5 Structure of Hospital Services in Bangladesh.

Level of hospital	Nature of hospital	Number of hospital	Number of bed/hospital
National	Specialized	14	30-300
	Teaching	2	650-1050
	General	2	500
Division	Teaching	6	650-1050
District	District hospital	59	50-250
Thana	Thana health complex	397	31
Union	Union health center	4451	* OPD

* Out Patient Department

Specialized hospitals are situated in the National level. The bed facility of these hospitals ranges from 30-300, and are equipped with sophisticated equipments. In these health institutions they deal with only one disease or with associated diseases. As because of limited number of institutions these hospitals are also over crowded with patient.

Teaching hospitals are situated in national and divisional levels and are used as the laboratories for the medical students, having 650-1050 bed capacity depending on the annual intake of

students, criteria for student bed ratio (minimum 1:5) according to the standard of British Medical Council, demand of the locality and are attached to the Medical colleges, but having separate administration. These hospitals are well equipped with modern equipments and specialist in different fields. Because of the presence of the modern equipments, the patients attend these hospitals from the different parts of the country and create over crowding.

General hospitals are normally 500 bedded and situated in National level to provide treatment facilities for all kinds of diseases. If any patient has some other complications and need specialized treatment, they are referred to relevant specialized hospitals, otherwise these hospitals treat all types of patients who need medical care concerning medicine, surgery, gynecology / obstetrics, paediatrics, dental, ophthalmology, ear nose and throat etc.

The District hospitals are situated in each district headquarter and in urban areas with generally 100 beds each, Because of its location in urban areas, the doctors and staff are interested to stay in those areas and provide services. In these hospitals also, the annual budget allocation for drugs is fixed, and provides drugs to the patients free of charge, but the budget is not sufficient to meet the requirement of drugs for one year, as a result the patients are to buy drugs from the market, which are not available at the hospitals. As because of its location, communication and availability of equipments and services, people consume more services beyond hospital capacity and thus create excess demand and over consumption. In that case the hospital has to manage extra beds and sometimes the patients have to stay even on floor. Some of the District hospitals have bed occupancy rate 33%, and some have 192% ; the average bed occupancy rate is 112%, consequently the staff can pay less attention to the patients in respect of time and other services.

From the records, it is evident that the Thana health complex has 52% bed occupancy rate, but in average the district level hospital has 112% bed occupancy rate, which indicates that the people prefer to avail treatment facilities from the district hospital, rather than Thana health complex, though Thana health complex are nearer to them, but the services are under consumed. Consequently, the district hospital become over crowded and is to manage extra beds to provide the services to the patients. The budget allocation and distribution of manpower remains the same. The quality of care at the District hospital is better than local hospitals,but due to over utilization the quality of services decreases to some extent. In these hospitals modern equipments are more, laboratory examination are free, no registration fee, always need extra beds.

Since most of the people are staying in rural areas, the Thana health complex are the nearest hospitals, which provide the treatment facilities to the rural population. But the fact is that most of the rural people prefer using the District hospital rather than the thana health complexes, resulting in the under utilization of the Thana

health complexes and over- utilization of the district hospitals.

It is, therefore, the focus of this study is to assess the impacts of this over-utilization of the District hospital. Since it is not feasible to do the empirical study of such impacts,the study thus will try to develop the methodology for assessments of the impacts of such overutilization.

The Thana health complexes are situated in Thana headquarter and in rural areas with 31 bed each. Some of these hospitals which are located in the remotest areas having 23% bed occupancy, but some hospitals which are nearer to the highways, because of well communication and road accidents the bed occupancy rises to 114%; over all, the bed occupancy of the Health complexes of the country is 52%.

Union health centers are situated in the union with only outpatient department facilities. The Union consists of approximately 9-10 villages which are the smallest administrative unit. There is a plan to establish health centers in each union, but till now 2800 health center have been established, the rest are going to be established soon in phases. These health centers have only out patient department (OPD). Each center is headed by a graduate doctor. Ambulatory patient attends these centers and gets treatment in the OPD. Each union has about 25000 population. Besides these static health centers, there are domiciliary house visits by the health worker who screens minor preventable diseases like Malaria, Diarrhoea, distribution of high potency "Vitamin A capsule", which prevents blindness due to vitamin A deficiency like Xerophthalmia, Keratomalacia.